PRACTICE MAKES PERFECT?
Managing the pressures behind the image of the ‘surgeon in shining armour’
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THE PRESIDENT WRITES…

AN UPDATE FROM MR DECLAN J. MAGEE

Mr Magee reports on a diverse range of issues including the latest phase of the surgical training pathway, the importance of acknowledging the unprecedented pressures faced by the modern surgeon, new developments at the College of Surgeons of East, Central and Southern Africa (COSECSA) and RCSI’s achievement of a top 50 position in the world in terms of International Outlook in the Times Higher Education World University Rankings

SURGICAL TRAINING PATHWAY

The evolution of the new surgical training pathway continues with the implementation of the progression process from ST2 to ST3. This is both an exciting and challenging phase in the development of the process, but the successes achieved to date – including, but not limited to, attracting strong numbers of trainees at intake stage and aligning numbers starting core training with those that go on to specialist training – augurs well for the future. Ultimately, our commitment to the implementation of the surgical training pathway will determine our ability to enhance the consistency of training while ensuring it aligns with the future needs of the health service and continues to attract top medical graduates to a career in surgery.

SURGICAL BURNOUT

Surgeons today are subjected to a range of intensifying pressures. In the first instance, there are the stresses presented in a health arena where there is a constant struggle to find a workable balance between the delivery of optimum healthcare and the limitations brought about by strict cost constraints and scarce resources. At the same time, the practice of surgery is under unprecedented scrutiny, with increasing requirements for documentation and accurate, detailed reporting.

In addition, levels of negligence claims are rising. And, exacerbating all these factors, the individual professional is adding to the strain by striving to match the idealised traits of the ‘all-knowing surgeon’, a problem ably explored by Dr Carol-anne Moulton in the Johnson & Johnson Lecture on Charter Day. RCSI is cognizant of these cumulative pressures and, clearly, the College, as well as all of us as a surgical community, must continue to enhance awareness of surgeon burnout and ensure that we take whatever steps we can to establish support structures to help individual surgeons, while continuing to work towards long-term solutions to the systemic challenges that lie at the root of the problem.

VASCULAR SURGERY

RCSI welcomes the formal recognition by the Medical Council of vascular surgery as a specialty in its own right in Ireland. It is an essential step in facilitating the enhancement of vascular surgery practice with consequent benefits for patient care and enables us to bring our structures here into full alignment with those in vascular surgery in the UK.

This is an important advance in developing reciprocity in vascular surgery training between here and the UK. Of course, it does present challenges for the general surgery rota here, where traditionally vascular surgeons have played an important role. However, the objective will be to counteract any negative impacts in this regard through the full and effective development of the Hospital Network model.

COSECSA DEVELOPMENTS

The College of Surgeons of East, Central and Southern Africa (COSECSA), the body that fosters postgraduate education in surgery and provides surgical training throughout the region of East, Central and Southern Africa, continues to build steadily on previous successes. It is encouraging to see that it is now firmly established as the main training body for 10 countries in the sub-Saharan region: Burundi, Ethiopia, Kenya, Malawi, Mozambique, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe. A number of other applicant countries are currently seeking to join COSECSA.

In an important recent development, COSECSA has signed a memorandum of agreement with the Global Alliance for Surgical, Obstetric, Trauma and Anaesthesia Care – the G4 Alliance. The Alliance, of which RCSI is a member, is dedicated to building political priority for surgical care as part of the global development agenda. Professor Pankaj Jani, secretary general of COSECSA, has been elected vice-chair of the Alliance board of directors. The last few months have also seen a strengthening of resources for the training body with the arrival of the COSECSA Mobile Surgical Skills Unit in Arusha in Tanzania. The unit is equipped with surgical training technology such as Virtual Reality simulators to train surgical trainees in hospitals across five of the 10 COSECSA countries: Kenya, Uganda, Burundi, Rwanda and Tanzania. Ultimately, the intention is to broaden the scope of this initiative to encompass all the countries served by COSECSA. The unit can accommodate 10 surgical trainees at one time and delivers surgical training to world-class standards. The provision of the unit came about as a result of the efforts of the ongoing partnership between RCSI, Irish Aid and COSECSA.

SUDAN ASSOCIATION OF SURGEONS (SAS) 40TH INTERNATIONAL CONFERENCE

In February, I was honoured to attend the Sudan Association of Surgeons 40th International Conference on behalf of Professor WAL MacGowan and RCSI, in order to participate in a tribute to the recently deceased Professor Ahmed Abdel Aziz Yacoub, one of Sudan’s most distinguished surgeons, and to present the history of the Sudan Ireland surgical training connection. Surgical training co-operation between the Sudan and Ireland was initiated by the pioneering efforts of Professor Yacoub and Professor MacGowan. Professor MacGowan was a Lecturer of Surgery at Gordon Medical College Khartoum from 1956 to 1959 and it was then that he recognised Ahmed Abdel Aziz Yacoub as a promising student who went on to become an eminent cardiac surgeon in Khartoum. Their collaboration resulted in more than half of all Sudan’s surgeons training in Ireland and becoming Fellows of our College.

HIGH RANKING

With a noticeably increasing focus on the whole issue of university rankings, it was encouraging to see RCSI ranked in the top 50 institutions in the world in terms of International Outlook in the Times Higher Education World University Rankings announced earlier this year. RCSI was ranked as number 49 in the world. The announcement was made following on from the Times Higher Education World University Rankings in October 2014 which listed RCSI in the top 400 institutions in the world for the first time. The Times Higher Education World University Rankings 2014-2015 lists the best global universities and judges world class universities across all of their core missions – teaching, research, knowledge transfer and international outlook. The ‘International Outlook’ sub-category gives recognition to universities for international students and staff, as well as research publications with international partners.
The image of the all-knowing, autonomous surgeon is one that persists inside and outside the surgical profession. During a recent visit to RCSI to deliver the Johnson & Johnson Lecture entitled The Vulnerability of the Surgeon in Shining Armour, Dr Carol-anne Moulton spoke to Surgical Scope about the idealisation of the surgeon and the resulting implications for patients and surgeons themselves.

Dr Moulton, a staff surgeon at the University of Toronto, has been researching surgical culture and behaviour for a decade. Her work has looked at a range of issues including the teaching of surgical skills, and surgeons’ emotional reactions to adverse events, as well as the impacts of surgeons’ image management strategies on their patients and themselves. She has employed a qualitative research methodology in her work to uncover the attitudes, vulnerabilities and insecurities that exist behind the image: “It’s important that the research approach aligns with the type of questions being asked. A qualitative approach allows you to explore naturalistic data, the ‘how’ and ‘why’ type questions. In studying the impact of surgical culture within the operating theatre, it’s particularly useful for addressing questions such as, for instance, how do surgeons slow down when they should?”

DONNING THE SURGEON’S ‘ARMOUR’

Dr Moulton acknowledges that the image of the surgeon is changing: “Newer generations of surgeons are questioning old constructs. There is certainly a move away from the notion of the autonomous surgeon and a greater realisation of the importance of being part of a team. However, it is also evident that the idea of the all-knowing surgeon remains prevalent and continues to strongly influence perceptions and behaviours within the profession and among the wider public.”

And, to some extent, the surgeon is responsible for this: “The individual surgeon tends to adopt a front and consciously works to manage her or his image, presenting themselves to the world in a way that conveys assurance and authority.”

But the individual is only part of a wider environment – the social context encompassing the profession – including work practice, education and training, and social interactions in general. The existing surgical culture reinforces the surgeon’s image as a heroic figure, the invincible ‘knight in shining armour’, according to Dr Moulton: “The idealised image is embedded in the day-to-day communication that takes place between surgeons, when they are chatting with or about colleagues, or comparing their profession with others. It’s in this kind of minutiae that strong messages about the ideal surgeon are conveyed.”

From when training begins, young surgeons become aware of, and internalise, expectations to which they must ‘measure up’. This training is not necessarily overt, according to Dr Moulton, but is implicit in the everyday interactions and attitudes of trainers and trainees, and is part of what she calls the hidden curriculum. “Trainees learn to display certainty, confidence and autonomy because they perceive that the demonstration of these traits will help them learn more and progress in their field. The image of the confident, autonomous surgeon is constructed as the individual adopts the social performance that is seen to be accepted and admired within the particular surgical, cultural context.”

Through multiple exchanges and interactions, the individual builds a framework of the qualities that she or he ‘should’ embody as a surgeon. “Trainees can observe a trainer or senior surgeon’s behaviour and pick up implicit messages. Trainees view the quality of their training as being largely dependent on perceptions of their ability. From this standpoint, therefore, it is apparent to them that the more they meet expectations, the more likely they are to have access to additional learning opportunities and patient responsibilities. From the trainee’s perspective, this places a priority on maintaining an image of competence and ability, even if this means attempting to camouflage weaknesses.”

IMPLICATIONS FOR THE PATIENT AND THE SURGEON

However, Dr Moulton points out, in the high pressure, crucible-like context of the operating theatre, living up to an image of consistent certainty has far-reaching implications for patient safety, as well as the
health of surgeons and their ability to learn. “The pressures created by a surgical culture and setting that promotes the image of the idealised surgeon must ultimately impact on operative decision-making. In particular, there is the question of what effect the idealised image has on the surgeon’s ability to respond to unexpected, critical moments in operations. If a surgeon is experiencing a difficulty during an operation, the commitment to presenting an ideal image can create resistance to asking for help when, in fact, it is most needed.”

In terms of the surgeon’s own health, she adds, measuring up to an ideal creates significant pressures: “Where someone is constantly managing an image and keeping up a front, burnout is a real danger. In an environment where everyone seems to be doubt-free, the individual who is experiencing difficulties can feel isolated and is likely to respond negatively to complaints and errors. The constant awareness of the need to convey a particular image intensifies and adds to existing pressures.”

Surgical culture can also create difficulties for learning at any stage of a surgical career: “Lifelong learning is an essential element of surgical practice, but image-led pressures within the social surgical setting can actively stop us from being the best that we can be. An over-awareness of being evaluated by others can fuel anxieties, create a reluctance to ask questions for fear of appearing ill-informed and encourage avoidance of dealing with techniques or areas we’re uncomfortable with.”

“While surgeons acknowledge the importance of working on technical weaknesses to enhance skills, there is a reluctance to seek help in this regard or to be coached. In many instances, surgeons perceive looking for help or coaching as diminishing their perceived autonomy and their authority (see quote 3, panel 1). They see these actions being perceived as signs of weakness or lack of ability.”

Finding ways to negotiate the issues surrounding image management is not easy, Dr Moulton notes: “We can’t simply demand surgeons drop their ‘armour’. That wouldn’t work. And making an individual feel vulnerable and exposed will create its own problems. The first constructive step is for the surgical community to talk more openly about these issues. We need to talk about the reality of the problems surrounding the idealised image. In addition, we need to take the conversation forward to address what happens when the armour is removed and what the positive and negative consequences of doing that are. If we can increasingly recognise and acknowledge the effort involved in sustaining an unreal image and the negative impact it has on patients and surgeons, we can, crucially, help surgeons to respond more effectively to pressures and prevent surgical error.”

**DR CAROL-ANNE MOULTON**

An Associate Professor and Staff Surgeon at the Department of Surgery, University of Toronto, Dr Moulton gave the Johnson & Johnson Lecture at this year’s RCSI Charter Day. Dr Moulton graduated from the University of Melbourne, in Australia, in 1992 and completed general surgical training earning certification from the Royal Australasian College of Surgeons in 2001. She undertook several Fellowships including: a Fellowship in Upper Gastrointestinal and Laparoscopic Surgery at St Vincent’s Hospital in Melbourne, a Fellowship in Hepato-Pancreatico-Biliary (HPB) Surgery at Toronto General Hospital, and a Medical Education Fellowship at the University of Toronto, earning a Master’s of Higher Education in 2006 and a PhD in Education in 2010. Also in 2010, Dr Moulton became a Scientist at the University of Toronto Donald R. Wilson Centre for Research in Education. Dr Moulton’s research interests include the psycho-sociological considerations of surgical judgment and surgeon error. She is the recipient of the Early Researcher Award from the Ministry of Research and Innovation in Canada. Her research has been supported by the Medical Council of Canada, the Royal College of Physicians and Surgeons of Canada, and Physicians’ Services Incorporated.
MAPPING NEW DIRECTIONS IN ORTHOPAEDIC SURGICAL TRAINING

ONE OF THE PARALLEL SESSIONS WHICH TOOK PLACE ON CHARTER DAY, FRIDAY, FEBRUARY 7 FOCUSED ON ORTHOPAEDIC SURGERY, TRAINING AND INNOVATION. SURGICAL SCOPE REPORTS ON A SELECTION OF PRESENTATIONS FROM THE SESSION

Dr James Purtill, Orthopaedic Residency Program Director, Thomas Jefferson University, Philadelphia gave two presentations opening and closing the session. In his first contribution he discussed the North American experience of training the orthopaedic surgeon. He began by outlining the selection process in the US.

INTENSE COMPETITION

There has been an increasing number of medical student applications in recent years as a result of a combination of factors: an overall population increase, the Affordable Care Act (Obama Care), the opening of new medical schools and expanded enrolment. At the same time, there has not been an increase in graduate training positions, with the resultant intensification of competition for residency positions. There are 161 Accreditation Council for Graduate Medical Education (ACGME) accredited orthopedic training programs in the US with 695 orthopaedic residency positions per year. There is no limit to the number of applications residents can file but there is an incremental increase in cost for each application above 30 (not a deterrent, he notes). The National Resident Matching Program (NRMP) match process is a computerised mathematical algorithm that aligns the preferences of applicants with the preferences of the residency program.

Dr Purtill used his experience at Thomas Jefferson University Hospital (TJUH) to provide an insight into the application review process. In the sample year Dr Purtill looked at, TJUH received 800 applications for its six residency positions. Applications are screened for USMLE (US Medical Licensing Examination) scores, class rank, grades and research. The faculty review and rank the applications that pass this screening process. Then, 80 applicants are interviewed and the faculty does the final ranking.

Moving on to training of residents, he explained that residents rotate on each of the subspecialty rotations twice: as a junior resident and as an upper level resident. The resident has graduated autonomy but is never fully independent and is always under faculty supervision. Residents see patients in clinic, operate on patients, follow them in the hospital, see them in the ER and see them in post-op clinic. TJUH values continuity in the patient care experience, he added. Resident training is run as a preceptorship. Residents work with one or two faculties at a time and follow them to all practice settings. The ACGME recently instituted the NAS, the Next Accreditation System for the 21st century. In broad terms, it is a continuous accreditation system with an annual accreditation data system update (ADS) and encompasses among other criteria, the scholarly activity of faculty and residents; clinical experience (case logs), a 10-year, in-depth self study; semi-annual resident evaluation that entails assessment across six core competencies at the end of each rotation, with 360-degree reviews and the monitoring of 45 milestones by a clinical competence committee; and assessment by an annual program evaluation committee. Dr Purtill summed up the continuous accreditation through the ADS as “enormously time-consuming, logistically difficult and the largest challenge has been to get faculty and residents to fully integrate the new requirements into their daily lives.” Its introduction, he says, has been in response to increased public and political pressure for error reduction, improved patient safety and quality of care improvement. While it is early in the process, he commented, it is not clear that these comprehensive changes have had any effect other than increasing the administrative workload.

American Board of Orthopedic Surgery “Board certification” is the ultimate goal after successful completion of five years of orthopedic training, obtaining program director approval, completing minimum case numbers and passing a two-part examination.

CHALLENGES IN TRAINING

In the second of his two presentations, Dr Purtill outlined what he sees as the overall challenges in training orthopaedic surgeons in the US. They include:

- maintaining accreditation with ACGME;
- running a large number of fellowships and residency, and assuring education without interference; and,
- the lack of remedial training.

In regard to the latter, he said there are no remedial training programs and there is no time in the schedule to provide remedial training. Furthermore, he said, the wide use of physician extenders diminishes the resident’s clinical experience and this adversely affects the resident’s skill development. In addition, resident’s work hour restrictions have led to reduced experience and less time to train. There is also a loss of the ability for the resident to follow patients through the continuity of care that is so important for understanding certain patient diseases. The medical education process is effectively an apprenticeship, he said. This process clearly works, but hasn’t changed and is not evidence-
based. We practice evidence-based medicine but not evidence-based education, he said. In conclusion, he noted that developing innovative training methods remains one of the biggest challenges.

A GOOD TRAINER
Mr Gerry McCoy, Trauma and Orthopaedic Surgeon at University Hospital Waterford discussed what makes a good trainer. To answer that question, he looked back at his own training in orthopaedic surgery in Belfast in the eighties. Mr McCoy spent three years as Registrar (including a year of research) and five years as a Senior Registrar (including a year as senior registrar in Oxford). In the eighties there was a heavy caseload and extensive training hours. It was usual to have more than 1,000 cases as principle operator every year. The decade saw the launch of innovative new products and advances in fracture management and there were close working relationships with the SHO and Registrar colleagues.

However, there were disadvantages to training in this system, Mr McCoy said. Frequently, there was an absence of formal training from senior consultants and a complete absence of any structure to training. There was no limit to the number of hours worked per week/month. Based on that experience, he offered his view of what makes a good trainer. The first rule for a good trainer, he said is – be there! The consultant being present in theatre greatly increases the efficiency of the list. Have the patience to show your trainee how you do surgery and teach them your tips and tricks (but perhaps not all of them!). He emphasises that it was important to communicate clearly. He advised getting involved in formal teaching, which he said is beneficial both to trainees and trainers. Good trainers should facilitate research and publication and it is important to remember it is not a master/servant relationship – your trainees are your colleagues. Finally, he noted, training is not a one-way street. In receiving appropriate training, the trainee has a responsibility to the patients and the service.

PUBLISHING RESEARCH
Professor Timothy M. O’Brien, Cappagh National Orthopaedic Hospital and Central Remedial Clinic, Clontarf, Dublin, spoke on the topic of research publication. He emphasised the important role that publication of research plays in training and outlined the publication process. As an example of a research project, he provided an overview of research into the causes of accidental falls by flip flop wearers and an investigation into the role of the footwear in these accidents. A total of 15 volunteers took part in a 3D gait analysis study which concluded that while flip flops are suitable beachwear, they are not appropriate over broken and uneven surfaces and should be avoided if drinking alcohol.

SIMULATION IN SURGICAL TRAINING
Professor Kevin Mulhall of the Mater Misericordiae University Hospital, Dublin spoke on the use of simulation in surgical training. Simulation is an important resource at a time of extensive changes in surgical training including the introduction of the European Working Time Directive, he noted. Orthopaedic surgeons have been long-standing proponents of simulation as it allows skills to be practiced safely in a controlled environment and minimises patient risk. Professor Mulhall provided an overview of the different types of surgical simulation, including:

- cadaveric;
- synthetic models;
- bench models;
- robotic;
- cognitive; and,
- virtual reality.

He outlined the advantages and disadvantages of each and suggested that we may be seeing the beginning of a new training paradigm transforming the old pattern of ‘see one, do one and teach one’. In the new paradigm, the trainee will:

- see;
- cognitively simulate;
- virtually plan;
- surgically simulate; and
- carry out a procedure.

Simulation will have an increasingly relevant and evolving role in surgical training, Professor Mulhall predicted, although it is not yet able to recreate all components of surgery.
Optimum care for the multiply-injured patient – being both time-critical and spanning pre-hospital care through acute and rehabilitation care to ongoing care in the community – presents particular challenges to any health service.

WHY CHANGE IS NEEDED

Mr Paddy Kenny of Cappagh National Orthopaedic Hospital, Dublin and joint National Lead, National Clinical Programme in Trauma and Orthopaedic Surgery, believes the current system needs to be changed. He cites four primary reasons why change is necessary: to provide improved quality of care for trauma patients; to achieve optimisation of outcomes; to ensure more efficient use of resources including staff and facilities; and to save lives.

Mr Kenny outlined the overall framework for a major trauma network which would consist of an organised group of services and personnel, who would serve a defined population and aim to reduce death and disability following injury. Provision would have to be made to provide for the rapid and safe transfer of each major trauma patient to the hospital which could manage the definitive care of the patient’s particular injuries, either directly or by expedited inter-hospital transfer.

Having a major trauma network results in a range of positive benefits, Mr Kenny stated. They include:

- mortality rates associated with major trauma are reduced;
- patient outcomes are improved (a study by the National Audit Office in the UK estimated that 400 to 600 lives could be saved per year in England);
- long term disability is reduced; and
- patients have an improved ability to return to work and undertake recreational activities.

In relation to ambulance journey times for major trauma patients, Mr Kenny pointed to a key finding (from the National Audit Office Report, Major Trauma Care in England, 2010) that says specialist treatment at a major trauma centre has a greater impact than journey time on medical outcomes and increase survival rates by up to 20%.

Major trauma networks will facilitate the establishment of more effective clinical teams, Mr Kenny added, and will make more effective use of available resources, making major trauma centres and trauma units more sustainable. Mr Kenny concluded by stating that no hospitals should close as a result of a major trauma network launch, nor did he foresee the introduction of major trauma networks leading to reductions in Emergency Department (ED) services. EDs, he said,
will continue to receive patients that need urgent treatment, but do not require specialist services.

TRAUMA SERVICE PROVISION: EXAMPLE 1
In assessing the challenges presented by the management of major trauma from a general hospital perspective, Mr Tariq Cheema of the Cavan/Monaghan Hospital Group is well-placed to present an informative overview. Cavan General Hospital (CGH) delivers 24/7 emergency, surgical, obstetrics and gynaecology services while Monaghan Hospital (MH) provides day surgery, endoscopy, outpatients services and a minor injury unit. In 2014, CGH was the best performing ED in the country with an average of 0.9 patients waiting (trolley count) per day. Mr Cheema outlined the trauma service priorities: Mr Cheema shared the Trauma Audit and Research Network (TARN) data for CGH for the period from October 2014 to December 2014. It showed that of a total of 122 patients, 40 were treated in CGH, 64 transferred to OLOL, 14 transferred to Dublin and four were dead on arrival. CGH's role in trauma management encompasses initial assessment, resuscitation, stabilisation, monitoring, treatment and rehabilitation. In addition, CGH has the capability to manage abdominal visceral injuries and provide observation of stable head injuries and those not for intervention as advised by neurosurgical team. CGH can also provide care for selective paediatrics trauma patients and for chest trauma requiring chest drain/observation, including ribs and sternum fractures. For services that CGH does not have on site, rapid transfer to another facility is provided: for instance, orthopaedics/spinal patient to OLOL; neurosurgery patients to Beaumont, plastics/burns patients to St James's; and vascular patients to Beaumont/Mater. Particular challenges he said were presented by:

- patients with multiple injuries, requiring services at a number of different hospitals;
- paediatric trauma; and
- availability of resources and expertise.

A key issue, he said, is that in too many instances, major trauma patients are brought to hospitals with inadequate resources and/or expertise to deliver safe, high quality trauma care.

TRAUMA SERVICE PROVISION: EXAMPLE 2
Mr Shane Guerin provided a perspective on trauma services at Cork University Hospital (CUH). He shared some statistics from CUH's annual trauma demographics: out of 4,400 trauma related admissions in one year, 2,000 were orthopaedic admissions, 45% were under 65 years of age and 420 were hip fractures. CUH’s trauma services include pre-hospital care, emergency medicine and radiology, and a comprehensive range of specialties including anaesthetics/ICU, vascular, neurosurgery and cardiothoracics, as well as rehabilitation. CUH faced a number of challenges in coping with trauma care requirements, he explained. For example in relation to its Emergency Medicine Services, it has a total of 4.5 whole time equivalent emergency consultants with on-site presence restricted to 8am to 8pm. The current emergency department while only 10 years old, does not have a CT scanner and there are difficulties in recruiting NCHDs. However, overall, he concluded that CUH is uniquely positioned in the availability of specialties on site and that efforts to improve trauma service are slowly coming to fruition. He said that trauma audit will be important in guiding planning for the future. Overall, he said that CUH needs to strive to attain Level 1 trauma centre status with the objective of working cohesively within a properly organised national trauma service. Finally, he warned that trauma needs to be appropriately funded.

WHERE SHOULD WE BE?
Mr Morgan P McMonagle, University Hospital Waterford spoke about what a trauma system should or could look like. The structure he outlined consisted of an overall trauma system that, as described by Mr McMonagle, would cover a large area, either regional or national (both urban and rural) and would provide evidence-based trauma care based on a public health model. It would include additional related services such as ambulances, pre-hospital care, aeromedical retrieval, rehabilitation facilities, research, public health, education and governance for the whole system. A number of trauma networks would operate within this overall system consisting of groups of intrinsically-linked hospitals and services providing ‘hub and spoke’ models of care. Care responsibilities would be protocol-driven and there would be a single, primary major trauma centre. The major trauma centre should be a specialist trauma hospital, he noted, not a collection of specialists under one roof. The hospital should specialise in the care of the severely injured and its services should encompass all aspects of that care, including prevention, pre-hospital, acute management, operative management, critical care, rehabilitation and follow-up. Looking at the basic components of the trauma network, he discussed the shape of a trauma department within a hospital and what a trauma team should consist of. The department, he said, should be a defined trauma faculty within a hospital under the leadership of a trauma director. The trauma team, under a trauma team leader, would be available 24/7 and would be trauma-centric with personnel specifically skilled and dedicated to care for the severely injured.

WHERE ARE WE NOW?
Dr Conor Deasy, Consultant in Emergency Medicine, CUH and Clinical Lead, Major Trauma Audit, National Office for Clinical Audit outlined the fundamental role of performance measurement in facilitating the development of trauma care. Quoting WE Deming, he commented: “You can't manage what you don't measure.” Performance measurement through a trauma registry/audit was a prerequisite for meaningful progress in enhancing trauma care, he said, and can help in the development of strategy and in the measurement of change impact. In that context, he said the Major Trauma Audit (MTA) is the equivalent of a flight control panel for the trauma system. He outlined the roles of the MTA as follows:

- monitoring and setting a benchmark for care;
- monitoring compliance with best practice/evidence based guidelines;
- monitoring equity of access;
- providing feedback; and,
- stimulating competition.

TRAUMA – THE NEGLECTED DISEASE

- 5.8 million people per year die of injury globally
- Leading cause of death among those under forty
- More productive years of life are lost to traumatic injury than heart disease and cancer combined
- Trauma patients 15-20% less likely to die if admitted to a trauma centre within an organised trauma system (Geho et al, A systematic review and meta-analysis comparing outcome of severely injured patients treated in trauma centres, J Trauma. 2006)

DEFINITITIVE CARE FOR TRAUMA PATIENTS
A PASSION FOR LEARNING

AN INTERVIEW WITH PROFESSOR PIERCE GRACE, ADJUNCT PROFESSOR OF SURGICAL SCIENCE, UNIVERSITY OF LIMERICK, WHO GAVE THE RECENT BOSCO O’MAHONY LECTURE ON THE TOPIC OF LIFELONG LEARNING

SURGICAL SCOPE: COULD YOU SHARE AN OVERVIEW OF YOUR WORK WITH UL HOSPITALS AND YOUR EXPECTATIONS FOR THE HOSPITAL NETWORK MODEL?

PROFESSOR GRACE: I was appointed to Limerick Regional Hospital in 1996 as a general/vascular surgeon. Since then the hospital has been transformed culminating in the creation of the UL Hospitals Group in 2013. Change involved improving the physical structure of the hospitals, reconfiguring the services across the region and amalgamating six hospitals into one functioning unit while maintaining a quality service. I fully supported all these developments and was an early adopter for performing day and short stay surgery in our Model 2(5) hospitals. I also embraced enthusiastically the ‘surgeon of the week’ concept for the provision of emergency surgery at University Hospital Limerick (UHL). As Chief Clinical Director (2012/14), I was part of the management team that brought the UL Hospital Group into existence. I believe the hospital network concept is right for Ireland but I would like to see much more autonomy given to the groups to evolve locally within guidelines laid down centrally. While there is a great opportunity to provide surgery/investigations in the Model 2 hospitals, their role in medicine is less certain; most medical patients seem to need either within guidelines laid down centrally. While there is a great opportunity to provide surgery/investigations in the Model 2 hospitals, their role in medicine is less certain; most medical patients seem to need either sophisticated Model 3/4 services or to be at home. The private hospitals should also be associated with the networks so that their extremely valuable resources could be utilised for the benefit of all.

Q: WHAT WOULD YOU CONSIDER AS TWO PERSONAL HIGHLIGHTS FROM YOUR DISTINGUISHED CAREER?

A: The first has to be the founding of the Graduate Entry Medical School (GEMS) at the University of Limerick (UL) in 2007. It was always my ambition to have a medical school at UL. While I was not directly involved in setting up GEMS, my position as the first UL Adjunct Professor in a medical discipline gave me the opportunity to promote the idea among colleagues in the hospital and the university. The tipping point came when the university, in response to the Fotrell and Buttimer Reports, appointed Professor Paul Finucane to lead its bid to government for a graduate-entry medical school and the rest is history. The school is now firmly established and has had a huge and positive impact on the health services of the Midwest. Another highlight was being a member of the team led by Professor David Bouchier-Hayes that brought laparoscopic cholecystectomy to Ireland in 1989. Laparoscopic surgery is now standard practice in Irish hospitals but it all started in 1989 when we did the first ‘lap chole’ for a young woman with gallstone pancreatitis in Beaumont. We spent the next two years training people in the procedure and travelling around Ireland and Britain proctoring surgeons with their first cases. It was an exciting time and the start of an innovative surgical revolution that has transformed Irish surgery for the benefit of patients.

Q: IN YOUR RECENT BOSCO O’MAHONY LECTURE, YOU DREW A DISTINCTION BETWEEN EDUCATION AND LEARNING. COULD YOU EXPLAIN THIS DISTINCTION AS YOU SEE IT?

A: This distinction comes from Joi Ito who is director of MIT Media Lab, an interdisciplinary research facility at MIT that brings together technology, multimedia, sciences, art and design. According to Ito, education is ‘what others do to you’ and learning is ‘what you do for yourself’. Both have their roles; the former provides a foundation and the latter allows us to cope with our constantly changing lives. Arguably, learning is more important than education and continues throughout life. Many of the graduate medical programmes are based on the principle of self-directed learning, accepting that much of what is learned will change over the lifetime of the graduate.

Q: IN THE LECTURE YOU RAISED AN INTERESTING POINT ABOUT “LEARNING HOW TO LEARN”. COULD YOU OUTLINE WHAT THIS MEANS?

A: There is so much information available now, and in such a variety of formats, that people need skill in accessing material and judging its quality. Modern surgery is very technological and to provide a state-of-the-art service surgeons must learn to embrace new technology or be left behind. These are examples of ‘learning to learn’. Increasingly surgery is a team activity and people who are isolated and working alone will have difficulty in keeping up-to-date or even realising that they are not current in the first instance.

Q: OVERALL, WHAT WOULD BE YOUR FIVE TOP TIPS FOR SURGEONS IN RELATION TO MANAGING LIFELONG LEARNING?

- be organised;
- be a team player;
- learn from your juniors;
- use information technology; and
- take time for reflection

Q: ON A NON-SURGICAL TOPIC, WHAT ARE THE ROOTS OF YOUR PASSION FOR HISTORY?

A: I have had a deep interest in history all my life. My grandmother was a significant influence. When she was a young girl in the 1890s she met a woman who had attended the ball in Brussels the night before the Battle of Waterloo in 1815. I later discovered that this was Lady Louisa Tighe from Inistioge whose mother, the Duchess of Richmond, hosted the ball. I think it amazing that I knew someone who knew someone who remembered the events of 200 years ago. Over the years I have read, talked and written extensively about history and, for me, it provides an absorbing insight into human behaviour. In 2010, I underpinned my interest with an MA in local history resulting in the publication later this year of a book entitled The Middle Class of Callan, 1825-45, part of the Maynooth Local History Series. I am very proud of this little book.
Mr Lars Nölke's presentation at the RCSI Charter Day Meeting 2015 featured a history of paediatric cardiac services north and south of the border; a synopsis of the work done to date on the development of a single all-Ireland programme; and an outline of the possible scope and make-up of such a programme.

In Our Lady's Children's Hospital, Crumlin (OLCHC), congenital cardiac surgery commenced in 1978, while in Royal Victoria Hospital (RVH) in Belfast, congenital cardiac surgery began in 1968, Mr Nölke said.

As of 2010, OLCHC had three surgeons, five cardiologists (including grown-up congenital heart [GUCH] disease), 11 anaesthetists, four to five operating days per week, and saw 550-580 cases per year; while RVH had one surgeon (now retired), four cardiologists and three GUCH, two anaesthetists, and saw 100-120 cases per year.

Highlighting the tragic events at Bristol Royal Infirmary in the UK in the 1990s, Mr Nölke said: “The report of the public inquiry into children’s heart surgery at the Bristol Royal Infirmary 1984-1995 gave some guidance in terms of structures within the congenital cardiac services.” To ensure hospitals maintain best standards and benchmark performance, Mr Nölke stressed the importance of ongoing audit.

“In 2015 OLCHC is still very actively involved in international audit. We submit surgical data to the National Institute for Cardiovascular Outcomes Research in the UK, which allows us to compare ourselves with the UK.”

“Here’s also an intensive care audit. All OLCHC intensive care patients’ outcomes go to the Paediatric Intensive Care Audit Network and extra-corporeal life support (ECLS) is also audited.”

CENTRALISING SERVICES

Mr Nölke reviewed the evidence for centralisation, which included data from California, where better outcomes were reported in high-volume centres; from Sweden, where mortality reduced from 9.5% to 1.9% when the number of centres decreased from four to two; and from the US, where there was a 34% difference in mortality between centres performing more than 125 cases a year and centres performing fewer than 40 cases, especially for arterial switch and atioventricular septal defect repairs. “With more volume, it’s not just about the surgeon operating, it’s about the whole team. It’s about the anaesthetist, the theatre staff, the ICU care and the support services.” So, what does the ideal programme look like? “The optimal structure of a congenital heart surgery department in Europe, as determined by the European Association for Cardiothoracic Surgery heart disease committee in 2003, would consist of three surgeons, performing 375 major cases per year (125 per surgeon), with 250 cases per operating room and extracorporeal life support (ECLS).”

A safe and sustainable review in the UK in 2010 recommended fewer units in the UK, though this did not look at Scotland or Northern Ireland. The UK recommended structure is likely to be four surgeons and over 400 cardiopulmonary bypass cases per year.

‘ABSOLUTE SENSE’

Having one programme rather than two in Ireland would make “absolute sense”, Mr Nölke said. He explained that, in 2006, discussions took place between surgeons and cardiologists to advance the idea of a single all-Ireland service. “We asked: how do we get the two programmes to work as one programme?” Since then there have been multiple reviews, the most recent of which was the report of the International Working Group on the Assessment of Cardiology and Cardiac Surgery for Congenital Heart Disease in Northern Ireland and the Republic of Ireland in 2014, whose recommendations included: an all-island governance committee; a central database for all Ireland; staff flow between jurisdictions; expansion and upgrade of telemedicine links; integration of Clinical Nurse Specialist and Advanced Nurse Practitioner activities in Belfast and Dublin; upgrade of paediatric and neonatal transport services; possible mobile ECLS with enhanced transport services in Ireland; and an all-island symposium on congenital heart disease management.

Mr Nölke said there is now recognition that transport between Ireland north and south is easier than transporting to the UK; that there is an option of delivering complex neonates in Dublin; that medical teams can now move between the institutions; and that training programmes for medical and nursing staff can be maintained. Technical proficiency, volume, audit, modern facilities and equipment, and teamwork are components of a world-class paediatric cardiac programme, Mr Nölke said. The challenges ahead include addressing capacity problems in OLCHC, consultant recruitment, changing the focus of audit from mortality to developmental outcome, and operation of a common waiting list.
PAN-EUROPEAN QUALITY REGISTRY WILL IMPROVE PATIENT OUTCOMES AND STRENGTHEN PRACTICE

ATTENDEES AT THE 2015 RCSI CHARTER DAY MEETING HEARD THAT PAN-EUROPEAN NETWORKS IN MEDICAL SPECIALTIES, PARTICULARLY THOSE CONCERNED WITH RARE DIAGNOSES, WILL IMPROVE PATIENT OUTCOMES AND STRENGTHEN PRACTICE

Eurocrine is a pan-European registry for quality control and clinical research in endocrine surgery. The registry gathers knowledge and identifies best practice regarding rare endocrine tumours by collecting and sharing data on performed treatment and medical performance. It has a particular focus on rare diagnoses. Professor Anders Bergenfelz, professor of practical medical education and consultant surgeon in endocrine and sarcoma surgery, Lund University, and Skåne University Hospital, Sweden, is the Eurocrine project leader. He shared his experiences with attendees at the Innovations in Surgery session at the 2015 RCSI Charter Day.

Professor Bergenfelz explained that quality specialist medical registries are common in Sweden, where they have specific legal status. He initiated the Scandinavian Quality Register for Thyroid, Parathyroid and Adrenal Surgery (SQRTPA) in 2004. Among the lessons learned from SQRTPA, he said, were that "complications in thyroid, parathyroid and adrenal surgery are not uncommon; that outcomes could be better; and that collaboration is of paramount importance".

STRONG SUPPORT

Based on these findings, Professor Bergenfelz and colleagues started networking in Europe to establish a pan-European registry and apply to the European Union Health Programme. "We had strong support from the European Society of Endocrine Surgeons and we secured 40 per cent of the co-financing for this project via one of the healthcare regions in Sweden, Skåne," he explained.

Eurocrine’s application to the Health Programme was successful in 2012. It has a budget of €1.2m, of which EU funding accounts for 60 per cent. It is scheduled to run over 39 months, from September 2013 to November 2106. Skåne University Hospital is the project main partner and is responsible for the technical and financial management of the project. The project has multiple partners and collaborators, including the European Society of Endocrine Surgeons and the British Association of Endocrine and Thyroid Surgeons.

"Together, the collaborators and the partners cover a great part of the European continent," Professor Bergenfelz said. "The benefits of the Eurocrine registry are the ability to identify best practice, to benchmark performance, to stratify outcome data and to avail of opportunities for research.”

In terms of functionality, Professor Bergenfelz outlined a number of key attributes of the registry, including real-time access; easy registration; the capacity for partners to define variables; to generate their own surveys; dashboard reporting; a statistics module; and the ability to export data. There are three types of variables permitted in the registry. These are the core variables, which are obligatory and which all partners have agreed upon; the extended variables for partners, which may be country or partner-specific; and the variables for uncommon tumours, including medullary thyroid cancer, anaplastic thyroid cancer, parathyroid cancer, adrenocortical cancer, malignant phaeocromocytoma, paraganglioma, and GEP-NET.

EUROCRINE INTERFACE

Professor Bergenfelz displayed screenshots of the Eurocrine interface for attendees, including the login page and the dashboard, which displays the number and type of operations registered. “You can see how many operations per month you register, either by department, or by country, or the total all across Europe. You can also see the waiting time for operations after the decision is made to operate – how long you’re on the waiting list before the actual operation – and also the length of hospital stay.”

Professor Bergenfelz highlighted the importance of Article 12 of Directive 2011/24/EU on the application of patients’ rights in cross-border healthcare, which states that the European Commission should support Member States in the development of European reference networks (ERNs) between healthcare providers and centres of expertise in the Member States, in particular in the area of rare diseases. The Directive states that ERNs: “can improve the access to diagnosis and the provision of high-quality healthcare to all patients who have conditions requiring a particular concentration of resources or expertise, and could also be focal points for medical training and research, information dissemination and evaluation, especially for rare diseases.”

"The bottom line," Professor Bergenfelz said, "is that European leaders should create ERNs and they should specifically aim for specialised healthcare services.”

The process for the formation of ERNs is underway, with a call for networks currently expected in the fourth quarter of 2015 and the establishment of networks set for the second quarter of 2016.

In conclusion, Professor Bergenfelz told the RCSI Charter Day audience that the Eurocrine database represents a leap forward for European endocrine surgery, that it will strengthen endocrine surgery as a specialty, and that patients will benefit. “It’s the right thing to do,” he said.
Dr James Kinross PhD FRCS, a colorectal surgeon at Imperial College London (ICL), treated attendees at the RCSI Charter Day 2015 to an overview of some cutting-edge technology being pioneered at ICL, in his presentation entitled Surgical Systems Biology: from the iKnife to Augmented Histology. Dr Kinross highlighted the growing prominence of precision medicine, citing a significant recent announcement by US President Barack Obama, who, in his January 2015 State of the Union address, announced the launch of a new $215m precision medicine initiative in the US.

EMERGING APPROACH
Precision medicine is an emerging approach for disease treatment and prevention that takes into account individual variability in genes, environment, and lifestyle for each person. “Personalised medicine is about getting the right care to the right patient at the right time and precision medicine is really a variation on this theme,” Dr Kinross said.

Dr Kinross outlined the importance of metabolomics and gene-environment interactions, stressing that studying the phenome, metabolic phenotyping and phenome centres are integral to much of the work being carried out in this area at ICL.

He defined the phenome in two ways: firstly, in analytical terms, as “an integrated set of measurable physical and clinical features coupled to chemical, metabolic and physiological properties that define biological sub-classes”; and secondly, in philosophical terms, as “the direct product of gene-environment interactions on an individual or group operating throughout development and life – a dynamic property.”

“Increasingly in my laboratory we talk about the phenome,” he commented, “which is effectively a chemical expression of the sum of your gene-environment interactions. The critical thing about it is that it’s highly individualised and it’s dynamic. You can follow it and you can track it through time.

“At ICL we have two phenome laboratories: the NIHR-MRC national phenome centre, which aims to deliver broad access to a world-class capability in metabolic phenotyping; and the Imperial Clinical Phenome Centre, which is more translational.”

Dr Kinross gave attendees an insight into the concept of profiling, explaining that local perturbations lead to global changes in any highly interconnected system, and that the pattern of global changes is informative about the nature, location, progression, and level of the perturbation.

REIMS
Dr Kinross said there is a need for a rapid, reliable method for real-time tissue identification within the operating theatre – which is met by the intelligent knife, or iKnife.

The iKnife can tell surgeons whether the tissue they are cutting is cancerous or not. It is based on electrosurgery, a technology invented in the 1920s that is commonly used today. Electrosurgical knives use an electrical current to rapidly heat tissue, cutting through it while minimising blood loss. In doing so, they vaporize the tissue, creating ‘smoke’ that is normally sucked away by extraction systems.

The full name of the technology is rapid evaporative ionisation mass spectrometry (REIMS). REIMS is an emerging technique that allows near-real-time characterisation of human tissue in vivo by analysis of the aerosol (smoke) released during electrosurgical dissection. The iKnife couples REIMS technology with electrosurgery for tissue diagnostics. Its inventor, Dr Zoltan Takats, is also based at ICL.

Dr Kinross told RCSI Charter Day attendees about other applications for REIMS technology, such as mapping the colon with the iEndoscope, which provides for prospective ex-vivo observational analysis of tissue samples via the development of an endoscopic set-up adapted for REIMS analysis.

REIMS microbiology allows identification of bacteria, while DESI MSI – spatially resolved MS imaging – allows visualisation of the tumour environment and systematic data collection in cases such as colorectal adenocarcinoma.

“REIMS technology provides a novel way of looking at human tissues and bacterial cells, and is potentially an effective tool to study host-microbiome interactions, providing for histopathology and microbial community analysis in a parallel fashion with the simple addition of mass spectrometry to electrosurgery,” Dr Kinross concluded.
A SURGEON WITH A MISSION

UAE’S FIRST FEMALE SURGEON AND A RECIPIENT OF THE ARAB WOMAN’S AWARD FOR MEDICINE, DR HOURIYA KAZIM WAS RECENTLY HONOURED BY INCLUSION IN THE ONE HUNDRED.ORG, MASSACHUSETTS GENERAL HOSPITAL CANCER CENTER’S FUNDRAISING AND AWARENESS INITIATIVE TO CELEBRATE INDIVIDUALS AND GROUPS WHOSE COMMITMENT TO THE FIGHT AGAINST CANCER INSPIRES OTHERS. SHE SPOKE TO SURGICAL SCOPE ABOUT HER WORK IN TREATING BREAST CANCER AND INCREASING AWARENESS OF THE DISEASE.
**SURGICAL SCOPE: WHAT MOTIVATED YOU TO BECOME A SURGEON?**

**DR HOURIYA KAZIM:** I come from a large family of doctors and my father is a surgeon but I actually started at RCSI wanting to specialise in infectious diseases. Some time in third med, while hanging out at night in Richmond Street Hospital casualty, the Registrar put a scalpel in my hand. And that was it! I was hooked. It was while working as a surgical intern back in Dubai that I started to see really advanced cases of breast cancer, the kind seen in “Bailey and Love” from a couple of generations ago. There are many reasons for these unfortunate women presenting with such advanced cancer but modesty was a big one. They didn’t want to show their breast to a male surgeon and we had no female surgeons. It was these women, and their sad demise, that made me chose to train as a breast surgeon.

After internship, I went to the UK and USA to train as a surgeon and, in particular, as a breast surgeon. I returned to Dubai, in the late 90s, pregnant with my first child, and could not find any part-time work or flexible hours in the public health system, so I opted to work in a private hospital. Once my practice there became more and more established, I realised that patients (with a potential breast cancer) would wait a while to be seen by me, then they would wait for an appointment for mammograms, then wait for me to get those results, then wait for another appointment with me for the needle biopsy and then wait again for those results.

These five waiting periods were the cause of much anxiety for patients who were already stressed. I wanted to have a more patient-centred practice and it was just easier to do it on my own than to change a system that was already in place. I also wanted to do this in a holistic way - a one-stop facility that was not ‘clinical’ in appearance. Somewhere homey and friendly, and staffed by an all-woman team. I still needed to have access to imaging so I eventually sited my clinic in a two-storey, stand-alone building, of which the entire ground floor is a fully equipped radiology centre with the Well Woman Clinic upstairs. I spoke to a local path lab to get my samples fast-tracked so that results would get back in a timely fashion. We have a triage system in place at the clinic to expedite the appointment system as every patient with a breast lump thinks they have cancer.

Right now, we cover all well-woman screenings in addition to breast screening and diagnosis and we have a health psychologist on site who specialises in breast cancer. Because of all the issues I initially had finding flexible working hours, none of my doctors have contractual working hours. They come and go as they please as all of us have young children, which sometimes means school commitments during working hours.

**Q: COULD YOU EXPLAIN WHY YOU FOUND THE WELL WOMAN CLINIC IN DUBAI? WHAT WAS INVOLVED IN SETTING IT UP? CAN YOU DESCRIBE THE RANGE OF DISCIPLINES/EXPERTISE THE CLINIC OFFERS?**

**A:** After internship, I went to the UK and USA to train as a surgeon and, in particular, as a breast surgeon. I returned to Dubai, in the late 90s, pregnant with my first child, and could not find any part-time work or flexible hours in the public health system, so I opted to work in a private hospital. Once my practice there became more and more established, I realised that patients (with a potential breast cancer) would wait a while to be seen by me, then they would wait for an appointment for mammograms, then wait for me to get those results, then wait for another appointment with me for the needle biopsy and then wait again for those results.

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**Q: HOW DO YOU SEE THE CLINIC DEVELOPING IN THE YEARS AHEAD?**

**A:** We are just about to launch, within the same building, a separate breast radiology department staffed with a breast radiologist and with facilities for interventional work. I would then like to take this clinic’s model to other parts of the UAE and the Gulf.

**Q: CAN YOU TELL SURGICAL SCOPE READERS A LITTLE ABOUT THE NGO YOU SET UP, BREST FRIENDS, AND THE WORK THAT IT DOES?**

**A:** When I came back to Dubai, breast cancer awareness was nonexistent. The issue of women presenting with advanced breast cancer clearly had to be addressed. So through the charity, we raised money to produce some educational audiovisual aids in five regional languages for free distribution. I gave talks to women’s groups/clubs and colleges all over the country encouraging women here to be more proactive about their health in general, not just their breast health. Brest Friends also has a support group for breast cancer patients which meets once a month in a five star hotel and will celebrate 10 years next month. They are an amazing group of women!

You must remember that many women here are expatriate, so they do not have the support from their family and friends that they would have at home. The Brest Friends support group therefore has buddy-lists of survivors who will accompany new patients to their first chemotherapy/radiotherapy session etc. We also supply goody-bags to surgical patients post-operatively. Until a couple of years ago, oncological treatment was covered by the UAE government for all legal residents. This changed and until we mandate that employers cover their employees with health insurance (coming in 2016), there are many women here who are unable to cover the cost of their breast cancer treatment. Brest Friends will raise money to help patients financially cope with these costs.

Finally, what we really want to raise money for is for some locally-based research on breast cancer in the region. The disease I see here (Middle East, North Africa and Indian subcontinent) occurs in much younger women than you see in Europe and North America, and we see more aggressive types of cancer. As such, Brest Friends has now partnered with the Al Jalila Foundation, which is an NGO established by His Highness Sheikh Mohammed Bin Rashid Al Maktoum, Vice President and Prime Minister of the UAE and ruler of Dubai. Our joint mission is to promote early detection, facilitate medical treatment, provide academic scholarships, fund groundbreaking research, champion healthcare awareness programmes, and foster a culture of excellence in medical education and research in the UAE.

**Q: HOW WOULD YOU CHARACTERISE AWARENESS OF WOMEN’S HEALTH ISSUES IN THE UAE TODAY AND WHAT ARE THE MAIN CHALLENGES TO BE ADDRESSED?**

**A:** Awareness has grown in leaps and bounds. And I can’t take all the credit for that - the internet has helped and young people pass the message home to their mothers and grandmothers. The challenge now is to research why we are seeing our women getting breast cancer at such a young age.

**Q: WHAT DO YOU SEE AS THE CRITICAL ISSUES IMPACTING ON WOMEN’S HEALTH GLOBALLY?**

**A:** I wouldn’t know where to begin and would rather comment on my own region and specialty. I would say education (and, in that, I mean education and knowledge of the general workings of a woman’s body and good health of the body) and access to good and affordable health care should be everyone’s right. I have patients with no health insurance who earn say $1,000 a month and then have to find $150,000 for their breast cancer treatment. What do you tell them? We can’t treat you because you are poor?
SUPPORTING THE PURSUIT OF EXCELLENCE

RCSI AIMS TO HELP SURGEONS ACHIEVE THE HIGHEST STANDARDS OF PROFESSIONALISM. IN AN INTERVIEW WITH SURGICAL SCOPE, PROFESSOR SEAN TIERNEY, DEAN OF PROFESSIONAL DEVELOPMENT & PRACTICE, RCSI, OUTLINES THE SUPPORTS THAT THE COLLEGE OFFERS TO ASSIST SURGEONS ACHIEVE OPTIMUM PERFORMANCE LEVELS

Professor Tierney acknowledges that surgeons practise in an ever-changing, high pressure environment: “The College is conscious of the demanding daily schedules that surgeons have to contend with and the resource constraints within which they must practise. Our intention is to help surgeons rather than add to the hurdles they must face. The range of initiatives provided by RCSI to support the highest standards of professionalism are designed to be responsive to the demands of a surgeon’s busy work schedule.”

The core support tool is the Professional Competence Scheme (PCS), operated under arrangement with the Irish Medical Council. “Since its launch in 2011, the College has worked to make the PCS as user friendly as possible. All surgeons need to look regularly at our practice and identify areas where we need to be updated. And we need to be proactive in finding the education we need to fill any particular gap. The PCS aims to make this a little easier.”

SUPPORTING REFLECTIVE PRACTICE

While the PCS is at the heart of the College’s commitment to professionalism, it is only part of its array of services to support optimum professionalism for surgeons at every phase of their careers. One vital factor in enabling surgeons to assess and address professionalism levels, Professor Tierney notes, is the provision of detailed, reliable data on surgical outcomes and the establishment of the National Office of Clinical Audit (NOCA) has been essential in sourcing such data. He comments: “Reflective practice is the recommended approach to enhancing surgical skills. The primary way we can facilitate reflective practice is, in the first instance, by the collation of high-quality, reliable data. NOCA is vital in facilitating the establishment of sustainable clinical audit programmes that enable this kind of measurement and assessment.

“The development of the Irish National Orthopaedic Register, the National ICU Audit, the Major Trauma Audit, the Irish Audit of Surgical Mortality and the Irish Hip Fracture Database by NOCA is crucial in terms of advancing surgical professionalism. The provision of good data enables the individual surgeon to look at her/his performance and assess it, in an evidence-based way, against the highest standards being achieved.” The commitment to gathering reliable data is also evident in the College’s training programmes, where RCSI has put in place a systematic gathering of feedback from trainees via e-logbooks. The e-logbook is an online system that facilitates a complete record of procedures performed. Professor Tierney notes: “The logbook incorporates an analytical tool that gives particular values and scores to a range of operations and represents an additional stream of valuable data for Hospital Programme Directors and trainers. It’s easy to select the specific data you require and it provides an objective measure of training, which will, ultimately, contribute to enhanced standards of patient care.”

Professor Tierney foresees further developments in data collection that will benefit surgical professionalism. For instance, from a clinical perspective, the Medical Council is in the process of rolling out a patient feedback tool involving the selection of a group of patients who will provide anonymised responses. “We would like to work with the Medical Council to ensure that this new data tool has a focused framework and that it will measure relevant processes and practices within the surgeon’s control, as distinct from, say, waiting lists. This will be important in order to ensure that the findings are actionable from the surgeon’s perspective and, therefore, worthwhile and beneficial to the patient.” From an educational perspective, RCSI has been at the forefront globally in developing a human factors programme, a cornerstone of a comprehensive approach to professionalism in surgical practice. It is estimated that 75% of important events during a surgical procedure relate to factors such as decision-making, communication, teamwork and leadership. All of these factors are explored in RCSI’s MSc. Postgraduate Diploma in Human Factors and Patient Safety. The course, led by Dr Eva Doherty, Director of Human Factors and Patient Safety, also deals with issues such as awareness, conflict resolution and error management. Professor Tierney adds: “Mindful of the heavy workload that most surgeons have to manage, we strive to make the open enrolment process for this course as straightforward as possible.”

EVIDENCE-BASED MEASURES

The development of new evidence-based measures that meaningfully measure patient outcome and the quality of care is key to supporting and developing surgical professionalism: “Over many years, the College has played a significant role in advocating a range of initiatives to enhance patient care. In that context, the College is seeking to establish a new research centre focusing on expanding our understanding of the drivers of patient outcomes. One of the centre’s objectives will be to develop and validate academically robust, data-driven measures that will form part of a suite of indicators that can be used to ensure optimum outcomes for surgical patients.”
The global health agenda since 2000, in line with the objectives of the UN’s Millennium Development Goals for 2015, has, in large part, focused on combating communicable diseases such as HIV/AIDS, malaria and TB. Now, with UN member states finalising the Sustainable Development Goals which will guide the global health agenda beyond 2015, additional priorities are emerging. Eric O’Flynn, Programme Director, RCSI/COSECSA Collaboration Programme comments: “While work must continue to fight specific diseases, there is a growing consensus that we must move urgently to strengthen the global health system through increased resources. In that context, COSECSA and RCSI are advocating that surgical care must be a focal point for enhanced funding and support."

“RCSI sees its primary role in this process as acting as a facilitator for COSECSA, which is best positioned to assess priorities and target effective initiatives in the development of global surgical services.” There is a compelling case to be made for the impact of surgical care in lower and middle-income countries. Over two billion people lack access to basic surgical services worldwide with less than 4 per cent of all operations being delivered to the world’s poorest countries. Marginalized populations continue to suffer due to a lack of trained healthcare providers, inadequate infrastructure, disproportionate out of pocket healthcare costs, and lack of prioritisation of surgical, obstetric, trauma and anaesthesia care as part of national health plans and more widely, the global agenda.

Eric notes: “In Uganda alone, studies suggest that if the population had access to surgical services, 26,500 lives a year could be saved. That’s just in one country; a global strategy that delivers improved surgical services could save millions of lives.”

As part of its advocacy strategy, COSECSA, along with RCSI, became one of the founding members of the Global Alliance for Surgical, Obstetric, Trauma, and Anaesthesia Care (the G4 Alliance), an advocacy-based organisation dedicated to building political priority for surgical care as part of the global development agenda.

Professor Stepehen Ogendo, President of COSECSA, explains its involvement in the alliance: “Funding for enhanced surgical services is vital and this means provision for the training of a range of ancillary roles, such as anaesthetists and OT nurses, as well as surgeons. The G4 Alliance provides a collective voice for member organisations united in their commitment to supporting increased access to safe, essential surgical, obstetric, trauma, and anaesthesia care for all.”

THE COLLEGE OF SURGEONS IN EAST, CENTRAL AND SOUTHERN AFRICA (COSECSA) AND RCSI ARE PARTNERING TO ADVOCATE FOR SURGICAL CARE WITHIN THE GLOBAL HEALTH AGENDA AS MEMBERS OF THE GLOBAL ALLIANCE FOR SURGICAL, OBSTETRIC, TRAUMA, AND ANAESTHESIA CARE (THE G4 ALLIANCE)
surgeons have, for many years, embraced the concept of clinical audit as a means of ensuring best practice and as a professional prerogative, according to Professor Frank Keane. In that context, he continues: “NQAIS is an important element within the wider development of the models of care, facilitating more in-depth analysis of surgical metrics and the setting of ‘stretch targets’ that allow all surgeons to benchmark themselves against national norms and to work towards greater efficiency and, in so doing, provide better patient care.”

CHECKS AND BALANCES
The development of the system has been informed by a strong clinical perspective, Professor Keane explains: “While NQAIS has been designed by a technologically expert team led by Dr Howard Johnson of the HSE’s Health Intelligence Unit, there has been extensive clinical input at all stages of its development to ensure, in so far as is practicable, that the system incorporates appropriate checks and balances. “The initial focus is on outcome metrics but this is only the beginning of a process that will develop over time to encompass a granular view of surgical services nationally. Clinical directors, surgeons, hospital and hospital group management can use these metrics to develop and evaluate strategies for providing patient care in the most appropriate manner, while using scarce hospital resources more efficiently. For example, the system can provide predictive metrics on bed days freed up or additional cases that could be performed, if a particular hospital reaches average length of stay and day case percentage targets. The predictive metrics provide a framework for specific, measurable and achievable performance improvements.”

PIVOTAL ROLE
Mr Ken Mealy believes the implementation of NQAIS surgery is particularly timely: “With the impending introduction of the activity-based funding model, NQAIS can make a pivotal contribution by identifying areas for efficiency improvements in the delivery of patient care. As we move to a ‘money-follows-the-patient’ model, this kind of data will be critical in developing evidence-based strategies to enhance surgical performance and improve patient care. “In terms of clinical probity, NQAIS will play an important role in identifying anomalies in outcomes, clarifying their causes and, ultimately, resolving them. Where surgeons have issues about resource constraints impacting on patient care, now they will have access to data to provide objective, evidence-based supports for their concerns. Used properly, NQAIS can be a powerful tool to help surgeons drive change in the process of care.” Mr Mealy adds: “It’s important to note that NQAIS is not a league table of surgeons. Its objective is to achieve significant performance improvements across surgical procedures nationally, not to place surgeons in competition with each other.”

HOW NQAIS WORKS
NQAIS analyses Hospital In-Patient Enquiry (HIPE) data for patients discharged following a surgical operation as the primary procedure during their episode of care. The metrics include process outcomes that measure the efficiency of surgical care within the system, including average length of stay, day of surgery admission and day case (DC) rates. However, in surgical audit, clinical rather than process outcomes are of greater significance for patients themselves, not least to measure the potential unintended consequences of greater efficiency. For this reason, 30-day acute readmission rates are also included as an outcome metric. Gerry Kellihier, Business Intelligence, NCPS says: “These metrics are available at hospital, surgical specialty and procedure level with supporting metrics and graphical representations of the metrics and their trending over time. Predictive values are provided to illustrate how a hospital’s metrics would change if it were to achieve the performance levels of the top performing surgical teams in Ireland or, where set by the national clinical leads, international best practice.”

Patient and clinician identifiers are anonymised, he notes, and access is graded securely. “Each hospital level user can only see their own hospital’s data. Hospital Group level users can see the group summary data or individual hospital data for hospitals in the group. And the national user can view national, hospital group or hospital level data.” NQAIS surgery has been developed and will be deployed through the Health Atlas portal managed by the Health Intelligence Unit of the HSE.

NQAIS SURGERY
- Covers all surgical procedures performed more than 60 times per annum nationally (more than 400 procedures)
- Enables surgical specialty teams at a national level to select additional surgically significant procedures for inclusion in the reports
- Enables drill down modes to see individual records, with patient and clinician identifiers anonymised and encrypted for confidentiality
- Displays information on additional surgical workload for each procedure/surgical specialty done as secondary procedures (in conjunction with a different primary procedure)
CHARTER DAY MEETING

More than 400 surgical delegates attended the annual Charter Day meetings in RCSI from February 5 to February 8. A range of clinical topics were discussed at the meeting including breast and plastic surgery, head and neck surgery, surgical training, innovations in surgery and gender reassignment surgery. The purpose of the meeting was to promote debate and discussion among surgeons; to highlight best practice, innovation and advances in surgical practice; and to discuss issues of relevance to the surgical profession.

Mr Declan J. Magee, President RCSI and Leo Varadkar TD, Minister for Health at the Honorary Fellowship Confering Ceremony, RCSI.

Liz Connolly, St. James Hospital; Jemima Dorairaj, Galway University Hospital; and Ann McKenna, St. James Hospital.

Mr Declan J. Magee, RCSI President, presents the Abraham Colles Medal to Professor Stan J.Monstrey, Professor and Chairman, Department of Plastic Surgery, Ghent University Hospital, Belgium.

Fiachra Martin, Mater Hospital; Niall McInerney, Cork University Hospital; and Shirley Potter, Mater Hospital.

Mr Kieran O’Rourke and Mr Paul Burke, both of University Hospital Limerick; with Mr Stephen Sheehan, St. Vincent’s University Hospital, Dublin.

Mr Frank Thompson and Mr Emmet Thompson.

Caoimhe Byrne, University Hospital Limerick; Chwanrow Baban, University Hospital Limerick; and Hatem Al-Saadi, St. James Hospital, Dublin.

Dr Toni Byrnes and Mr Dermot Byrnes.

Professor Kevin O’Malley, FRCSI (Hon); H.E. Mr Kevin F.O’Malley, American Ambassador to Ireland; and Mr Kevin O’Malley, FRCSI.
**IRISH DOCTORS IN THE FIRST WORLD WAR LAUNCHED AT RCSI**

*Irish Doctors in the First World War*, a new book documenting the immense contribution of Irish medics in the First World War was recently launched in the RCSI. Published by Merron Press, in association with RCSI, the book is co-authored by Joe Duignan, retired surgeon and former RCSI Council Member along with co-authors Patrick Casey and Kevin Cullen. Mary O’Doherty, Assistant Librarian, Special Collections, RCSI and Meadbh Murphy, Archivist, RCSI were among the contributors to the book. *Irish Doctors in The First World War* tells the unique story of the thousands of Irish doctors and medical students who joined the British armed forces. More than 240 Irish doctors lost their lives during the war, many with no known graves.

Speaking ahead of the launch, Mr Declan J. Magee, President, RCSI said: “It is timely as we commemorate the centenary of World War I, that we remember all Irish doctors who served in the conflict and made great sacrifices in service of their fellow man, caring for the sick, wounded and dying. This period in history is of immense significance to our College with 1,086 doctors and 180 students who served in some capacity during the conflict listed on the Roll of Honour for RCSI.”

“I congratulate the authors and contributors on this important historical work, including our past RCSI Council Member Mr Joe Duignan, on bringing his expertise as retired surgeon to this landmark publication.” This new illustrated hardback title is available in bookshops and from [http://www.iap.ie](http://www.iap.ie), priced €35.

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**LEADING JOURNALIST DELIVERS ‘LESSONS IN LEADERSHIP’ LECTURE**

Ms Dearbhail McDonald, Associate Editor and Legal Editor of the *Irish Independent* gave a talk entitled ‘Lessons in Leadership’ as part of the RCSI Institute of Leadership Lecture Series. The lecture was delivered to approximately 100 health professionals. Ms McDonald examined leadership in disruptive times, with an emphasis on leadership in challenging clinical situations and the role of political leadership. In her presentation, she explored how “authenticity of voice” is a key leadership competency. Ms McDonald reflected on the nature and impact of political and clinical leadership, as well as discussing how, in leadership terms, we can learn from the past and approach the future.

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**RCSI RESEARCHERS MAKE BREAKTHROUGH IN STUDY OF GENE ACTIVITY IN EPILEPSY**

RCSI Neuroscientists have made a breakthrough in understanding what controls gene activity in epilepsy, a disease associated with excessive electrical activity in the brain that gives rise to seizures. The findings may also help explain why epileptic states can be so persistent. The research was published in the March edition of the leading neurology journal, *Brain*.

Epilepsy is often associated with altered levels of genes in the brain and this is thought to make the brain more excitable. The researchers looked for a chemical change to DNA called methylation which acts as a long-lasting on/off switch for gene activity and is thought to be one way that brain cells store biochemical memories. More than 30,000 gene sites were studied using brain tissue from patients with epilepsy. The research found that a number of human genes are controlled in this way and many were not previously linked to epilepsy. In some cases, the more DNA methylation that occurred, the more gene activity was turned off. The research also found that certain types of genes are more likely than others to be under this type of control. This study is the first of its kind in human epilepsy. It specifically aligns deterioration of parts of the brain with structural changes in patient DNA and gene activity. The researchers say that the study can help us to understand what is controlling gene activity in epilepsy and why the epileptic state can be so persistent.

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**MEDICAL VALIDATION IRELAND REVALIDATES QATAR CONSULTANTS**

Medical Validation Ireland (MVI), a consortium of Irish postgraduate training bodies, led by RCSI, has successfully completed a two-year project to revalidate all consultants working for the Hamad Medical Corporation (HMC) and Primary Health Care Corporation (PHCC) in Qatar. Nearly 800 HMC and PHCC consultants have had their credentials revalidated against the international benchmark criteria used by MVI. HMC and PHCC engaged the Irish consortium, which was managed by MVI (a subsidiary of RCSI), in 2013 to complete a peer review of the credentials of every consultant in their respective organisations.

“We are delighted to have worked closely with HMC and PHCC on this major initiative. This was the first time that the postgraduate training bodies have worked together in providing a co-ordinated response to an international request of this kind. This significant project offers an example of cooperation across the training bodies that will, I hope, provide a template for further overseas initiatives,” said Professor Cathal Kelly, Director of MVI and Chief Executive of RCSI.
BEYOND THE OT: SOCIAL MEDIA

The Internet offers abundant opportunities for education, networking and communication, but it can also present challenges when it comes to professional self-presentation online. There is evidence that some individuals use social media in their professional capacities in a careless way. For example, a physician practising in a Rhode Island hospital had to appear before state regulators when she inadvertently identified a patient via a social media post. A team of medical staff from a Chinese hospital were reprimanded for taking group photos in the operating theatre, the series of photos were circulated on Sina Weibo (a Chinese social media site), and showed the surgeons and nurses in scrubs, posing with reportedly unconscious patients on the operating table. According to a 2012 study published in the Journal of the American Medical Association, about 30% of US state medical boards have reported complaints of “online violations of patient confidentiality”. One patient took offence to an online post in which a doctor described the patient as being “lazy” and “ignorant” for repeatedly failing to control her glucose level, a good example of how the use of social media and social networking may undermine the doctor patient relationship, and, importantly, public trust.

Human memory may be weak but the Internet does not forget. A moment of ‘cyber impulsivity’ may have unintended consequences such as a disciplinary process, suspension from medical school, and loss of employment (Chretien, 2009).

GUIDELINES

The American Medical Association Policy on social media use provides a number of useful guidelines which also apply to surgeons; physicians should be aware of standards of patient privacy and confidentiality especially online, and must refrain from posting identifiable patient information. When online, physicians should use privacy settings to safeguard personal information. If interacting with patients on the Internet, physicians must maintain appropriate boundaries (patient-physician relationship) in accordance with professional ethical guidelines, as they would in the real world. The AMA recommends that physicians should consider separating personal and professional content online. For example, a surgeon could use Facebook to connect with friends and family, and could use LinkedIn to connect with professional colleagues. And, finally, the AMA advises that physicians must recognise that actions online and content posted may negatively affect reputations among patients and colleagues, and may have consequences for medical careers, particularly for surgical or medical students (for a full list of guidelines see www.ama-assn.org). The British Medical Association recently released similar guidelines for physicians and medical students regarding social media use. Here in Ireland, the Medical Council, in its Guidelines for Medical Schools and Medical Students on Undergraduate Professionalism, offers a number of recommendations (see www.medicalcouncil.ie/Education/Ethical-And-Professional-Guidance/General-Behaviour/Guidelines-Consultation-/Guidelines-Professionalism-for-Stakeholder-Consultation-.pdf). The Council states that it intends to produce guidelines on use of social media for the profession.

PRIVACY ISSUES

Privacy settings and name changes can partially block online social media content from the public, but these approaches are not foolproof and certainly not hack-proof. For surgeons, the only way to absolutely ensure that unprofessional behaviour is not shared with the public, is to refrain from unprofessional behaviour, and/or to refrain from generating permanent digital evidence of unprofessional behaviour in the form of post, blogs, tweets, photographs or videos. Once something is uploaded to the Internet, it is very difficult, if not impossible to remove content from websites. It’s even harder to remove content from search engines that cache results (Google, Safari etc). In addition, Internet archive platforms, such as the Wayback Machine, store records of websites dating back to the 1990s. Wayback is an invaluable data source for longitudinal studies; it does, however, create a permanent record of digital content – some of which might be undesirable.
REPUTATION MANAGEMENT ONLINE IN SIX STEPS

Reputation management online is an area of keen commercial interest, with many companies offering a service known as ‘search suppression’ but this can be an expensive, and not always effective, exercise. Best Colleges offers handy tips concerning the basics of professional reputation management online, which I think may be interesting for surgeons – both younger and more senior.

1. Evaluate your reputation; start by searching for your first and last name, refine by city and profession, and don’t forget to search usernames and nicknames. Check for inappropriate information on social media, dating site accounts, message board posts, images, videos, blog articles, comments and mentions.

2. If you are on Facebook, check for inappropriate photos that feature you, uploaded to either your page or your friends’ pages. Look for tagged posts or comments that reflect poorly on you; remember, even clicking the “like” button on a post can associate you with certain undesirable or inappropriate content.

3. If you use Twitter, click on view profile. Then select “Tweets” to examine your history. Click on “Notifications” and “Mentions” to view interactions and instances where you have been mentioned.

4. Once you’ve identified problematic or unprofessional content associated with your identity online, you’ll need to take steps to remove or hide it. On Facebook for example, if you are tagged in another person’s photo, post, or comment, then contact the person who uploaded it and ask that they remove it. Twitter is a little more difficult. Tweets don’t always disappear immediately after they have been deleted. Make sure to consider this delay before you post anything that is potentially embarrassing or inappropriate – something that seems hilarious at 2am can be a completely different read in the cold light of day.

5. Once you have completed your cyber forensic audit, put a preventative strategy in place by setting Google Alerts. You can customise Google search settings so that you receive an email alert every time a search listing with your name is added. This way, you as a surgeon can actively monitor your online reputation. Simply go to the Google Alerts website, type your name in the “Search Query” box, and customise the parameters. Select your email in the “Deliver To” box and click “Create Alert”.

6. Finally, take a proactive step and focus on creating original content for search engines. Interestingly, this can also suppress and displace any negative content that is currently popping up. This can take the form of anything from blog posts to informative articles (for further good advice, check out the Bestcolleges.com website).

HOW SURGEONS USE SOCIAL MEDIA: A RESEARCH OVERVIEW

Indes et al. (2013, p.1159) give a positive account of the use of social media by surgeons. They point out that the use of social networking sites has had a positive impact on vascular practice through the incorporation of this technology into patient care and communication. The authors maintain that integration of social networking technologies has potential to be used to promote goals, patient awareness, recruitment for clinical trials, and professionalism within the specialty of vascular surgery. “First, they have enormous reach, capable of covering a global audience. They are ‘accessible’ for little or no cost, and many applications are considered ‘user friendly’, requiring very simple directions and little specialised or advanced knowledge of computers or programming. Social media is immediate, and communications can be instantaneous, unlike industrial media where lag time can be days to weeks. However, there still are some limitations. Social media can be less permanent than traditional media, communications can be edited and altered at any time, and end user content lacks accountability.”

In terms of negative use of social media by surgeons the news is not so good. Langenfeld et al. (2014) conducted a study involving 57 residency programs on the American College of Surgeons website, 996 surgical residents were identified and 319 (32%) of these had identifiable Facebook profiles. The profiles were analysed and it was found that the majority, 235 residents (73.7%), had no unprofessional content on their profile. However, 45 (14.1%) had potentially unprofessional content, and 39 (12.2%) had, what the authors considered, clearly unprofessional content consisting of binge drinking, sexually suggestive photos, and Health Insurance Portability and Accountability Act violations. The study highlighted that unprofessional behaviour was prevalent among surgical residents who use Facebook, and, notably, this behaviour did not appear to diminish as residents progressed through their training. The authors point out that this posting of unprofessional content on social networking sites represents a risk to the reputations of hospitals and residency programs. They highlighted that residents should be educated on the dangers of certain uses of social media. This approach is supported by Von Muhlen and Ohno-Machado (2012) who argue that a new generation of clinicians are entering training with a different set of communication habits than any of their predecessors, i.e., social media.

ENGAGING WITH CRITICAL FEEDBACK

Daniel Shay (2014) provides some good advice in terms of dealing with negative comments online:

- any public response should be courteous;
- any response to negative comment should be professional; and
- responses should not include any confidential or protected health information.

It should be remembered that online is a ‘lean medium,’ devoid of social cues and, therefore, misunderstandings can happen. An exchange can easily become heated or escalated. In cyberpsychology, we call this ‘flaming.’ For this reason, it may be easier not to publicly engage in this type of negative discussion on a public social media site. A phone call or face-to-face meeting may resolve the issue much more effectively and, importantly, will not leave a permanent record.
A RIGHT TO BE FORGOTTEN?
In May 2014, the European Court of Justice (ECJ) ruled that individuals have “the right to be forgotten.” The ECJ judgment applies to any content that is deemed “inadequate, irrelevant or no longer relevant, or excessive.” The Medical Defence Union (MDU) has issued advice to members on the implications of the ruling. Dr Caroline Fryar, MDU head of advisory services, made the following statement: “Increasingly doctors are seeking our advice about how to deal with critical online coverage. They may have found to their distress that an online search of their name brings up an unfavourable or unflattering story such as a news report about a patient complaint or a past GMC investigation, which may have happened many years ago. The recent European court ruling is good news for doctors as it means they can apply to Google and other search engine operators to request the removal of certain results on privacy grounds. However, we urge a note of caution as it remains to be seen whether requests to remove results will be successful, given that decisions will be taken on a case-by-case basis, balancing the public interest with the right to privacy.”

It has been reported that Google has received a large number of requests for removals. In the healthcare sector, requests have been submitted by professionals who want to remove negative patient comments from review sites, or, in more serious cases, remove reporting of so-called ‘botched procedures.’ While I think this form of self-curation online is a positive, empowering step, the ‘right to be forgotten’ does however raise an interesting ethical question; can doctors or surgeons who have been involved in a medical negligence case exercise their ‘right to be forgotten’ and thus clean up their online reputation – and, if so, is this fair to patients?

MAKE THE MOST OF ONLINE MEDIA
Three key ways that you can maximise the professional value of online media.
► As a platform to connect and network with fellow surgeons.
► To raise awareness about research, conditions and surgical treatment options.
► In remote settings, clinicians can access tertiary care centres and expert surgical opinions via social media or can conduct telemedicine on platforms such as Skype.

Antheunis et al. (2013) points out that there is a need to formulate clear social media policies that can offer health professionals guidelines as to how they can maximise potential benefits through engagement with social media and avoid pitfalls such as violating patient privacy or the mixing of personal and professional information.

SUMMARY
Social media has many upsides and some downsides – but none worth jeopardising a hard-earned professional qualification and career. We live in an era of pervasive technology, where every sentiment or action can be digitally captured, widely-disseminated and can form a permanent record. The challenge for surgeons is to make the most of technology regarding education, communication, patient care and professional development, and to minimise risk in terms of professional reputation. At one time, a favourite expression of some weight-loss professionals was to remind patients ‘you are what you eat.’ For surgeons developing a professional reputation in an age of technology, unfortunately, ‘you are what you tweet.’ Technology, in itself, is not good or bad. It mediates human behaviour, and, therefore, is simply used well or poorly. When it comes to online media and professional reputation management, the challenge for young surgeons is to ‘be smarter than your smartphone’.

REFERENCES
HIQA CHIEF OUTLINES AUTHORITY’S PRIORITIES

IN AN EXCLUSIVE INTERVIEW WITH SURGICAL SCOPE, PHELM QUINN, CHIEF EXECUTIVE OF THE HEALTH INFORMATION AND QUALITY AUTHORITY (HIQA), OUTLINES THE AUTHORITY’S CURRENT PRIORITIES, ITS STANCE ON THE KEY CHALLENGES FACED IN THE IMPLEMENTATION OF DAY SURGERY AND ITS ASSESSMENT OF THE STANDARD OF TECHNOLOGIES SUPPORTING SURGICAL PRACTICE IN IRELAND

SURGICAL SCOPE: PLEASE OUTLINE HIQA’S WORK AND CURRENT PRIORITIES, PARTICULARLY IN RELATION TO PATIENT SAFETY IN A SURGICAL CONTEXT.

PHELM QUINN: In the last year, HIQA has undertaken an ambitious programme of assurance in line with our statutory responsibilities. Throughout 2014, there was a significant concentration on risk with the commencement of the investigation into the Midland Regional Hospital, Portlaoise and moving forward our plans in respect of a review of pre-hospital emergency care.

In the same year, we also completed and published a governance review of the University of Limerick Hospitals. While these investigations and reviews were not specific to surgical services, the outcomes of all of this activity are designed to have a constructive impact on the governance and management of such services.

In 2015, we will continue our programme of unannounced inspections of hospitals against infection prevention and control standards. During the year, there will be a specific focus on antimicrobial stewardship within hospitals.

In addition, we will also commence a review of the arrangements in place to ensure that patients utilising the general acute healthcare services are adequately assessed, managed and evaluated to effectively meet their individual hydration and nutrition needs. It would also be our intention to commence a review of Medical Assessment Units and the Local Injury Units in the hospitals included in the Smaller Hospitals Framework, to monitor the efficacy of the arrangements in place to progress the development of these units and to ensure the safety of the care being delivered there. HIQA is currently undertaking a rapid health technology assessment (HTA) to evaluate the safety and efficacy of mechanical thrombectomy for acute ischaemic stroke. This is an emergency procedure that is used in addition to current care for efficacy of mechanical thrombectomy for acute ischaemic stroke. This was done in collaboration with a specially convened Expert Group.

Q. WHAT IS YOUR ASSESSMENT OF WORK BEING DONE TO IMPROVE CLINICAL SERVICES FOR PATIENTS VIA THE NATIONAL OFFICE OF CLINICAL AUDIT?

A. We welcome any development that promotes the safety of people using healthcare services. HIQA has developed Guiding Principles for National Health and Social Care Data Collections, including the National Office for Clinical Audit data collections. Our guiding principles provide a framework of best practice to enable all national health and social care data collections ensure the quality of the data they gather, and use the outcomes of that work to drive improvements in health information, ultimately leading to safer better care for all.

Q. WHAT IS HIQA’S ASSESSMENT OF THE STANDARD OF TECHNOLOGIES SUPPORTING SURGICAL PRACTICE IN IRELAND AND WHAT CAN BE DONE TO ADDRESS CHALLENGES IN THIS AREA?

A. HIQA’s health technology assessment (HTA) programme focuses on informing national health policy and service decisions. HTAs relating to surgical procedures undertaken by HIQA to inform national health-service decisions have included a comprehensive assessment of the clinical and cost-effectiveness of robotic surgery and a HTA of a national deep brain stimulation programme.

At the request of the Director General of the HSE, we have also produced a series of 22 rapid HTAs on clinical referral/treatment thresholds for scheduled procedures. The HTAs included an analysis of Hospital In-Patient Enquiry (HIPE) data, a systematic review of the international literature and the development of thresholds.

This work was done in collaboration with a specially convened Expert Panel, and the findings have been disseminated to relevant stakeholders, including healthcare professionals, patients and the public.
HIQA Advisory Group that included nominees from the relevant surgical disciplines, as nominated by the post-graduate colleges and clinical programmes. The aim of the thresholds is to provide patients and referring primary care practitioners with greater clarity about the clinical criteria used by surgeons to inform the decision to operate. The benefits include appropriate management of patient expectations, reduced referrals to surgical outpatients and shortening of the patient’s elective surgical journey. The use of transparent criteria may also allow for more efficient audit to ensure that there is equity of access to beneficial care throughout the publicly-funded healthcare system.

The HTAs are provided as advice to the HSE and implementation rests with the HSE. Nevertheless, we welcome the fact that the 2015 operational plan for the acute services division of the HSE states that three of these thresholds will be implemented this year in the context of day surgery.

To date, due to resource constraints, our HTA programme has primarily focused on informing decisions about national programmes. However, there remains the potential that investment decisions taken at a local or regional level, around use of specific technologies including diagnostics, medical devices and surgical procedures, could potentially benefit from independent, robust, evidence-based health technology assessment as happens in other jurisdictions.

Meanwhile, our work in health information has potential to have an important bearing on surgery in the future. The Health Identifiers Act, underpinning the introduction of health identifiers in Ireland, was published in 2014. It provides the legal basis for setting up the National Register of Individual Health Identifiers and the National Register of Health Services Provider Identifiers. HIQA’s role is to develop information governance and management standards for the Health Identifiers Operator, and to then monitor the implementation of these standards.

Individual health identifiers (IHIs) will be used to improve patient safety, including in surgical settings. For example, a patient’s IHI will be recorded on their medical record in the hospital’s computer system if the patient is admitted to hospital. Post-surgery, their IHI will be included in the hospital’s communication to the GP. This will allow the patient’s GP to safely identify the individual when they receive the discharge letter.

Separately, we are carrying out an international review of patient safety surveillance systems as part of a project to set up a national patient safety surveillance system in Ireland.

The Chief Medical Officer’s report to the Minister for Health in 2014 on perinatal deaths in Portlaoise Hospital recommended the establishment of a National Patient Safety Surveillance System. To address this, the Chief Medical Officer requested that HIQA develop a set of recommendations on the coordination of patient safety intelligence in Ireland. This is being undertaken as part of our statutory remit in improving the quality of existing information and identifying gaps where information is needed but is not currently available.

To this end, we are currently documenting the existing sources of patient safety information in Ireland by undertaking an ‘as is’ analysis. We are also undertaking an international review of patient safety surveillance systems in four locations: Canada, Scotland, England and Denmark. The international evidence, coupled with the ‘as is’ analysis, will form the basis for a set of recommendations to the Minister for Health on the coordination of patient safety intelligence in Ireland.
Dr John Gleeson, is CEO and director of SurgaColl, a venture capital-backed, start-up company established in 2010 to commercialise HydroxyColl and ChondroColl, which were developed by the Tissue Engineering Research Group at RCSI. Although new, these products are set to change the face of traditional orthopaedic grafting procedures and recovery outcomes, Dr Gleeson predicts. Both are naturally derived, drug-free and encourage tissue repair and growth, he says.

AN INSTRUCTION TO HEAL

The latter characteristic is what sets HydroxyColl apart from products currently available in an already saturated bone graft market, Dr Gleeson explains. “Most of the products on the market will support bone healing but they won’t actively direct it. They will support bone cells that are already in the environment but they won’t give an instruction to heal.”

Products that encourage tissue repair and growth do so with the aid of pharmaceuticals. HydroxyColl’s unique selling point is that it is drug-free and, as such, risk-free of drug-related safety concerns. Pre-clinical trials in the equine sector have proved highly successful and, as a result, present another unique opportunity for SurgaColl to tap into a lucrative market in Ireland and around the world. SurgaColl received a €2m seed investment grant in 2012 to fund the development and commercialisation of HydroxyColl. The product is awaiting CE Mark approval which will grant it access to the European orthobiologics market. SurgaColl will immediately commence the process of achieving FDA clearance in the US, and it is anticipated that this will be market approved in early 2016.

GROUND-BREAKING PRODUCT

SurgaColl’s second product, ChondroColl, is a ground-breaking innovation that boasts the same natural and drug-free properties as HydroxyColl, but in a market that has fewer competitors and products that rarely guarantee success. In this regard, ChondroColl has the potential to become ‘a real game changer’, says Dr Gleeson.

“The cartilage regeneration market is a very exciting area at the moment because pretty much all of the existing approaches and technologies in that market don’t work long-term, and a lot of the time the material that is repaired is inferior to your body’s natural tissue. So the holy grail in cartilage repair is a product that is cell and drug-free, is resorbed rapidly once implanted, and that encourages the complete regeneration and restoration of some of your damaged cartilage tissue in your knee or shoulder.”

A number of case studies involving ChondroColl are scheduled to take place in a key centre of excellence in the UK over the next few months, with full clinical trials expected to commence in Ireland, the UK and mainland Europe early next year.

The naturally-derived raw materials and drug-free approach of ChondroColl are hugely important. “A drug requires more clinical evaluation, at significant cost, as well as a pharmaceutical safety study. Not having a drug, but being able to have the performance associated with a drug- or cell-based approach to cartilage regeneration, is very exciting,” he says.

ChondroColl is a significant advancement for the sports industry, Dr Gleeson says. As an early-intervention product, it can regenerate cartilage and delay the onset of arthritis and the need for joint replacement. “Generally, the accepted paradigm is that any large scale damage to cartilage - like you would have with osteoarthritis - can’t really be regenerated. What is very exciting is that we treated a very large defect, representative of an osteoarthritic joint, in a horse, not really expecting it to work, but the surgical team achieved some fantastic results. That horse is now back running and its owner is thrilled to have it back training this summer,” says Dr Gleeson.

SurgaColl has celebrated successful ChondroColl case studies with other horses and while it may have started out as a product for the human market, the focus is now shifting to veterinary applications also.
THE 23RD SYLVESTER O’HALLORAN PERIOPERATIVE SCIENTIFIC SYMPOSIUM

THIS YEAR’S SYLVESTER O’HALLORAN SURGICAL SCIENTIFIC SYMPOSIUM HAD AS ITS FOCUS THE PERIOPERATIVE CARE PATHWAY, AND FEATURED A TRULY MULTIDISCIPLINARY PROGRAMME

The 23rd Sylvester O’Halloran Perioperative Scientific Symposium was held in the Graduate Entry School, Faculty of Education and Health Science, at the University of Limerick on Friday and Saturday, March 6 and 7, 2015.

Professor J Calvin Coffey, Chair of Surgery and Consultant General and Colorectal Surgeon, University Hospitals Limerick and University of Limerick, oversees the organising team behind the symposium. He told Surgical Scope that the evolution of the Sylvester O’Halloran meeting has reflected the changing role of the modern surgeon, which now encompasses management of a perioperative care pathway that extends beyond the operating theatre.

NATIONAL FORUM

“The Sylvester O’Halloran meeting is a national forum,” Professor Coffey explained. “The theme of the forum is the perioperative care pathway. Increasingly, the emphasis in surgery now is perioperative, as opposed to purely on the craft component. Increasingly, surgeons find themselves co-ordinating several pre, intra and postoperative activities involving multiple specialties. “That has become the central aim of the meeting: to highlight areas in the perioperative care pathway and to see how we can improve on them.” The programme incorporated a range of clinical sessions including orthopaedics, anaesthesia and critical care medicine, ENT and general surgery.

PRIZE PAPER

Also on the programme was the Association of Surgeons of Great Britain and Ireland (ASGBI) Prize Paper session, which was chaired by Mr John Moorehead, ASGBI President, and Professor Michael Larvin. The prize was awarded to Terri McVeigh, while the prestigous Sylvester O’Halloran award went to Katie O’Sullivan, Institute of Molecular Medicine, St James’s Hospital.

Professor Pierce Grace, who was formerly Chief Clinical Director of the University of Limerick Hospitals Group, was honoured with a festschrift at the symposium. “Professor Grace is world renowned for his publications and surgery, and for his educational programmes in surgery,” Professor Coffey said. “It’s fitting that we had quite a number of very significant speakers at that festschrift.

“A lecture was given by Professor Paul Finsucane, the Foundation Head of the Graduate Entry Medical School at the University of Limerick, who gave a wonderful, deeply personal tribute to Professor Grace, one that was remarkably human in terms of its pitch, and it’s something that people continue to talk about.”

Among the other sessions at the symposium was a head and neck session co-chaired by Professor John Fenton and Professor Aongus Curran; orthopaedic sessions held by Mr Dermot O’Farrell, including an orthopaedic trauma session that is now regarded as one of the key educational calendar events for orthopaedic surgery; an anaesthetic, critical care and pain session coordinated by Dr James Shannon; and a residents’ presentation session for anaesthesia run by Professor Dominic Harmon.

Dr Catherine Nix introduced sonoanatomy at UL and Dr Siobhan Grimes coordinated a highly successful simulator session. Professor Coffey said that the organising team was very pleased with the success of this year’s symposium.

“We are indebted to the companies who support the meeting annually and to the RCSI for its ongoing support. There were over 300 registered participants, including several international participants and presenters, which is excellent for an Irish meeting. In all, there were over 130 oral presentations and 90 poster presentations, and it was a record turnout for us,” he said.

SYLVESTER O’HALLORAN (1728-1807)

Sylvester O’Halloran was born in Caherdavin, Limerick, in 1728. He went to London to study surgery at the age of 17 and after further study at Leyden and Paris he set up practice as a surgeon in Limerick in early 1749. O’Halloran wrote several learned treatises. He was a founder of the County Limerick Infirmary that started with four beds in 1761 before moving to larger premises at St Francis’s Abbey in 1765. The foundation stone of the original infirmary is now preserved in the Sylvester O’Halloran Post Graduate Centre at the Mid-Western Regional Hospital, Limerick. O’Halloran became instrumental in founding RCSI, by writing Proposals for the Advancement of Surgery in Ireland in 1765. In 1780, he was made an honorary member of the new ‘Dublin Society of Surgeons’, and when RCSI received its charter in 1784, he was elected an honorary member.
NATIONAL SURGICAL TRAINING CENTRE ACHIEVES NASCE ACCREDITATION

IN FEBRUARY 2015, THE NATIONAL SURGICAL TRAINING CENTRE (NSTC) BECAME ONE OF THE FIRST TRAINING CENTRES IN EUROPE TO BE AWARDED NASCE ACCREDITATION

The NSTC’s recent accreditation, based on a new Europe-wide quality model for the Accreditation of Clinical Skills Centres, showcases how successful RCSI is as a leading national and international centre for surgical education and training.

The Network of Accredited Clinical Skills Centres of Europe (NASCE) is a multidisciplinary joint committee (MJC) of the European Union of Medical Specialists (UEMS). It is an active community working for quality in undergraduate and postgraduate medical education and progression in teaching techniques. NASCE represents a network of training centres all over Europe that are dedicated to medical training in different medical specialities and professions. Within the network, Surgical Training Centres share their experiences and best practice models for good medical education.

CENTRE OF EXCELLENCE

According to Mr Padraig Kelly, Programme Manager Quality and Process Transformation, RCSI Surgical Affairs, this accreditation is a major coup for RCSI in terms of the NSTC achieving recognition for developing a Training Centre, which clearly meets the highest of standards.

“There was a rigorous accreditation process, which was undertaken by the NASCE, and it is a great achievement that the NSTC received full unconditional multispecialty accreditation for four years,” he says. The assessor complimented the excellence structures and continuous renewal ethos within the NSTC and identified particular strengths of the centre including:

- very good use of technology to support learning;
- close links with other educational structures and personnel within the large healthcare education organisation (RCSI);
- high output of good quality research/publications related to skills acquisition;
- comprehensive assessment processes;
- well-developed human factors curriculum; and
- good administrative and QA support processes.

The NSTC was assessed against a defined set of criteria under six headers which provided the framework for assessment:

1 – governance;
2 – administration;
3 – teachers;
4 – learners;
5 – competencies; and
6 – research and development.

The NASCE accreditation process was a review of an entire surgical education centre, including facilities, resources and faculty, education portfolio, and the infrastructure and quality management processes that underpin the delivery of its educational products and services.

The NASCE Accreditation is an award of excellence in recognition of outstanding surgery-related educational provision by a surgical education centre. It is only awarded where there is a clear demonstration of, and a broad confidence in, each of these components. As part of an application, evidence must be provided which demonstrates that the delivery of all provision meets the quality and standards as defined by the NASCE. Where Centre Accreditation is awarded, the Centre receives a time-limited institutional accreditation. The NASCE Training Centre accreditation and the current Medical Council accreditations of the trauma and orthopaedic surgery and vascular surgery training programmes, have provided a platform for RCSI to enhance the quality and outcomes of the surgical training, which it offers. “Accreditation has also given another platform for the College to leverage existing quality improvement to make sure that the training programmes we offer are continually improved in the best interest of the Irish patient,” says Mr Kelly.

“RCSI is acutely aware of the changing and challenging nature of our hospital-based, service delivery model and the NSTC adapts to this dynamic and evolving system to ensure the quality of the training programme and the safety of our patients. Now, with the successful introduction of the new eight-year surgical training pathway and the restrictions on working hours under the European Working Time Directive, there will be a much greater emphasis on off-site training within the NSTC. The NSTC allows us to offset the challenges presented by the shorter duration of training and reduced doctors’ working hours. It enables trainees to learn safe surgical practice, develop their operative skills and it will reinforce the importance of surgical training to patient safety. The NASCE accreditation process is a key element of RCSI’s improvement strategy and has provided a very valuable and positive external perspective on RCSI’s training programmes, Mr Kelly says. “Our approach to improving quality is inclusive and team-based. We are extremely grateful to the ever-enthusiastic staff of our Department for continuing to rise to the challenge in identifying and delivering these much-valued improvements,” Mr Kelly adds.
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References:

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As Members & Fellows of RCSI, we would be delighted to support you by hosting future surgical meetings here in RCSI or by providing conference management for your meetings taking place around Ireland.

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Professor Sean Tierney
Dean of Professional Development and Practice, RCSI

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"It is thanks to RCSI’s Conference & Events Team that the 12th International Congress of the European Society of Paediatric Otorhinolaryngology (ESPO 2014), which welcomed 1,200 delegates over 4 days in June 2014, was such a success. Their diligence and dedication to this event, from start to end, was unwavering. I would have no hesitation in recommending their services."

Mr. John Russell, FRCSI, Chairman, 12th International Congress of the European Society of Paediatric Otorhinolaryngology (ESPO 2014)