REBELS IN RCSI
Surgeons, Insurgents and the 1916 Easter Rising
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THE PRESIDENT’S ADDRESS
Highlights from Mr Declan J. Magee’s wide-ranging President’s Address on Charter Day.

VASCULAR TRAINING DAY
A Vascular Surgery Training Day, under the direction of Ms Bridget Egan, Consultant Vascular Surgeon, AMNCH, Tallaght and Council Member, was held at RCSI on Charter Day.

TRAUMA CARE IN 1916
A glimpse of trauma care 100 years ago in Dublin during the Rising.

SURGEONS & INSURGENTS
A special exhibition exploring the human stories of surgeons and insurgents associated with RCSI and the 1916 Easter Rising opened recently at RCSI.

SPORTS-RELATED CONCUSSION
There has been increasing concern surrounding sports-related concussion in recent years, in particular in relation to chronic traumatic encephalopathy.

RESUSCITATION OF DEAD HEARTS FOR TRANSPLANTATION
An overview of the pioneering work taking place in the resuscitation of dead hearts for transplantation.

EMPOWERING THE PATIENT
Professor Michael Griffin, who was conferred with an Honorary Fellowship of RCSI on Charter Day, talks to Surgical Scope about developing the largest Oesophago-Gastric (Upper Gastrointestinal) Unit in Europe and North America.

Supporting Surgeons
The plenary session on Charter Day focused on the multiple demands placed on today’s surgeons, the difficulties that these demands can create, and the supports that can be provided to manage those difficulties.

RCSI NEWS
Uachtarán na hÉireann receives Honorary Fellowship. Professor the Lord Ara Darzi receives UK’s highest honour. RCSI publishes first data on adverse events.

DEPARTMENT OF SURGICAL AFFAIRS ANNOUNCES FIVE-YEAR STRATEGY
RCSI recently published Supporting Excellence in Surgical Training and Practice – A strategy for 2016-2020, setting out the strategic priorities for the Department of Surgical Affairs for the next five years.

FUTURE OF GENERAL SURGERY IN SMALLER HOSPITALS
Smaller or Model Three Hospitals face serious challenges in maintaining general surgical consultancy staffing levels.

TRAUMA AUDIT UNDERGOES NCEC ACCREDITATION PROCESS
Chair of the National Clinical Effectiveness Committee, Hilary Humphreys, on the imminent NCEC National Clinical Audit accreditation process for the Major Trauma Audit and the importance of clinical effectiveness processes.

J&J LECTURE
This year’s Johnson & Johnson Lecture on Charter Day was given by Vice Admiral Mark Mellett DSM PhD, Chief of Staff, Defence Forces Ireland.
Mr Declan Magee, President, RCSI.

PREScription FOR CHANGE

In his President’s Address on Charter Day, Mr Declan J. Magee spoke on a wide range of issues. Here are some highlights from Mr Magee’s Address, focusing on surgical training, a changing practice environment and the importance of encouraging future generations of surgeons.

ADDRESSING TRAINING CHALLENGES

We continue to pursue an ambitious change agenda which will refine and consolidate surgical training for the future. Those of you involved in specialty training committees and the overarching Irish Surgical Postgraduate Training Committee will know that the new training pathway is forging ahead. Progression of the first cohort into ST3 took place last July, but, not surprisingly, there have been, and will continue to be, challenges along the way. Recognising that all is not perfect, there is a readiness to comprehensively address all the issues requiring attention and to move without delay on what can be fixed quickly. There is no doubt that our trainees have been globally well-regarded wherever they have gone, and, for now at least, those applying for surgery are among the brightest and the best. We must and will ensure that our training programmes enable them to achieve their fullest potential. The task requires us all to remain committed to, and engaged with, training. It will continue to be challenging, requiring hard work and commitment from trainers and trainees alike. Training the next generation is not an optional activity but arguably one of the most important obligations of the profession. Of course, government, through its structures, has a duty to ensure delivery of training by creating an enabling environment, including recognising training as an intrinsic part of the consultant’s role.

In the past few years, the Medical Council has made a valuable contribution by highlighting issues related to the training environment including issues around lack of support and bullying. We have a serious and ongoing commitment to addressing these concerns. We had an excellent and insightful discussion on bullying at the Millin Meeting and the College is providing a broad range of support resources and educational inputs across the entire span of our training programmes.

FORTHRIGHT DISCUSSION

The most topical national issue in surgical practice must be the controversy over trolleys in emergency departments and the constant cancellation of planned surgery. We have resisted the temptation to engage in megaphone point-scoring. Earlier this year, an RCSI delegation met with and had a forthright discussion with the Minister for Health. The unpalatable reality for now is that no one has all the solutions to this issue and, until there is further economic recovery, the much needed investment that is required to resolve these issues, will not be forthcoming. We know that we can now generate valuable data from the national surgical programmes and this will help us to keep our own surgical house in order. Furthermore, the establishment of our new Health Outcomes Research Centre, which will in the first instance focus on surgical activity, should provide us with data to make an unassailable argument for the appropriate structures and infrastructure of the future. I believe the next disruptive change both for general surgery in Ireland and for political representatives, will centre around trauma care and, more problematically, provision of appropriate emergency abdominal surgery countrywide. The solutions for trauma care may be relatively straightforward, and much credit is due to our trauma and orthopaedics colleagues for this. However, emergency surgery faces serious issues. Current trainees have been unequivocal about their career intentions (see feature on general surgery in smaller hospitals, page 23). As a profession and a college, we will have to be strong enough to espouse and stoutly defend the best solutions. It has been and is an incredible honour and privilege to represent RCSI and to have the opportunity to contribute to the development of solutions to the challenges ahead.

THE POWER OF ENCOURAGEMENT

Having already acknowledged the quality of applicants we are currently attracting, I must sound a note of warning that there are indications that, for a number of reasons, this may change. Changes in medical school curricula and in time-table schedules, and, indeed, changes in junior training rotations have eroded the potential for role modelling and mentoring.

I believe that there is an obligation on all of us to do what we can to attract new talent into our specialty. The power of encouragement, even at an early stage, should not be underestimated. Anthony Hollander is an example of how impactful encouragement can be. A stem cell biologist, Mr Hollander was a key member of a large international, collaborative team that, in a life-saving operation, successfully transplanted an artificially-grown organ into a woman in Barcelona. As a nine-year old in 1973, he wrote a letter to Blue Peter, the BBC children’s television programme saying that he knew how to “make people alive” but needed the programme’s help to acquire the necessary materials to carry out these life-saving tasks. His shopping list included “a model of a heart split in half” and “tools for cutting people open” as well as “the sort of syringe for cleaning ears that must be very clear.”

The programme responded with a positive, encouraging letter that advised him to seek the information he needed from the family doctor. Recently, Mr Hollander said that if the letter had shown any hint of dismissiveness he might never have trained to become a medical scientist.

In medical school, professors of surgery and other surgeons must strive to protect and enhance worthwhile exposure for students to the work of surgery and should foster and encourage initiatives such as surgical societies. For the last number of years, we have supported and conducted surgical skills competitions in each of the medical schools’ societies with an intercollegiate final – offering a substantial prize – held in the National Surgical Skills Centre in RCSI.
A VASCULAR SURGERY TRAINING DAY, UNDER THE DIRECTION OF MS BRIDGET EGAN, CONSULTANT VASCULAR SURGEON, AMNCH, TALLAGHT AND COUNCIL MEMBER, WAS HELD AT RCSI ON CHARTER DAY.

With an overall theme of diabetic foot/distal vascularisation, the course ran throughout the morning of Charter Day and featured classroom teaching followed by practical skills work in the Anatomy Lab. The classroom teaching sessions were led by Professor Sean Tierney and Dr Deirdre Brady. Topics covered included:

- pathophysiology of diabetic foot; lower extremity vascular imaging in diabetes; multidisciplinary management;
- revascularisation in diabetic patients with critical limb ischaemia options; patient selection and outcomes; and,
- medical management of diabetic foot sepsis.

PRACTICAL SKILLS
The classroom teaching was accompanied by work at practical skills stations in the Anatomy Lab where the course participants broke into small, rotating groups to work at separate skills stations, giving them the opportunity to work closely with Faculty instructors. The five stations featured:

- clinical cases/wire skills (utilising a Medtronic Vascular Simulator);
- endovascular simulation;
- open surgery fem peroneal anastomosis;
- critical care/emergency surgery/academic viva; and
- an MCQ station.

Trainees welcomed the high number of Faculty in attendance and the opportunity it offered for one-to-one feedback.
The course participants were supported at the skills stations by a strong cohort of Faculty in addition to Ms Egan including: Ms Mary Barry, Consultant Vascular Surgeon, St Vincent’s University Hospital; Professor Simon Cross, Consultant Vascular Surgeon, Waterford University Hospital; Mr Martin Feeley, Consultant Vascular Surgeon, Tallaght; Ms Zenia Martin, Consultant Vascular Surgeon, St James’ Hospital; Mr Gerard McGreal, Consultant Vascular Surgeon, Mercy University Hospital, Cork; Mr Denis Mehigan, Consultant Vascular Surgeon; Mr Adrian O’Callaghan, Consultant Vascular Surgeon, St James’ Hospital; Mr Muhammad Tubassam, Consultant Vascular Surgeon, University Hospital Galway; Professor Stewart Walsh, Consultant Vascular Surgeon, University Hospital Galway.

In total, there were 24 trainees, ranging in grade from ST3 to ST7, taking part in the training day which was massively over-subscribed.

TRAINEE REACTION

During a coffee break on training day, Surgical Scope had the opportunity to get the reactions of some of the participants. Emily Boyle (ST7), St James’ Hospital, said the training day was extremely helpful: “It’s a great opportunity to get hands-on experience and, with just three or four people at each skill station, there’s plenty of scope for feedback from the instructors. All the support facilities have been of a very high standard. Trainees really look forward to training days like these and this is one of the best I’ve attended.”

Hazem Hseino (ST 5), Beaumont Hospital, was impressed by the efficient organisation of the schedule and the chance to get hands-on training: “The day has had a well thought-out blend of the didactic and the practical. The opportunity to exercise practical skills is really useful and the number of instructors taking part is a tremendous advantage. It means that there’s a chance for one-to-one communication and immediate feedback. An added benefit is that it’s been really enjoyable to get the chance to meet trainees from different hospitals around the country and share experiences.”

Hilary Hurley (ST7), St Vincent’s University Hospital, also noted the low trainee to trainer ratio: “The high attendance of Faculty has really added to the value of the training day. The teaching and practical work is well-integrated. The collaborative approach to the training has been really encouraging and there’s been a great atmosphere to work in. We don’t normally have the opportunity to get as much access to equipment as we would like. So it’s been great to get to use the wide range of technology and simulators available at the skill stations today. And, in addition to all that, it’s a great opportunity to network.”
Mr Brown said that Dublin was the first European capital to burn since Moscow in 1812. He provided details of the scale of the casualties that were incurred. Of the 590 people killed during the Easter Rising, 374 were civilians, 116 British soldiers, 77 insurgents and 23 members of the police forces. In total, 38 children – aged 16 and under – were killed.

The city had three motorised ambulances and, according to a witness statement by John McDonagh, Lieutenant 3rd Battalion Irish Volunteers, it became impossible for ambulances to access parts of the city because of the barricades erected across streets and thoroughfares. He also noted that the Corporation ambulance was working under great difficulties and “was fired upon, presumably unintentionally, by both sides”.

Mr Brown provided an overview of how the city’s hospitals coped with the extraordinary demands of Easter Week 1916. Here are some of the stories from three of those hospitals.

**MERCER’S HOSPITAL**

Mercer’s Hospital recorded 16 dead and 278 wounded during Easter week. The hospital was overwhelmed and temporary casualty clearing stations had to be provided at premises on Merrion Square and Harcourt Street. People injured in RCSI were brought there.

**MATER MISERICORDIAE HOSPITAL**

During Easter Week, according to a witness statement, Mr Alexander Blayney (surgeon) was on duty in the hospital. He did not leave throughout the week and was operating day and night. There was no gas or electricity and he had to operate by the light of candles brought from the sacristy. There was no sterilisation of instruments or dressings as there was no boiling water at hand, yet “there was no case of sepsis following any of the operations”. Tuesday was the first day that any wounded were brought to the Mater Misericordiae. Nine of these were detained and the rest were treated and discharged. One of those badly wounded was James Kelly, a schoolboy who was shot through the skull.

Another schoolboy, John Healy aged 14, a member of the Fianna “whose brain was hanging all over his forehead” when he was brought in, died after two days. Citing Joe Duffy’s list of children killed in the Rising, Mr Brown noted that of the 38 children who died that week, a disproportionate number of teenagers had gunshot wounds to the head.

According to a witness statement from a Sister of Mercy, Mater Misericordiae Hospital, Dublin: “Another wounded man that was brought in on the Wednesday was Patrick McCrea. He was suffering from pellet wounds in the hand, back-side and leg which he told me he got in the Post Office fighting. He was brought to the hospital for treatment in a cart, covered up in a load of cabbage. “Almost immediately a G-man called McIntyre came to the hospital. He identified McCrea and took up his position on the corridor outside the ward to keep him under observation. He did not even go out to get his meals and I was unwilling to supply him with any. The medical students made various suggestions for dealing with McIntyre, including chloroforming him. In spite of McIntyre’s vigilance, McCrea managed to get away safely. While McIntyre was in the pantry having his dinner, one of the sisters who had made all the necessary preparations beforehand, got the key to the street and let him out.”

**THE CHARITABLE INFIRMARY**

While British snipers on the roof of the hospital fired up Henry Street, and both Henry St and Abbey St were ablaze, it was business as usual inside the Charitable Infirmary.

In a witness statement recounting the occurrences on Wednesday, April 26, 1916, Right Rev. Monsignor M. Curran, P.P. said: “At 7.45a.m. sniping and machine-guns became active towards the lower quays. At eight, the Helga, in front of the Custom House, battered at Liberty Hall for 12 minutes and fired some six shots at longer intervals. Sniping was very general all day, the streets reverberating with sounds of shooting. A large number of civilians were killed and wounded last evening and during the night. There were 90 such cases in Jervis St. hospital alone.”

**CHAOS**

Reviewing the historical record, Mr Brown said there was no apparent plan for managing a major incident of the magnitude of the Rising. The confusion and chaos was worsened by the failure of utilities such as electricity and gas, and the disruption of phone services. Even so, despite the fires, bullets and shells, patients were treated. The personal cost to nurses and doctors working under these conditions should not be forgotten, he said.
A special exhibition exploring the human stories of surgeons and insurgents associated with RCSI and the 1916 Easter Rising opened recently at RCSI. The exhibition ‘Surgeons and Insurgents – RCSI and the Easter Rising’ formed the centrepiece of RCSI’s 1916 Commemorative programme, coinciding with the official State commemorations and an accompanying public lecture series.

This free exhibition was open to the public from March 23 to April 17, 2016 and brought visitors on a journey through RCSI’s occupation during the 1916 Easter Rising with a focus on the stories of nine surgeons and nine insurgents involved in those historical events. The exhibition was officially opened by Dr Maurice Manning, Chancellor of NUI and Chair of the Expert Advisory Group on Commemorations.

RCSI holds a unique place in the historical events of 1916. Despite being a focal point for the Rising, remarkably, the RCSI building on St Stephen’s Green is the only significant building directly involved in the Easter Rising that stands as it did in 1916, with all others having either rebuilt or demolished since. The College’s occupation by insurgents under the command of Michael Mallin and Countess Markievicz is a well-known aspect of the Easter Rising. However, few will be aware of the role RCSI surgeons played in surrounding hospitals, where they worked tirelessly, treating the wounded during the rebellion.

Mr Declan J. Magee, RCSI President said: “The centenary commemorations of the 1916 Easter Rising are of particular significance to RCSI. Our building on St Stephen’s Green was one of the principal sites occupied by the Volunteers, but, also, many of the College surgeons played important roles in treating the injured. Despite being a focal point for the Rising, the building and rooms occupied during Easter week remain intact as they did in 1916 and we are privileged to host this commemorative exhibition in these historical surroundings.”

Professor Cathal Kelly, CEO/Registrar, RCSI commented: “One of the most inspiring aspects of this process has been the human stories that have surfaced, largely through the efforts of Mary O’Doherty, Special Collections Librarian, and Meadbh Murphy, RCSI Archivist. For example, the daughter of James Connolly, Commandant of the...
Irish Citizen Army – whose comrades took over this site during the Rising – came to RCSI as a medical student in 1919 and graduated subsequently. Human stories like this bring to life our history in all its dimensions and complexity."

The exhibition takes place in the rooms occupied by the insurgents, which are virtually unchanged since 1916 with original features including a bullet-hole from a bullet that struck the brass plate of an internal door during the Rising.

Artefacts on display in the exhibition include the tricolour, which is believed to have flown over RCSI during the Rising, and the will of Countess Markievicz, both reportedly taken from the College by the wounded Margaret Skinnider. This tricolour, which is on loan to the College from relatives of Margaret Skinnider, is on public display for the first time. A sword disguised as a walking stick, belonging to Captain Christopher Poole, on loan from the Poole family was also on display at the event.

Features of the exhibition included a scale model of St Stephen's Green in 1916 with visual and sound-effects, showing the firing-lines across the Green and reconstructions of furniture barricades and the first aid station, re-creating some of the scenes found in the College during the Rising.

The surgeons featured in the exhibition were: Sir Thomas Myles, John Stephen McArdle, Michael Francis Cox, Sir Robert Henry Woods, Charles Hachette Hyland, Euphan Montgomerie Maxwell, William Ireland de Courcy Wheeler, Francis Tobin and Sir Charles Alexander Cameron. The insurgents featured were: Countess Constance Markievicz, Thomas Clifford, Michael O'Doherty, Frank Robbins, Madeleine ffrench-Mullen, Helen 'Nellie' Gifford, Michael Mallin, Christopher Poole and Margaret Skinnider.

A publication also called Surgeons and Insurgents – RCSI and the Easter Rising was published to coincide with the exhibition. Its author is Mary McAuliffe, who holds a PhD from the School of History and Humanities, Trinity College, Dublin and sits on the National Archives Advisory Committee.

The College was also involved in a number of the official city-wide events over the Easter period. On Easter Sunday, a military ceremonial took place outside the College as part of the Easter Sunday State Commemoration Ceremony and Parade.

On Easter Monday, RCSI President, Mr Declan J. Magee was a guest speaker at a wreath-laying ceremony outside RCSI as part of the synchronised wreath-laying events at six iconic sites associated with the Easter Rising in Dublin. Later that afternoon, the College hosted lectures and live broadcasts as part of RTÉ Reflecting the Rising.

**LECTURE SERIES**

The lecture series accompanying the exhibition included:

**Wednesday, March 23**
Dr Mary McAuliffe
Surgeons and Insurgents – RCSI and the Easter Rising

**Thursday, March 24**
Padraig Yeates
The Easter Rising: Fighting for the Crown or Half Crown?

**Tuesday, March 29**
Paul O'Brien
Shootout - The Battle for St Stephens Green

**Wednesday, March 30**
Tony Kinsella
Blood and Bandages - Medicine and the Easter Rising

**Thursday, March 31**
Lisa Godson and Joanna Bruck
Stuff Matters – The Material Culture of 1916

**Friday, April 1**
Comdt Victor Laing
The Rising: A statement of intent, successes and failures

**Saturday, April 2**
Brian Hughes
Michael Mallin

**Thursday, April 7**
Padraig Allen
St John Ambulance and the Easter Rising

**Friday, April 15**
Meadhbh Murphy
To Surgeons and Beyond! RCSI, Rebels and the Republic
Professor Ryan outlined the consensus statement on concussion in sport from the 4th International Conference on Concussion in Sport in Zurich in 2012 which was published in the British Journal of Sports Medicine in 2013. The Zurich consensus statement included a definition of concussion as “a complex pathophysiological process affecting the brain, induced by biomechanical forces” and characterised by common features such as:

- a direct blow to the head, face, neck or elsewhere on the body with an ‘impulsive’ force transmitted to the head;
- rapid onset of short-lived impairment of neurological function that resolves spontaneously, although, in some cases, symptoms and signs may evolve over a number of minutes to hours;
- it may result in neuropathological changes; and,
- it results in a graded set of clinical symptoms that may or may not involve loss of consciousness.

The prognosis, Professor Ryan continued, is that the vast majority of concussive symptoms settle within a few weeks allowing athletes to return to their sports.

**CHRONIC TRAUMATIC ENCEPHALOPATHY**

The focal point for recent widespread public and media concern is chronic traumatic encephalopathy (CTE), a progressive degenerative disease of the brain found in athletes (and others) with a history of repetitive brain trauma, including symptomatic concussions as well as asymptomatic sub-concussive hits to the head. Concern about this topic is particularly intense among athletes, coaches, parents, sporting bodies, the media and the medical world. Professor Ryan discussed several key research papers, including Chronic traumatic encephalopathy in a National Football League player, Omalu BI, DeKosky ST, Hamilton RL et al., Neurosurgery, 2005. The paper focused on the results of the autopsy of a retired professional American football player that revealed neuropathological changes consistent with long-term repetitive concussive brain injury. This case highlighted potential long-term neurodegenerative outcomes in retired professional National Football League players subjected to repeated mild traumatic brain injury. The story of the film Concussion, released in cinemas in Ireland earlier this year, was based on Dr Omalu’s work. Professor Ryan also discussed Chronic traumatic encephalopathy in athletes: progressive tauopathy after repetitive head injury, McKee AC, Cantu RC, Nowinski CJ et al, J Neuropathol Exp Neurol, 2009, reviewed 48 cases of neuropathologically-verified CTE and documented the detailed findings of CTE in three professional athletes, one football player and two boxers. In the context of rugby specifically, he spoke about Chronic traumatic encephalopathy: a potential late and under recognized consequence of rugby union? W. Stewart, P.H. McNamara, B. Lawlor et al QJM, 2015. This paper reviewed current understanding of CTE and, via an illustrative case in rugby union, highlighted the value of a detailed history on head injury.

Professor Ryan also looked at the findings of Chronic traumatic encephalopathy in sport: a systematic review, Andrew Gardner, Grant I. Iverson, Paul McCrory, British Journal of Sports Medicine, 2013, which provided a critical review of CTE by considering the range of clinical presentations, neuropathology and the strength of evidence for CTE as a distinct syndrome. This paper concluded that further research is required to clearly define the clinical phenotype of the modern CTE syndrome and establish the underlying aetiology.

**TEACHING SYMPTOMS**

As we await more research on CTE, Professor Ryan noted, it is vital to teach both the early and late symptoms of concussion. Early symptoms (minutes to hours) include:

- lack of awareness of surroundings,
- nausea or vomiting; and,
- memory loss.

Late symptoms (days to weeks) include:

- memory dysfunction;
- anxiety and/or depressed mood; and,
- sleep disturbance.

In conclusion, Professor Ryan said CTE is an illness which may have a relationship to repeated concussions, however more research is awaited before more definitive conclusions can be reached. In the meantime, Professor Ryan says, the emphasis must be on identifying concussed individuals early; removing them from the arena/field of play before a second injury has a chance to occur; and watching for worrying symptoms and signs.
Heart transplantation remains the gold standard for end-stage heart failure. But, Mr Large explained, in the UK, limited by a finite number of donation after brain death (DBD) donors, demand massively outstrips supply, resulting in almost 20 per cent of listed patients dying while waiting for a heart.

GROWTH IN NUMBERS OF DCD DONORS
In contrast, the number of UK donation after cardiac death (DCD) donors (non-heart beating donors) has grown 16-fold over the last decade. A donor after cardiac death is a donor who has suffered devastating and irreversible brain injury and may be near death, but does not meet formal brain death criteria. In these cases, the family has decided to withdraw care.

Over the last few years, the UK has established a world leading programme of donation and transplantation of kidneys, livers and lungs from non-heart beating donors. DCD renal transplantation has increased by approximately 600 per cent and DCD donors currently constitute a quarter of all liver transplants (The Potential of Transplanting Hearts From Donation After Circulatory Determined Death [DCD] Donors Within the United Kingdom, Messer, S., Lannon J., Wong, E. et al, The Journal of Heart and Lung Transplantation, 2015.)

THE FIRST ‘DEAD HEART’ TRANSPLANTS
In relation to heart transplantation, the central question to be determined was whether it would be possible to transplant hearts from patients who die after circulatory determination of death. In 2014, surgeons in Australia successfully performed the world’s first ‘dead heart’ transplant. In March 2015, a team of surgeons in Papworth, led by Mr Large, carried out the first heart transplant operation in Europe to use a non-beating heart. The recipient made a remarkable recovery, spending only four days in the hospital’s critical care unit. The successful operation was the culmination of research spanning over a decade in which Mr Large and his Papworth team pioneered investigations into transplantation using hearts from non-heart beating donors. During that time, the Papworth team was able to develop the process used to assess and maintain the quality of these organs prior to heart transplantation.

In the year prior to the successful operation, Mr Large and his team gained ethical approval for normothermic regional perfusion (NRP) of six DCD donors.

Key elements of the breakthrough made by Mr Large’s Papworth team involved the use of pioneering techniques to restart the unbeating heart inside the donor minutes after death, and then monitor the heart’s functioning to ensure it was in good enough condition to transplant. Ultrasound was used to assess the function of the restarted heart for 50 minutes before approving it for transplantation. It was then removed from the donor, placed in a perfusion apparatus, a ‘heart-in-a-box’ machine, which perfused the organ with blood and nutrients and kept it beating for three hours until the operation went ahead. The perfusion apparatus, Mr Large explained, is a wheeled cart with an oxygen supply, a sterile chamber, and tubing to clamp onto a donor heart and keep it fed with blood and nutrients.

With the knowledge that DCD heart transplantation is possible given a short ischaemic period, research has indicated that a heart transplantation programme utilising DCD donors has the potential to increase the total heart programme activity in the UK by over 30 per cent, enabling people who previously could not get a heart transplant to have one.
Professor Michael Griffin is Professor of Gastrointestinal Surgery in the Royal Victoria Infirmary, Newcastle upon Tyne in the UK, where the Northern Oesophago-Gastric (Upper Gastrointestinal) Unit is the largest in Europe and North America. According to Professor Griffin: “This is directly related to the fact that the region has the highest incidence of adenocarcinoma in the UK. Adenocarcinoma as a disease is associated with obesity and gastro-oesophageal reflux. The reflux and heartburn cause changes in the lining of the oesophagus which can lead to Barrett’s Oesophagus which can go on to develop into cancer.”

SUCCESS AND THE ONGOING CHALLENGE

Professor Griffin established the Oesophago-Gastric (Upper Gastrointestinal) Unit at the Newcastle General Hospital in the early 1990s and has led its development in the ensuing years. The unit’s recently published 25-year results show some significant success, best summed up by the tremendous increase in successful treatment: “Today, nearly 60 per cent of all patients we treat with curative intent are cured. When I started, that figure was only 4 per cent. We’ve achieved this by a combination of factors including earlier diagnosis and advances in neoadjuvant therapy (medicines that are administered before surgery, such as chemotherapy), which have improved long-term outcomes for more advanced cancer. The continuing challenge is that although we cure 60% of those we try to cure they still only represent a third of all those who present. Sadly, the other two-thirds are not fit for treatment or their cancer has spread to the extent that we cannot cure.”

One of the keys to alleviating this situation is to create greater awareness among the public, Professor Griffin believes: “We have run a campaign for ten years in the north east of England called the ‘Oesophagoose’ campaign. It grew out of research we carried out with 2,000 members of the general public where we discovered that the vast majority had no idea what the oesophagus was. The Oesophagoose campaign is all about increasing awareness of oesophageal and gastric cancer. The campaign has involved lots of PR, advertising on the metro and the backs of buses, on radio and TV, and in town centres all around the North of England. It’s had a major impact and other campaigns have since been devised to deliver more information on cancer.”

EMPOWER THE PATIENT

Professor Michael Griffin, OBE MD FRCS, was conferred with an Honorary Fellowship of RCSI and gave the 92nd Abraham Colles Lecture on Charter Day. He spoke to Surgical Scope about developing the largest Oesophago-Gastric (Upper Gastrointestinal) Unit in Europe and North America, the importance of empowering the patient and future directions in treatment.
The UK government last year launched its Be Clear on Cancer brand to promote awareness and early diagnosis of bladder and kidney cancer, as well as bowel cancer. It was piloted on a regional basis for oesophageal cancer and then went on to a national campaign in 2015. Be Clear on Cancer has overseen a number of awareness campaigns including the ‘blood in pee’ campaign, which promotes the key message: “If you notice blood in your pee, even if it’s ‘just the once’, tell your doctor.”

The advertising highlights that finding cancer early makes it more treatable which, Professor Griffin emphasises, is a crucial message to get across to the public particularly for oesophageal cancer. The Be Clear on Cancer message was: “Symptoms of heartburn are worth reporting if it has gone on for more than three weeks. It could indicate Barrett’s oesophagus, where the cells that line the lower gullet (oesophagus) are abnormal. The main cause is long-standing reflux of acid from the stomach into the oesophagus. People with Barrett’s oesophagus have an increased risk of developing cancer.”

**Communicating with the Patient**

One of the key themes of Professor Griffin’s Colles Lecture was the importance of communicating with patients. The roots of why he places such a priority on open communication and transparency lie in his early days as a Consultant Surgeon: “When I started in 1990, I was horrified at the way patients were spoken to about cancer. Patients never really got told the truth. Families were often told but patients were kept in the dark, which created distrust between the patient and clinician and between the patient and the patient’s family. I decided that every single patient of mine would know what was happening to them. It was almost a rule that I wasn’t prepared to see them unless the family were there, so everyone heard the same thing and there was no misunderstanding. It engendered total trust and made the whole cancer journey more manageable.”

He also believes it is vital, as a surgeon, not to promise what you and/or your colleagues can’t deliver. “The surgery involved is huge, very major surgery. Some operations can take seven to eight hours and patients need to be told what that entails, what the chances for success and long-term survival are, the potential cure and mortality rates. Sharing this information is now standard practice across the UK.”

**Centralisation and Improved Cancer Outcomes**

Professor Griffin played an important role in developing the Improving Outcomes programme for oesophageal and stomach cancer by encouraging the centralisation of services in the UK. In 2001, the then Minister for Health Alan Milburn, introduced a strategy called Improving Outcomes for Cancer. This strategy demonstrated how effective centralisation of cancer services could be and a lot of the data that underpinned its message came from the Northern Oesophago-Gastric (Upper Gastrointestinal) Unit in Newcastle.

“Centralisation was not an easy process and took a long time to implement. There was massive resistance from smaller hospitals and a lot of persuasion was required to bring about changes. Originally it was to be delivered in five years but it has now been implemented across most of England and Wales. The statistics are there now to show that there has been an improvement in outcomes.”

Professor Griffin has taken part in many external reviews of cancer services throughout the UK and abroad, giving him a well-informed perspective on cancer services in a number of countries. What are the key advances he has seen in service delivery in the last decade or so and what does he predict as key advances in the next 10 years?
SUPPORTING SURGEONS

THE MODERN HEALTHCARE ENVIRONMENT PLACES MULTIPLE DEMANDS ON THE INDIVIDUAL SURGEON WHO IS EXPECTED TO DELIVER HIGH PERFORMANCE IN MYRIAD ROLES – TECHNICAL EXPERT, SKILLED COMMUNICATOR, ABLE MANAGER, SUPPORTIVE TEACHER, TRAINER AND MENTOR TO JUNIOR COLLEAGUES, AND A SCHOLAR OR RESEARCHER.

The plenary session on Charter Day, entitled Supporting Surgeons, featured a range of expert speakers who explained the difficulties that these demands can create, outlined the types of support available in other disciplines and jurisdictions and explored new support solutions that RCSI could adopt to assist in managing these demands effectively.

HOSPITAL STRESSORS
Dr Blánaid Hayes, Consultant Occupational Physician, Beaumont Hospital, Dublin opened the session with a discussion of hospital stressors. Dr Hayes shared the findings of a study of the wellbeing of hospital doctors in Ireland, a collaborative project governed by a multi-stakeholder steering group that includes representatives from the RCPI, RCSI, College of Anaesthetists, College of Psychiatry, Irish Association of Emergency Medicine and Dublin City University. The study aims to identify sources and levels of work stress, assess psychological distress and lifestyle health behaviours, identify coping strategies, report experiences of coping and seeking help, and elicit views on preferred care pathways and suggestions for intervention.

As part of this research project, a preliminary Delphi study sought opinion on the key stressors for doctors within their particular specialty. Three common themes emerged:

- the impact of the shortage of NCHDs and/or consultants on doctors’ ability to deliver safe care;
- a perceived devaluing of the contribution of doctors by commentary from employers and the media contributing to a negative working environment and lack of trust; and,
- the increased and sometimes unrealistic expectations of patients and/or their families.

Among consultants, the three primary stressors related to management planning and decision-making, the sense of being undervalued and the challenge to ensure quality of care. For trainees, the main sources of stress arose from the sense of being undervalued, personal issues and the challenge to ensure quality of care.

Dr Hayes looked at how doctors deal with stress, acknowledging the view that physicians are notoriously careless of their own health. She cited a 2009 Royal College of Physicians UK poll of doctors which stated that only 13 per cent said they would speak to a professional if suffering from mental health problems. She noted that doctors who are reluctant to seek professional advice for mental health issues may be putting themselves, and possibly their patients, at risk. It is vital that doctors should fully understand the importance of maintaining their own health and the stress inherent in a medical care role and how to manage this.

The role of the surgeon brings with it a shared unwritten code of rules, norms and expectations. Of these unwritten ‘rules’, three are particularly embedded:
1. the surgeon will work long hours;
2. the surgeon will perform a high volume of procedures; and,
3. the surgeon must keep emotional and personal problems separate.

Rather than simply accepting these rules, Dr Hayes said, they need to be scrutinised. Are they laudable or self-destructive? What consequences will they bring for the patient and the doctor? In the case of the patient, they have potential implications in terms of length of stay, costs, and the possibility of errors in care and treatment. For the doctor, there are potential personal and professional issues. From a personal perspective, the effect on health, family and relationships must be considered, while professionally, possible impacts are burnout, time off, legal and regulatory difficulties and early retirement. The extent of burnout risk was underlined by US research findings (Arch Intern Med. 2012) that found the mean burnout among all participating physicians to be over 40 per cent.

In the study of wellbeing of hospital doctors in Ireland, there is evidence of high levels (in excess of 50 per cent) of emotional exhaustion, according to Dr Hayes. The study suggests emotional exhaustion is inversely related to seniority. Emotional exhaustion is strongly correlated with over-commitment, while there is evidence of only moderate correlation with measures of psychological distress, depression, anxiety and stress.

The study indicates that individual doctors tend to present late, are reluctant to take time off and tend to try to cope via self-care. There is a sense that the system is indifferent: if you're sick, you get cover, you make up the time. Equally, colleagues are seen as unsupportive and ‘avoidant’.

Closing her presentation, Dr Hayes suggested four practical steps for the individual who is subject to stressors:

- accept vulnerability;
- be alert for triggers;
- ask for help; and,
- access care appropriately.

PHYSICIAN, HEAL THYSELF?
As part of the session’s stated intent to learn from the types of support employed by other disciplines, Dr Andrée Rochfort, Director of Quality Improvement and the Doctors’ Health in Practice (HiP) programme, Irish College of General Practitioners (ICGP) looked at the role of the GP in doctors’ healthcare. She began by explaining the rationale for setting up HiP. The programme grew out of discussions that began in the 1990s around late presentations of illness in GPs to GPs and a whole range of related issues that included: the need for mental health support; stress management, acute and chronic illness; work/life balance; burnout; and the challenges of sustaining doctors over decades of a career of patient care.

Established in 2000, the ICGP Doctors’ HiP programme aims to promote and maintain good physical health, psychological health and occupational health and wellbeing. It offers confidential healthcare from four health networks focusing on primary care services for doctors (GPs, psychiatrists, talking therapists and occupational physicians).

Dr Rochfort also listed other sources of doctor support including:
- the Practitioner Health Matters Programme, (www.practitionerhealth.ie) which deals with substance misuse, addictions, psychiatric problems in doctors, dentists, pharmacists and medical students with an ethos of ‘support rather than report’;
- the Medical Benevolent Fund, which provides financial assistance and can be contacted c/o the Communications Department, RCSI; and,
- the Health Committee of the Medical Council (www.medicalcouncil.ie).

Dr Rochfort looked at the factors that act as obstacles to seeking healthcare. They include embarrassment, time cost and financial cost, and who to see. There are also obstacles from the perspective of those who seek to provide healthcare such as the need for confidentiality and delivery of the quality of care required. The overall health system also imposes obstacles both in its culture and its structure. The individual creates their own obstacles to early action through denial and delay as well as by taking a ‘self-reliant’ approach that can include self-diagnosis, self-prescribing and self-referral.

Why might one doctor not help another in difficulty, Dr Rochfort asked? There can be several reasons, she said, including workload issues and a lack of ability to be objective because of over-identification.

When a doctor does treat another doctor, there are pitfalls too. Embarrassment, short-cuts and prescriptions are all factors and questions arise as to whether advice is given and as to who is responsible for results, referral and follow-up. In relation to care of colleagues, Dr Rochfort offered some key guidelines:
don't turn a blind eye;

- don't make assumptions;
- offer help and support;
- encourage the colleague to access a GP/formal healthcare facility, or take them there;
- you don't need to provide their healthcare personally;
- take anonymous advice if it's a 'sensitive' issue; and,
- if you are not sure what to do, don't act alone.

Dr Rochfort highlighted some of the psychological vulnerabilities of doctors. Doctors tend to have a highly developed sense of responsibility, try to please everyone and feel guilt for things they can't control. They tend to be perfectionist, conscientious and highly self-critical. Their medical training and work environment encourages peer pressure, competitiveness, self-reliance and professional detachment versus compassion.

In addition, there are job hazards that are specific to medical doctors, including:

- unique relationship with patients;
- medical error, complaints, litigation;
- distress and deaths of patients, e.g. suicide;
- self-directed care boundaries; and,
- self-prescribing.

There is an increasing amount of international activity focusing on doctors' healthcare and related issues. The European Association for Physician Health (EAPH) has been founded with free membership for doctors and students. The association's founding members are: the Norwegian Medical Association (Institute for Studies of the Medical Profession and Villa Sana Resource Centre); the Galatea Foundation, Barcelona, Spain (www.paimm.org); the British Medical Association, Doctors for Doctors Unit; Paracelsus Medical University, Salzburg; and the Irish College of General Practitioners. The International Conference on Physician Health (ICPH) is a collaborative meeting organised by the American Medical Association (AMA), the Canadian Medical Association (CMA) and the British Medical Association (BMA), which is scheduled to take place on September 18–20, 2016 in Boston.

The international research literature demonstrates that doctors have healthcare needs as a special patient group. It also shows that these needs deserve to be addressed, Dr Rochfort added.

**IMPROVING CLINICAL PRACTICE**

Ms Clare Marx, President, Royal College of Surgeons of England (RCS), addressed the topic of improving clinical practice. She began by providing some historical context to clinical practice improvement initiatives in the UK, recalling the Stafford Hospital scandal, where the Healthcare Commission Review, among other key findings, noted a lack of clinical engagement, poor leadership, a poor governance system, distorted priorities and a culture that accepted poor practice. These scandals led to a public perception of cover-ups, collusion and professional indifference, she said.

In looking at measures to improve clinical practice, RCS believes that invited reviews offer a highly valuable resource by providing healthcare organisations with independent expert advice. Invited reviews are a partnership between the RCS, the specialty associations and lay reviewers representing the patient and public interest. An invited review supports, but does not replace, existing procedures for managing surgical performance.

Ms Marx’s presentation highlighted problems regularly identified in the reviews relating to issues surrounding clinical engagement, leadership and teamwork. In relation to working relationships and team working, there is recurring reporting of poor team communication, poor interactions and lack of colleague respect. A lack of functioning team structures was cited, with teams not meeting or poor behaviour occurring at meetings.

At an individual level, there was evidence of a lack of insight, avoidance of personal responsibility for complications or a defensive response, an inclination to challenge those raising concerns, and day-to-day behaviours that others reported as unacceptable.

In relation to surgical audit processes, it was found that there was a lack of focus on quality and safety of clinical care, and on the use of audit to drive quality improvements.

Trainee doctors raised multiple concerns, including feedback being ignored, poor training environments and being subjected to bullying and harassment.

Looking at the management of concerns, the reviews indicated:

- poor immediate handling of the individual or individuals raising concerns;
- poor initial response/lack of expertise or unwillingness to use disciplinary processes or external support;
Ms Marx prefaced her report on issues raised by the invited reviews in regard to the standard of clinical leadership with a quote from Michael West, Senior Fellow, King’s Fund, the independent charity working to improve health and care in England: “The best leaders deal effectively and quickly with quarrelsome, rude and disruptive behaviour and poor performance, especially (but not exclusively) among senior staff.”

Invited reviews noted a lack of clarity around clinical leadership roles and standards and a lack of acceptance of leadership from surgeons who are team members. The review findings suggested that surgeons are not good at being ‘followers’.

Ms Marx said that the invited review experience is used to drive professional standards publications and guidance. Personally reflecting on the invited review data, she said that she believes the fundamental guiding principle in improving surgical practice should be ‘show me the evidence’. She emphasised the importance of good leadership, noting that in over half of the reviews poor leadership had a significant impact on the inability to deliver safe and effective patient care. She concluded by commenting: “We are all leaders, with that comes responsibility.”

**PSYCHOLOGY INTERVENTIONS**

Ms Barbara Wren, Consultant Psychologist, discussed the development of psychology interventions to provide support to surgeons and improve effectiveness. Echoing the views of other speakers, she spoke of a context in which the pace of change has accelerated and is less controlled, levels of uncertainty and anxiety have increased and there is a perception that organisational commitment to the individual is reducing. Overall, surgeons are surviving, not thriving. Poor mental health and a resort to drugs and alcohol is very common, accompanied by attendant risks of secrecy and collusion.

Re-iterating recurring themes of the session, she said that doctors have high rates of stress/poor mental health; may conceal or deny problems; carry on working when unwell; seek help late; have access to prescription drugs; and have working environments that can add to stress.

Developing psychology services in healthcare settings involves adapting the world of therapy to the world of work and mapping explicit theories, psycho-education and empowerment to the achievement of performance enhancement, stress management and goal achievement, Ms Wren said.

Multi-level interventions are important to achieve an effective impact on wellbeing and effectiveness. They must encompass the building of resilience and skills at individual level and the identification of risks alongside the development of accompanying structural and systemic solutions at organisational level. These interventions must also include the provision of consultancy training and mediation for managers.

Ms Wren pointed to the link between staff and patient experience in a hospital and how the quality of one impacts on the quality of the other. She pointed to the need for protection of staff through the provision of clarity and consistency to individuals as well as the importance of supporting and encouraging staff resilience. There is a need, she said, to develop the concept of teamwork as solace, as well as a route to effectiveness.

Having outlined the principles behind the strategic design of interventions, Ms Wren described a practical example – Schwartz Rounds. As a hospital-wide reflective process, Schwartz Rounds are meetings which provide an opportunity for staff from all disciplines to reflect on the emotional aspects of their work. Ms Wren described the Schwartz Rounds as private conversations in public places that facilitate individual and cultural change and tend to have a high uptake and high value. They use psychology to make safe links between private and public experience.

The organisational impact takes place in a number of ways, Ms Wren explained. It is felt in the selection of specific cases and the preparation of the Schwartz round panel, through the performance of each contributor in telling their story, through group reflection and in the ripple effect, subsequently.

Ms Wren gave examples of the issues dealt with in some Schwartz Rounds, including:

- dealing with a patient who threatened to kill a nurse;
- an organ retrieval team sharing their experience of work and how it impacted them;
- senior clinicians describing making errors/being reported to the GMC; and,
- senior staff sharing traumatic memories and how they built resilience through those experiences.
Benefits that can accrue from the process, according to Ms Wren, include:

- the creation of safe links between private and public experience;
- the development of authenticity and resonance;
- relation of stories, which creates a sense of permission to speak out; and,
- keeping the organisation and the individual in mind in order to manage disappointment realistically.

HELPING SURGEONS

Professor Sean Tierney, Dean of Professional Development & Practice, RCSI, spoke about the development of a strategic approach to the strengthening of professional support, noting that a key RCSI mission is “to be the lifelong professional ‘home’ for our Fellows and Members through the provision of meaningful professional and collegiate support and to provide leadership, insight and support to healthcare policy makers, regulators and service providers in pursuit of excellence in surgical care.”

He then outlined some of the measures, driven by that mission statement, that are contained in the new Supporting Excellence in Surgical Training and Practice – A strategy for 2016-2020 document, which sets out the strategic priorities for the Department of Surgical Affairs for the next five years. The measures include:

- development and support of a lifelong Professional Development Framework for surgeons;
- development of a Healthcare Outcomes Research Centre;
- development and launch of a Surgeons Assistance Programme;
- support of the development of service delivery structures;
- expansion of national clinical audit; and,
- support and engagement with Fellows and the wider surgical community.

Looking in more detail specifically at the Surgeons Assistance Programme, he explained why he believes it is necessary. Specifically, he pointed to the highly stressful environment within which surgeons practise, an environment characterised by escalating clinical, training, governance and regulatory demands that challenge the provision of optimum patient care and excellent training.

The surgeon in difficulty will be a focal point for assistance with processes aimed at preparation and prevention in the first instance, identification and support where necessary, followed up by a commitment to re-skilling and remediation.

In developing structures to help identify and support the surgeon in difficulty, Professor Tierney said the pathways created need to be primarily supportive and robust, not regulatory and disciplinary. Mentorship will play a vital part in the re-skilling and remediation process. Graduated practice will take place off-site in a structured framework that is goal-driven and time-bound.
RCSI PUBLISHES FIRST DATA ON ADVERSE EVENTS

New research has found that one in eight patients admitted to hospital during 2009 experienced adverse events. This is the first time such research has been carried out in Ireland and the figures are broadly consistent with baseline studies conducted in other countries. The study, which was carried out by RCSI in collaboration with the Royal College of Physicians in Ireland, has been published in the *BMJ Quality & Safety Journal*. It was funded by the Health Research Board (HRB) and the Health Service Executive (HSE).

An adverse event is an unintended injury or complication as a result of healthcare management that results in a prolonged hospital stay, disability at the time of discharge from hospital, or death.

THE IRISH NATIONAL ADVERSE EVENT STUDY: KEY FINDINGS

- **Numbers:** one-in-eight patients (12.2 per cent) experienced an adverse event as a result of hospital care in 2009.
- **Impact:** Almost 7 in 10 of these were rated as having a mild to moderate impact on the patient (ranging from no physical impairment at discharge to moderate impairment but recovery within 6 months), a further 5 per cent caused moderate impairment with disability lasting 6 to 12 months, 10 per cent caused permanent impairment (disability lasting greater than a year), 11 per cent the level of impairment was not recorded at the time of discharge and 7 per cent contributed to death. Over 70 per cent of the events were considered preventable.
- **Type:** The adverse events included: readmission with additional symptoms, hospital acquired infections, delayed diagnosis, and surgical adverse events.
- **Risk:** Adverse event risk was higher in admissions for surgical procedures.
- **Cost:** The estimated annual cost of adverse events in 2009 was €194 million.
- **Age:** The average age of patients with an adverse event was significantly higher than those without (61.8 years versus 55.4 years). There was an 18 per cent increase in the risk of an adverse event with every 10 years added to the patient’s age.
RCSI MYHEALTH PUBLIC LECTURE SERIES

RCSI has kicked off a new series of public lectures called the RCSI MyHealth Public Lecture series. The first lecture focused on ‘The Rise and Rise of Diabetes in Ireland’. Medical and research experts discussed the rapid growth of diabetes to help people make informed health decisions about living with the condition. Professor Paul Johnson, Paediatric Surgeon, from the University of Oxford, discussed ‘Type 1 Diabetes - ‘One Step Closer to a Cure’. Dr Aisling O’Leary, Lecturer in Pharmacy Practice, RCSI discussed ‘Diabetes Medications - Current Treatments and What the Future Holds’ and Dr Diarmuid Smith, Consultant Endocrinologist from Beaumont Hospital explored ‘Type 2 Diabetes - Prevention and Treatment’.

The second lecture on April 27 focused on “Active Lifestyles - Helpful or Harmful?” Speakers on the topic included Professor Fergal O’Brien, Head of the Tissue Engineering Research Group, RCSI; Professor John M. O’Byrne, Orthopaedic Surgeon & RCSI Professor of Orthopaedic Surgery; Ms Louise Keating, Chartered Physiotherapist and RCSI Lecturer in Physiotherapy; and Mr Peter Connolly, Occupational Therapist, Saint John of God Hospital. The lectures are available to view on youtube.com/RCSIIrl

NOMINATIONS OPEN FOR MILLIN LECTURE 2016

The 39th Millin Lecture will be delivered during the Millin Meeting on 11th November 2016.

Fellows of the College are invited to nominate candidates who are either Members or Fellows of the College, in good standing, for this lectureship. Completed applications must be received before Friday 6th May 2016.

This is a prestigious award and open to all the Surgical specialties. Usually, the successful applicant will be well advanced in his/her surgical training or in their first five years in consultant practice. Preference will be given to candidates whose surgical research has been carried out wholly or in part in Ireland. The subject chosen should be of clinical interest embodying original research.

For further information visit rcsi.ie/millinlecture
PROFESSOR THE LORD ARA DARZI RECEIVES UK’S HIGHEST HONOUR

Earlier this year Professor the Lord Ara Darzi of Denham OM KBE PC, an Alumnus and Fellow of the College was admitted to the UK’s Order of Merit for outstanding contribution to medicine and global health. He was one of three new admissions to the Order, which were announced as part of the Queen’s New Year’s Honours 2016.

He holds the Paul Hamlyn Chair of Surgery at Imperial College, London and is an Honorary Consultant Surgeon at the Imperial College Healthcare NHS Trust and the Royal Marsden NHS Trust Hospitals.

‘SURGEONS AND INSURGENTS – RCSI AND THE EASTER RISING’

More than 8,000 visitors attended RCSI to view the College’s exhibition exploring the human stories of surgeons and insurgents associated with the College and the 1916 Easter Rising. The exhibition brought visitors on a journey of RCSI’s occupation during the 1916 Easter Rising with a focus on the stories of nine surgeons and nine insurgents involved in these historical events. A video of the exhibition will be available to view on the RCSI YouTube channel (youtube.com/RCSIrl) from early May.
CSI recently published Supporting Excellence in Surgical Training and Practice – A strategy for 2016-2020, setting out the strategic priorities for the Department of Surgical Affairs for the next five years. Speaking to Surgical Scope, Mr Eunan Friel, Managing Director, Surgical Affairs, provides an overview of what has been accomplished in the previous five years; Professor Oscar Traynor, Professor of Postgraduate Surgical Education, outlines what the strategy will mean for surgical training; Professor Sean Tierney, Dean of Professional Development & Practice, discusses its implications for surgical practice; and Mr Paul Nolan, Associate Director for International Programmes, Surgical Affairs, highlights key developments in international activities.

I. SURGICAL TRAINING

Looking to the future of surgical training as outlined in the new strategy and the context in which it will be delivered, Professor Oscar Traynor comments: “Surgical training takes place in an intensely challenging environment. There are ongoing pressure points arising from the hospital-based training environment, from trainees as well as those who fund surgical training. Full implementation of the European Working Time Directive (EWTD) in Ireland has limited the number of working hours to 48 per week. “Regulatory oversight continues to place demands on RCSI to ensure training programmes produce specialist doctors/surgeons who are ‘fit-for-purpose’ and verifiably safe for independent practice.”

RCSI continues to evolve its training structures to meet these challenges. Our most significant step in this regard was the introduction of the new Surgical Training Pathway in July 2013. According to Professor Traynor: “The pathway has successfully addressed several issues in training, but there remains much to do to further refine it. The new strategy document outlines measures that need to be taken to refine the new Core Training programme and implement other strategic initiatives across the continuum of training.”

The strategic priorities identified for surgical training are:
1. refinement of the new Core Training Pathway;
2. development of the Specialist Training Pathway;
3. development of a robust, integrated e-learning programme;
4. development of a robust, quality assurance programme and capability;
5. curriculum refresh; and,
6. research and academic surgery.

CORE TRAINING PATHWAY

Professor Traynor says that a review of the core training pathway is planned to recommend appropriate refinements to selection, assessment and progression processes, and to ensure broad-based input from all specialties. “Further developments will include a structured and supportive programme of trainer and training site development and accreditation, as well as the establishment of a robust and broad-based trainee support and mentorship programme.”

SPECIALIST TRAINING PATHWAY

A number of important, innovative developments are planned for the Specialist Training Pathway. Professor Traynor explains: “The
Intercollegiate Surgical Curriculum Programme (ISCP) is to be rolled out to all surgical specialties and, working through the ISCP, we will develop a robust assessment framework which will demonstrate that trainees have verifiably achieved the required competencies. There will be a refreshed Human Factors and Patient Safety Curriculum delivered to support broad-based medical professionalism.

“At a wider level, structured engagement with the HSE NDTP (National Doctors Training and Planning) will aim to enable integrated consultant manpower planning while a rigorous training programme accreditation cycle will be supported in conjunction with the Irish Medical Council.”

**INTEGRATED E-LEARNING PROGRAMME**

Innovative, structured learning interventions will be critical to the formation of our future surgical consultants, Professor Traynor says. “In recognition of this, we will integrate a technology-enhanced learning programme within a broader curriculum review.”

Key aspects of an integrated e-learning programme will include refocusing of RCSI-based learning to practice-based simulation and maximising the focus of RCSI training days towards skills training rather than didactic teaching.

**QUALITY ASSURANCE**

The delivery of more objective criteria to underpin selection, assessment and progression processes will be crucial to the evolution of the Surgical Training Pathway, Professor Traynor notes. “The high stakes implications, in terms of training and progression, require that these processes are robust and fully quality assured. In the broader arena of organisational efficiency, we must strive to ensure that our responsibilities across training, professional development and Fellowship management are discharged efficiently, impartially and in a reproducible and defensible manner.”

**CURRICULUM REFRESH**

Professor Traynor believes the planned opening of the new clinical skills and simulation suite within the new RCSI Academic and Educational Building offers an unprecedented opportunity to reimagine the structure and delivery of both skills and behavioural curricula. “The investment in online learning facilitates the direction of RCSI-based learning towards simulated skills, procedural and behavioural learning events. Our curriculum will support the broad dimensions of surgical professionalism and underpin the medical competencies as defined by the Irish Medical Council.”

He says there will be an end-to-end review of the Core Training curriculum, in both technical and procedural skills.

**RESEARCH AND ACADEMIC SURGERY**

There is, he says, significant potential to refine and improve the quality of surgical education and training through the pursuit of original research within Surgical Affairs with a singular focus on surgical education and training. Important steps that will be taken to accomplish this objective include the development of a suite of Masters programmes and a structured surgical research plan within Surgical Affairs.
II. SURGICAL PRACTICE

RCSI’s mission in support of surgical practice reflects its role as both a college of surgeons which supports the lifelong professional needs of its Fellows, and its role as a college of surgery which provides leadership in the care of surgical patients. Professor Sean Tierney, Dean of Professional Development & Practice says that RCSI is committed to playing a leadership role in supporting the journey that policymakers, clinical and non-clinical healthcare partners, regulators and Fellows will make to deliver the standards of surgical care that patients expect and deserve. The strategic priorities identified for surgical practice are:

1. the development and support of a Lifelong Professional Development Framework for surgeons;
2. the development of a Healthcare Outcomes Research Centre;
3. the development of a Surgeons Assistance Programme;
4. support for the development of service delivery structures;
5. expansion of national clinical audit; and,
6. support for, and engagement with, RCSI Fellows and the wider surgical community.

PROFESSIONAL DEVELOPMENT

Professor Tierney says that, while the existing PCS meets the obligations set out under the Medical Practitioners Act, it is necessary to move beyond supporting competence to accept the challenge and responsibility of leading and developing the whole breadth of medical professionalism. “This broader vision will include the development of a surgical professionalism framework document that will map the Irish Medical Council Ethical Guidelines and other guidance on medical practice to the specifics of surgical practice in Ireland.”

HEALTHCARE OUTCOMES RESEARCH CENTRE

The new Healthcare Outcomes Research Centre will leverage and benefit from RCSI’s existing research infrastructure to develop a dedicated unit providing evidence-based input to improved patient pathways in the clinical care setting. Professor Tierney comments: “The unit will bring together existing capability and related research output as well as conduct its own bespoke research to better understand differential patient outcomes across care pathways.”

SURGEONS ASSISTANCE PROGRAMME

Professor Tierney says RCSI recognises that surgeons experience many pressure and change points throughout their careers which can challenge the provision of excellent training and optimum patient care. “We believe it is vital, therefore, to develop a professional, collegiate and trainee support unit to facilitate the provision of both clinical and extra-clinical care support. Among the key initiatives planned is a ‘surgeons in difficulty’ programme that will offer process support and mentorship to surgeons undergoing regulatory or employer investigation, or disciplinary processes. “Alongside this, we will develop an appropriate education and support programme for surgical trainees to prevent the difficulties that can arise as a result of challenges within their professional training environment, or their personal lives, and to provide mentorship and support when difficulties do occur.”

SERVICE DELIVERY

RCSI is committed to providing the clinical leadership that will inform service improvement planning, Professor Tierney says. The College also supports the broader service aspiration for more integrated care pathways and is committed to contributing meaningfully to the practical implementation of the hospital networks in support of service and training.

In pursuit of these objectives, Professor Tierney says that RCSI believes it is necessary to refocus its own efforts in a number of ways: “RCSI is working in collaboration with the HSE through the clinical programmes to develop appropriate specific service models of care and service pathways across all surgical specialties including robust referral pathways for care that are regionally or nationally centralised.”

NATIONAL CLINICAL AUDIT

Since the National Office of Clinical Audit (NOCA) was established in 2011, it has grown significantly and has established robust governance, data collection and management frameworks to enable a national approach to clinical audit across a range of medical specialties. Professor Tierney says: “Contributing to the enhancement of NOCA will involve a range of measures. The finalising of data governance, management and data access policies to international best practice as determined by external audit and peer review will be a crucial aspect of these measures and it will also be vital to ensure hospital-based processes for data collection and validation are defined, resourced and implemented.”
SUPPORT AND ENGAGE OUR FELLOWS
RCSI is committed to optimal representation of its Fellowship. Professor Tierney says the College will continue to develop a strong professional, academic and collegiate value proposition, via the agreed strategic objectives, to support growth in membership in a number of ways. “This will include reinvention of the Fellows and Members Office within the recently enhanced Development & Alumni Office and effective use of technology to communicate with Fellows and Members developing, in particular, more responsive listening strategies.”

III. INTERNATIONAL PROGRAMMES
Paul Nolan, Associate Director for International Programmes, Surgical Affairs, outlines the Department’s rationale for operating in international markets: “Our objective is to build the reputation and awareness of RCSI and to generate financial resources that can be re-invested domestically in both professional practice and postgraduate surgical training initiatives.”

The priority areas for development across the International Programmes are:
1. Membership of the RCSI examinations;
2. International Medical Graduate training;
3. Medical Validation Ireland.

MRCS EXAMINATION
Part A of the Membership of the Royal College of Surgeons (MRCS) examination is a written paper and Part B is an Objective Structured Clinical Examination (OSCE). RCSI was the first of the four surgical Royal Colleges of Great Britain and Ireland to provide the intercollegiate MRCS Part B OSCE in all of its centres. Over the last four years, Mr Nolan says: “RCSI has driven membership examination candidate numbers in Bahrain, Ireland, Jordan and Malaysia through dedicated marketing communications efforts. RCSI will maintain this focus and explore potential new markets in 2016 and beyond, with a view to further growing applications. A suite of supports is being developed for the college’s MRCS examination candidates to assist them in preparing for the examination and meeting the required standard.”

INTERNATIONAL MEDICAL GRADUATE TRAINING
Surgical Affairs at RCSI has worked with internal stakeholders, other postgraduate training bodies, the HSE and client organisations since 2012 to develop a framework that would allow sponsored International Medical Graduates (IMGs) to undertake discrete periods of training in Ireland. Mr Nolan explains: “RCSI launched the Academic & Clinical Fellowship Programme (ACFP) in July 2013 when three Saudi Board-certified candidates commenced Fellowship training in General Surgery with RCSI. We have continued to refine and enhance the programme in the years since and also piloted a Collaborative Residency Programme. We are also considering establishing an RCSI Surgical Academy to attract international surgical trainees for Masters programmes in Surgical Science and Practice and other intensive skills courses in the new National Surgical Training Centre.”

MEDICAL VALIDATION IRELAND
Medical Validation Ireland (MVI), a wholly-owned strategic business unit of RCSI, was established in 2013 to undertake a Revalidation Programme for all consultants working at Hamad Medical Corporation and the Primary Health Care Corporation in Qatar. Mr Nolan says: “The programme undertaken in Qatar was very successful. We revalidated almost 800 consultant clinicians working across the public health system there. This success was largely due to our effective collaboration with Partner Training Bodies including RCPI, CAI, ICGP, CPsychI and the Faculties of Dentistry and Radiologists at RCSI. Thanks to that collaboration, MVI is uniquely positioned with the capacity to assess the full breadth of medical and dental practitioners. We also have the capability to assess disciplines such as Nursing, Pharmacy, Physiotherapy and Allied Health Specialties. We are actively pursuing new business with existing clients in Qatar, as well as working with Enterprise Ireland to develop client relationships in the United Arab Emirates and other Gulf States.”

SUPPORTING EXCELLENCE

Mr Paul Nolan, Associate Director for International Programmes, Surgical Affairs.
S maller or Model Three Hospitals – which admit undifferentiated medical and surgical patients and provide services such as acute medical assessment unit (AMAU), 24-hour emergency department (ED) and Intensive Care Unit (ICU) facilities – are facing serious issues in recruitment for key surgical posts in general surgery and the causative factors are set to exacerbate in the years to come, Mr Ken Mealy, Co-Lead NCPS told delegates at this year’s Charter Day Meeting.

THE CHALLENGES FACING MODEL THREE HOSPITALS
While these are smaller hospitals, Mr Mealy stated, this does not mean their range of activity is small. Hospital inpatient enquiry (HIPE) scheme statistics show that Model Three Hospitals account for 49.9 per cent of all general surgery discharges nationally. However, analysing these figures, reveals a more complicated picture. In total, 52 per cent of elective surgery in the Model Threes is accounted for by endoscopy procedures. In fact, the commonest operations on elective patients in Model Threes are the excisions of minor lesions, appendicectomies, cholecystectomies and hernia repair.
Furthermore, only 22 per cent of the acutely admitted general surgery patients in Model Threes actually undergo surgery. The other 78 per cent consist of patients being admitted for a variety of reasons, ranging from lack of in-community care resources to observation of conditions such as head injuries. Ultimately, the smaller the hospital, the greater the number of patients that are admitted for ‘surgery’ without actually having an operation.

Mr Mealy noted, that, in terms of processing patient care effectively within the low acuity framework outlined above, metrics are consistently better in the smaller hospitals. This level of performance, however, masks a growing and underlying problem – the increasing strain in maintaining general surgical consultant staffing within Model Three Hospitals.

The extent of the growing manpower issues that Model Threes face are evident from two recent studies on general surgical consultant staffing, RCSI’s Interim Report on a Working Group on Surgical Service Delivery and Workforce Planning in July 2014 and updated details obtained from Model Three Hospital Manpower Managers in December 2015. These figures indicate the 17 Model Three Hospitals are being served by 76 general/vascular surgeons; of these, 22 per cent are due to retire within the next five years; and 19, or 25 per cent of the total, are locums. In five years’ time, it is projected that 47 per cent of general surgery posts will be held by locums. Moreover, 54 per cent of surgeons have not gone through a recognised training scheme in Ireland and, by 2020, it is projected that figure will reach 76 per cent. Mr Mealy said that absence of formal training in Ireland is not in itself concerning, but the resulting knowledge gap in relation to the training of a substantial proportion of surgeons is a significant unavailable metric at a time when all aspects of the healthcare system are making committed efforts to adhere to increasingly rigorous audit processes.

THE TRAINEE PERSPECTIVE

The most serious question raised by these workforce studies is – why are so many surgeons training in Ireland not taking up positions in Ireland? In a first step to answering this question, RCSI commissioned a survey of all general surgery trainees (from ST 2 to ST 8 inclusive) in December 2015, under the direction of Padraig Kelly, Programme Manager Quality and Process Transformation, Dept. of Surgical Affairs, RCSI. With a 46 per cent response rate, the survey presents an overview of the career intentions of the respondents, as well as insights into the rationales behind their choices and their attitudes to careers in Model Three Hospitals.

Offered the option of rating potential career directions in order from ‘most desirable’ to ‘least desirable’, 73 per cent of respondents chose Model Four Hospitals (Academic Teaching Hospitals) as their most desirable option, while only three per cent opted for Model Three Hospitals. All other career directions specified scored higher than Model Three Hospitals, with 15 per cent selecting to work abroad and 11 per cent selecting a joint appointment between Model Three and Model Four Hospitals as their most desirable option. Looking at the latter figure, Mr Mealy suggested that the joint appointment proposal might offer a Model Three manpower solution in a limited number of instances.

By far the most significant determinant in trainees’ decision-making processes, as revealed by the survey, is the structure of the post being offered and the access it provides to complex cases (49 per cent gave this as the most relevant factor in choosing a post). The next most important determinants are research and academic opportunities (18 per cent) and training and skills enhancement (also 18 per cent). Thereafter, the determinants, in descending order of significance, are: lifestyle and cost of living (15 per cent); location and geographical issues (12 per cent); and work-life balance (9 per cent).

Overall, current general surgical trainees are unwilling to take up posts in Model Three Hospitals due to a cluster of issues relating to:

- emergency on-call rotas (57 per cent of those surveyed responded that a 1:6 rota would make a post more attractive, while 43 per cent said a 1:5 rota would be attractive);
- a lack of ongoing skills enhancement opportunities;
- lack of complex surgical conditions to manage;
- limited research and academic opportunities;
- isolation from colleagues; and,
- poor trainee support.

WHAT NEXT?

So, Mr Mealy asked, what are the implications for the future development of general surgery in Model Three Hospitals? The ‘status quo’ could be maintained but, in the medium to long term, as the manpower statistics and survey responses demonstrate, that is not a sustainable solution.

The second option is to make small adjustments to the organisation of surgical services at local/regional level, reconfiguring the acute/elective mix between Model Three and Model Four Hospitals within the existing Hospital Group structures. The Mid-Western Regional Hospitals Group has had success with this approach but it is questionable whether this strategy is workable for more geographically diffuse Hospital Groups. The third option – the global reform of national general surgical services – offers a comprehensive solution but is the most challenging to achieve. Acknowledging the complex political implications of a radical reorganisation of surgery services, Mr Mealy pointed to the overwhelmingly positive impacts such a transformation would accomplish, including:

- the transfer of many non-operative surgical patients to more appropriate specialty care;
- greater separation of acute and elective surgical care;
- stand-alone elective facilities; and,
- fewer and larger acute care facilities.

The delivery of reform on this scale is a major undertaking, which will ultimately require decisive political commitment, Mr Mealy said, but the initial impetus for change must come from within the heart of the healthcare sector. The vital first steps to create a wider understanding of the issues involved must begin at Hospital Group level with a concerted effort to promote awareness among local communities of the fundamental importance of models of care to patient wellbeing. This message must be accompanied and supported, he added, by ongoing, intensive and in-depth analysis of evolving demand and capacity requirements across the country.
Clinical effectiveness is a key component of patient safety and quality, according to Professor Humphreys. “The integration of national and international best-available evidence in patient care through the use of clinical effectiveness processes promotes healthcare that is up to date, effective and consistent. Clinical effectiveness incorporates the use of quality-assured national clinical guidelines and national clinical audit. It is a quality improvement approach which promotes healthcare that is evidence-based with improved clinical decision-making and clinical outcomes.”

**CLINICAL GUIDELINES**
The development of clinical effectiveness guidelines is aimed at assisting practitioners to provide optimum care and to reduce variation in standards. National clinical guidelines are systematically developed statements, based on a thorough evaluation of the evidence, to assist practitioner and patients in making decisions about appropriate healthcare for specific clinical circumstances and across the entire clinical spectrum.

While the guidelines are intended to improve patient care through a systematic evaluation of current practice, they also recognise that each patient is an individual, Professor Humphreys said. “The guidelines provide an evidence-base for best practice but there is a recognition that each patient is different and that it may be necessary to adjust care to a specific patient’s needs. The guidelines provide robust evidence-based approaches to underpin or define models of care as appropriate, which means there can be confidence in how they have been developed and the implementation plan that goes with them. They will apply to most patients and, in the absence of exceptional circumstances, it makes sense for every practitioner to use them.”

The NCEC’s work has, so far, predominantly concentrated on the setting up of methodologies and systems to develop guidelines. “So far, 14 guidelines have been developed and prioritised, the first in 2013. The most recent guideline prioritisation process was completed in November 2015. The guidelines being produced now are of international standard and subject to rigorous assessment, including a systematic review of the scientific literature, peer review and economic evaluation. “We have also received important input from the National Institute for Health and Care Excellence in the UK. They operate a different system, and are separate from the Dept of Health in the UK, but their advice and feedback has been invaluable. We have been particularly encouraged by their endorsement of our guideline on sepsis.”

**CLINICAL AUDIT**
Clinical audit is a cyclical process that aims to improve patient care and outcomes by systematic and structured review and the evaluation of clinical care against explicit clinical standards. Professor Humphreys said: “Clinical audit can look at the structures of care, the processes of delivering care or the outcome for individuals receiving that care. Clinical audit is about improving outcomes through review, evaluation and improvement in clinical practice, where indicated. It achieves this by collecting specific data and matching that against clinical standards.

“Where practice as determined through audit is shown not to meet the standards, clinical teams must make changes based on exploring why the standards were not met. Subsequent data collection then occurs to see if the implemented change has brought about the desired improvement.”

In order to become an NCEC National Clinical Audit endorsed by the Minister for Health, a clinical audit must go through the prioritisation and quality assurance processes of the NCEC. “We need processes that support and guide the health system and the NCEC hope to advance this through the endorsement of key audits.”

The NCEC audit function was developed during 2015 and, towards the
end of the year, the NCEC confirmed the prioritisation and quality assurance processes for National Clinical Audit and the Framework for Endorsement of National Clinical Audit. The next step was to identify a well-established national clinical audit to test the processes. “Not all clinical audit will become NCEC National Clinical Audit but rigorous and nationally-representative clinical audit is required to inform and evaluate national policy and help develop health services.”

PRIORITISATION
The prioritisation process is a tool to assist the NCEC with its deliberations in relation to identifying those national clinical audits most likely to reduce variation in practice, resulting in improvements in safety and quality. “This process provides transparency for the NCEC to consider potential audits and supports the Committee and the health system in structuring its audit development work for planned time periods.

“The quality assurance process is a tool to help the NCEC in its considerations in assuring that National Clinical Audits have been developed in a robust manner, are governed appropriately and are implemented in line with international best practice. These are evolving processes and will be reviewed by the NCEC annually and updated as necessary.”

Professor Humphreys continued: “We have worked closely in consultation with the National Office of Clinical Audit (NOCA) to prioritise the first audit to go through the process. We have received great cooperation and assistance from Fiona Cahill, Executive Manager, NOCA, and NCEC member, throughout the prioritisation process.

“The NCEC has taken the view that the Major Trauma Audit, as a well-established and mature audit, is an appropriate initial audit to go through the process. As this is the first audit, it is an extremely important process, both for the NCEC and for those carrying out audits. We want to support the audit groups and their work. Ultimately, our objective is that many audits will be sufficiently robust to achieve national endorsement. We’re confident that benefits will accrue to all involved from going through the process. In terms of duration, the accreditation process generally takes several months and involves extensive reviews of documentation, as well as detailed consultation with guideline developers and others. How it goes and what it will tell us remains to be seen.”

Professor Humphreys said he wanted to assure surgeons that this is not ‘a box-ticking exercise’: “My message is that our objective is to help practitioners to do what is best for the patient and improve the quality of care. We welcome feedback from all involved to help streamline and enhance our processes.”

He added: “I want to acknowledge the tremendous work of Dr Kathleen MacLellan, Director of Clinical Effectiveness, and her team at the Clinical Effectiveness Unit in the Department of Health who have supported the NCEC by advancing the processes and reaching out to relevant stakeholders. This has resulted in the allocation of resources for both the Committee and guideline and audit developers through assistance in the conduct of systematic review and economic evaluations.”
Vice Admiral Mellett, provided an overview of his strategic approach to his role as Chief of Staff of the Defence Forces since taking office five months previously. His responsibility is to work with the Secretary General, supported by the general staff, under the leadership of the Minister for Defence to continue the transformation of the Defence Forces to a fit-for-purpose organisation as a key element of Ireland’s security architecture, he said. As an organisation, the Defence Forces must be able to deliver defence, security and government services in accordance with the nation’s priorities and interests at home and abroad. He commented: “We must not only be relevant, usable and adaptable, but increasingly we must be able to anticipate the future against a background full of disparate and conflicting influences.”

**DOMESTIC JURISDICTION**

In terms of Ireland’s domestic jurisdiction, the Vice Admiral noted, few people appreciate its scale – one million square kilometres, 93 per cent of which is under water. Ireland has, statistically, some of the most hostile seas in the world and our air space is the centre of gravity for most travel between Europe and North America, with 90 per cent of North Atlantic air travel transiting space under Irish control. As one of the fastest growing economies in Europe, he said, we have to be mindful that economic security is inextricably linked with state security and that is why it is in our interests, from a defence perspective, that our economy is healthy and flourishing. He continued: “When you begin to mix defence and government with civil society and the market, you begin to enter a world of complexity, but when you inject strategic vectors such as growth in technology and international security, the complexity level rises.”

**INTERNATIONAL CONTEXT**

He outlined some of the most concerning factors in international security: “All over the world, we see situations characterised by extraordinary complexity. We must continue to be vigilant and conscious of the actual and potential implications of instability in the Ukraine, where we have a hybrid war. This is war where the full range of elements – conventional warfare, terrorist warfare and cyber attacks – are all employed. In Syria, there is a full-scale proxy war with the Iranian/Russian/Hezbollah trilogy backing Shia militias with the Assad regime, while Turkey and the US back anti-government armed elements. The malign influence of Isis extends right up to our Western European doorstep with the recent attacks in Paris. Its tentacles through social media are all around us and its attempts at radicalisation are a clear and present danger. And its activities align with other groups such as Boko Haram in Nigeria.”

All of these challenges undermine the institutions of state and civil society, he said. In this context, the soldiers, sailors and air crew of Óglaigh na hÉireann provide a bedrock which underpins our sovereignty and sovereign rights. Every man, woman and child has the right to live in a free, civil society, he continued, and that is why last year Óglaigh na hÉireann had almost 500 men and women in 16 missions in 15 countries and one sea, endeavouring to provide and protect a secure environment, a key element in the provision of a civil society. He said: “These deployments are in our national interests and they define us as a civilised society.”

**FUTURE STRATEGIC DEVELOPMENT**

Looking to the future strategic development of the Defence Forces, he said that key policy objectives are defined by the political. In that context, the publication of the White Paper on Defence last August, posed two key questions – what does the government want and what do the citizens want from their defence organisation? Some of the key requirements highlighted in the document include:

- a force structure of about 9,500 personnel;
- a commitment to ongoing capability development;
- greater innovation;
- a defence commitment to an employment support scheme where the Defence Forces will take in vulnerable 18 to 24 year olds to develop their competencies and confidence, with a view to creating greater opportunities for them in life;
- a new veterans policy; and,
- the development of an institute for peace and leadership.
STAYING PROFESSIONAL ON SOCIAL MEDIA

BY DR GORDON MCDAVID
Medicolegal Adviser at Medical Protection

Social media offers innovative and ever-changing ways to interact and share information and as such, has an important future in healthcare. Whilst there are significant potential benefits, social media can also present many new challenges for healthcare professionals such as blurring the boundaries between personal and professional life. Something as simple as a post about a situation at work, that was intended to be between close friends, could invite a complaint, disciplinary action or even a referral to the Medical Council.

Medical Protection has worked with the Medical Council to develop the eighth edition of the Guide to Professional Conduct and Ethics for Registered Medical Practitioners, which will be released on May 17. I’m pleased that particular guidance on using social media will feature in the updated guide, as this reflects both its pervasive influence and follows requests for such guidance from many doctors and healthcare professionals.

Whilst we await the release of the new guidance, Medical Protection recommends the following in relation to communicating via social media:

ACT PROFESSIONALLY
Doctors hold a unique position of trust in society and it is vital that they remain aware of their ethical duties. Social media has enabled any individual to publish comments online to a potentially national or global audience, however, there is no such thing as being truly anonymous online as identities can be traced. It is important for doctors to consider who may be able to access their online material (such as photographs of them), whether there is information on their profile that they would not want shared, and ensure their security settings are appropriate. Doctors should also consider whether they would be satisfied with their patients, colleagues and employers viewing their posts or uploads before commenting and pressing ‘enter’.

PRIORITISE PATIENT CONFIDENTIALITY
It is all too easy to make a comment online about a difficult or unusual patient interaction, yet such action could constitute a breach of confidentiality by releasing identifiable information about a patient - even if their name has not been used. It is important for doctors to ensure they remember their duty of confidentiality, take care to avoid unintentional disclosures and be aware that any comments they make may reach a far wider than intended audience.

ENFORCE BOUNDARIES
When interacting face-to-face with patients, it is often obvious if a professional doctor-patient relationship diverts from the norm and early correction can occur. However, this is not always clear when using social media as seemingly innocent online discussions with patients can be misinterpreted. It is therefore important for doctors to keep their online relationships with patients strictly professional, not accept ‘friend’ requests from patients on personal accounts, and ensure their online settings are secure.

CRITICISM: THINK BEFORE YOU TYPE
Although critical comments made about you online may be upsetting, potentially damaging to your reputation, or even defamatory, avoid giving a knee-jerk response in the heat of the moment, which you may later regret. Instead, consider seeking advice on how to manage the situation. If the complainant is agreeable, it may be useful to treat online expressions of dissatisfaction as you would any formal complaint. Using the appropriate formal complaint channels will allow you to explore and investigate the concerns and provide an explanation and apology where appropriate. On the other hand, it may be useful to signpost to the complainant a more appropriate route to provide feedback or to invite the complainant for a meeting to discuss their concerns.

Doctors who are unsure about how to respond to a challenging situation online should talk to Medical Protection (or their medical defence organisation) to discuss the best way forward.
HUMAN FACTORS IN PATIENT SAFETY

NEW MASTERS PROGRAMME FROM RCSi

RCSI has been at the forefront of educating healthcare professionals since 1784. As a health sciences institution, we educate both undergraduate and postgraduate students across the spectrum of health research topics. Based in Dublin with four overseas campuses, RCSi is dedicated to the improvement of human health through the development of healthcare leaders who make a difference.

Human Factors is concerned with the relationship between human beings and the systems within which they work. Human Factors training focuses on teamwork, decision-making, leadership and enhancing efficiency - with the goal of minimising errors and improving patient safety.

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