WOMEN IN SURGERY
A PLACE AT THE TABLE

Role models, old prejudices and new ways to work

CANCER, GENES, RISK AND US
365: A YEAR IN PERDANA / A SURGEON IN SLIGO
MEDICO-LEGAL ADVICE
SUPPORT OUR DRIVE FOR EXCELLENCE IN ASSESSMENT

RCSI’s Court of Examiners was established in 2014 to acknowledge the essential contribution made by our Examiners to Fellowship and Membership examinations.

We are currently inviting applications from College Fellows who wish to become Court Members and examine in the MRCS and/or FRCS.

Membership of the Court allows our Fellows to:

› Contribute to the assessment of junior colleagues
› Obtain PCS Credits
› Participate in Annual Meetings / Postgraduate Conferrings
› Network with colleagues
› Examine in Overseas Centres

To find out more about becoming a Court Member, please contact us at examiners@rcsi.ie

csci.ie/coe
Fellows and Members, it is my pleasure to welcome you to the first issue of the newly redesigned Surgeons Scope.

In 2017, we sought feedback from you on the content you would like to read. It was immediately clear that a greater emphasis needed to be placed on the issues and challenges facing you on a daily basis, on international surgical best practice and on what your fellow peers in the RCSI surgical community are doing to transform the face of healthcare every day.

You may have noticed a change in the title of your magazine, from Surgical Scope to Surgeons Scope. This is to reflect the change in content, shifting the focus from the impersonal to the personal, taking into account the surgeon as an individual in their own right. “Surgeons” is also a name used affectionately by many of you to refer to RCSI, and therefore serves the dual purpose of describing both you and us. Let Surgeons Scope therefore be the point where we can come together, for us to bring you the content you need, and for you to engage with us and with each other.

Our surgical community is all too familiar with the major challenges facing healthcare delivery around the world. I am privileged to have been elected your President at this exciting time in the history of our College. With almost 9,000 Fellows and Members across over 80 countries worldwide, our Fellow and Member community is international, influential, pioneering and diverse. We will continue to endeavour to support you at every step of your professional journey. I have utmost confidence that, working together, we can contribute positively to health science education and delivery in the coming years.

MEDICAL EDUCATION AND 26 YORK STREET

Educating doctors who are equipped to practice in diverse environments, facing increasing societal expectations, regulatory and governance pressures, maintaining competence in a rapidly evolving medical environment all the while maintaining an appropriate work-life balance is undoubtedly challenging. The complexity of healthcare is such that doctors of the future will have to work in a different way, recognising that the needs of society and patients are rapidly evolving and understanding that patients will demand greater clarity and involvement in their healthcare needs.

Acknowledging this societal shift in the doctor-patient relationship, it is clear we need to ensure trainees acquire the appropriate skills to perform in this complex environment. Equally, we need to extend and strengthen these programmes along the entire postgraduate training pathway.

The official opening of 26 York Street by Michael R. Bloomberg, three-time Mayor of New York and Founder of Bloomberg Philanthropies recognises and reflects our ambition in demonstrating global leadership in healthcare education.

This state-of-the-art clinical skills and simulation centre offers an unprecedented opportunity to reimagine the structure and delivery of both skills and behavioural curricula. Undoubtedly, the major challenge for all of us in delivering the medical care of the future is to master the communication skills required for effective leadership and team building and working which is vital for safe patient care within complex health environments. I cannot stress enough the importance of inter-personal skills development in the training of surgeons. Surgical care of the future will be delivered by teams and, while surgeons in many cases will lead those teams, risk management and patient safety can only be improved with appropriate team care. The simulation suites in 26 York Street are designed to embed these skills in both our undergraduates and postgraduate trainees.

SURGICAL TRAINING PROCESS AND SURGICAL RESEARCH

The surgical training pathway has changed considerably over the past number of years, reflecting pressures from various sources including the Medical Council who wish to see a shortened, more streamlined, relevant training pathway, and our trainees who want more certainty regarding the training process. I look forward to supporting the continuing evolution of this training process, which I believe now offers far greater certainty to most of our trainees.

Further work, however, needs to be done to outline the role of research within
the surgical training pathway and in this regard, an important research in surgery document will be published later this year under the direction of Council Member Professor Michael Kerin. There appears to be consensus that in attempting to streamline surgical training we have eliminated research opportunities for trainees. I believe research is a vital component of surgical training. Not all surgical trainees require PhDs to have a satisfactory surgical career, but some understanding of research methodology, clinical trial design and research data analysis is desirable.

GENDER DIVERSITY
Just 7% of surgical consultants in Ireland are female. However, almost 50% of trainees are female. One of the priorities of my immediate predecessor as President, Professor John Hyland, has been to support gender balance within the surgical workforce. “Progress: Promoting Gender Equality in Surgery”, the report of the Short Life Working Group chaired by Professor Deborah McNamara, outlines the important role we must play in highlighting the needs of all surgeons, especially in advocating for public policy change to address the issues identified.

Promoting gender diversity requires that all awards and selection committees have appropriate female representation. Reflecting this, RCSI has recently applied for an Athena Swan award, and I must acknowledge the work of Dr Avril Hutch, who has spearheaded our gender diversity programme and our Athena Swan application. RCSI is also pleased to host the Association of Women in Surgery (AWS) group from the American College of Surgeons on July 10th–11th 2018, and will take this opportunity to confer an Honorary Fellowship on Dr Barbara Bass, the first female President of the American College of Surgeons.

NATIONAL CLINICAL PROGRAMME FOR SURGERY
Societal engagement is vital if we are to improve patient care, and support surgeons in their delivery of care. For RCSI to be truly relevant in promoting the delivery of high quality surgical services, our engagement with the Department of Health and HSE through the National Clinical Programmes in Surgery is vital. I wish to acknowledge the role played by my predecessor as President, Professor Frank Keane, who initiated this process in 2010. His work will be continued now by Council members Professor Deborah McNama who is co-lead for the Surgery Programme and Mr David Moore and Mr Paddy Kenny, who are co-leads for the Trauma & Orthopaedic Programme. Professor Billy Power is the lead for the Ophthalmic Surgery Programme.

It is obvious that surgical practice, if assessed by waiting lists, remains dysfunctional in this country. Given the numerous difficulties the health services face, issues such as this will remain problematic for some time. Our engagement with the HSE gives us an unrivalled opportunity to have a say in how surgical care could and should be delivered. Over the last number of years, we have built constructive relationships with the Department of Health, senior management within the HSE and in particular the acute hospital division of the HSE and the Healthcare Pricing Office. In addition to our ability to train surgeons, RCSI has considerable experience in relation to data analysis and management through the Clinical Programmes and can offer valuable insight into healthcare economics with the use of the Health Outcomes Research Centre (HORC). Our Quality, Process and Improvement Centre and Institute of Leadership can all offer valuable support in the fields of quality improvement and healthcare management.

If we are serious in supporting improvements in the delivery of healthcare, we must engage constructively, not only with the HSE Management, but also with public representatives and the public as necessary, to articulate our vision of what surgical services could and should look like nationally. The historic adversarial relationship between clinicians and management is destructive, unprofessional and does not serve patients well. Despite the challenges we all face, we now need to move on in these relationships, to enhance the care provided to our patients.

DELIVERY OF SURGICAL CARE
Ireland’s aging population will have significant implications for the delivery of healthcare in future years. It is estimated that by 2036 surgical discharges will increase from just under 500,000/year to 660,000/year. Inpatient bed days will need to increase from 1,115,111 bed days to over 1,665,000 to accommodate the longer duration of stay of an increasingly elderly population. No amount of capital investment will accommodate this, and we need to find more efficient ways of delivering surgical care. For this to happen, our hospitals must work in functioning hospital groups, ideally aligned to the community health organisations, providing for better integrated care from primary and community care to the hospital setting. Accordingly, we await the review of the Public Consultation on Geographic Alignment of Community Healthcare Organisations and Hospital Groups which has come about as a result of the Oireachtas Committee on the Future of Healthcare’s Sláintecare Report.

While laudable, the implementation of the Sláintecare report will pose serious challenges for hospitals, due to the phasing out of privately insured patients and resultant reduction in income and possible consequences for workforce retention at a consultant level.

Consultant staffing in our smaller hospitals is already problematic and some form of rationalisation will be necessary to deliver high quality surgical services nationally. In this regard, the recent launch of the “Trauma Report – a trauma system for Ireland”, a report of the Trauma Steering Group under the Chair of past President, Professor Eilis McGovern, highlights the need for true integration of services. I look forward to the appointment of the Hospital Group boards and the legislative changes that will be required to allow Hospital Groups redesign surgical services at Group rather than hospital level. I also look forward to working with you, Fellows and Members of RCSI, to deliver better healthcare to all our patients now and in the future.
Contents

04 Scope News
News, notices, research and training courses

08 Where Are They Now?
Tracking the careers of Fellows and Members

09 Women In Surgery
Eminent surgeon Dr Barbara Lee Bass on practical fixes for gender imbalance

12 365: A Year In Perdana
Professor Michael Larvin on life and work at PU-RCSI in Malaysia

16 Where Do I Stand?
Valuable insights on medical malpractice cases from barrister Emily Egan SC

19 A Surgeon In ... Sligo
It’s all in a day’s work for consultant surgeon Mr Naishadh Patil at Sligo University Hospital

20 The Well Clinician
A new strategy to support doctors’ health and wellbeing is explained by Dr Lynda Sisson

22 Back To The Beginning
RCSI Fellow Dr Robin Tattersall’s spirit of adventure and passion for medicine

24 Cancer, Genes, Risk And Us
Oncologist and author Dr Siddhartha Mukherjee on his groundbreaking work

27 Scope Events
Fellows and Members gather for events, lectures and conferrings

31 Obituaries
The lasting legacy of two pioneering RCSI Fellows

32 The Colles Q&A
Member Dr John Duddy on life, work, medicine and music

33 Scope Diary
What’s next? Details of upcoming Fellows and Members events at RCSI

RCSI SURGEONS SCOPE MAGAZINE is published bi-annually by the Royal College of Surgeons in Ireland. Issues are available online at www.rcsi.com.
Your comments, ideas, updates and letters are welcome. Please contact Robyn Byrt, RCSI Development. Alumni Relations, Fellows and Members, 123 St Stephen’s Green, Dublin 2; telephone: +353 (0)1 402 2116; email: robynbyrt@rcsi.com. RCSI Surgeons Scope is posted biannually to our Fellows and Members in Good Standing. To ensure you receive your copy, please send your current contact details to fellows@rcsi.com. RCSI Surgeons Scope is produced by Gloss Publications Ltd, The Courtyard, 40 Main Street, Blackrock, Co Dublin. Copyright Gloss Publications.

RCSI’s mission is to educate, nurture and discover for the benefit of human health. Founded in 1784 with Surgery at our essence, we are an independent, not-for-profit, world leading international health sciences education and research institution, with a deep professional responsibility to enhance human health.
A breath test to diagnose lung cancer

RCISI scientists conducting research into lung cancer have discovered a potential new way to diagnose the disease in a patient's breath. This is the first time that a 'liquid biopsy' has been found to consistently and reliably detect a particular type of lung cancer from a patient's breath. Dr Robert Smyth, a Respiratory Specialist Registrar and MD student at the Department of Molecular Medicine, RCSI, presented this research at RCSI Research Day on March 7th 2018.

Lung cancer is now seen as a very diverse disease. Some tumours show specific signature genetic changes (mutations) that can be treated with recently developed targeted therapies, precisely tailored to an individual patient's disease, meaning longer survival and less side effects. To detect these mutations currently requires a tissue biopsy sample, which is invasive and often not enough cancer cells are obtained. Therefore further biopsies and delays in treatment may result. Extensive research is being undertaken to detect these mutations in a patient's blood sample or 'liquid biopsy', but to date blood tests were not found to be reliable. This study investigated the possibility of detecting these changes in the patient's breath (another form of liquid biopsy).

Professor Bryan Hennessy, Consultant Medical Oncologist at RCSI and Beaumont Hospital's the Principal Investigator on the project. “Our research focused on the most common mutation found in advanced lung cancer where a targeted therapy already exists (EGFR mutated cancer). Our research showed that we could consistently detect the presence of a mutation in the patient's breath, a finding not described anywhere in the world previously. We also found that our breath test was better than a blood test in the same group of patients. This breath test may prove the missing link in improving the accuracy of the liquid biopsy approach. Plans are underway to formally test the performance of breath vs blood samples in these patients in a multinational study sponsored by Cancer Trials Ireland.”

This study was funded by the American Society of Clinical Oncology (ASCO).
Working conditions, training and career opportunities still driving doctors from Ireland

A new report, "Retaining Our Doctors: Medical Workforce Evidence, 2013-2016", published in May by RCSI’s Health Workforce Research Group, includes preliminary findings on training and working conditions from a 2018 survey of over 1,500 NCHDs. While some of the measures introduced in early 2015 to retain Ireland’s non-consultant hospital doctor (NCHD) trainees are evidently having a positive effect, important root causes of why many of our young doctors emigrate are still not being addressed. Conducted by RCSI’s Health Workforce Research Group, the research reveals that over 30% of trainee doctors report improvements in supervision of their training and better mentoring supports. However, one in five trainees say that supervision and mentoring are worse and there has been little improvement in designated training time.

STRESS IN THE WORKPLACE
The new research confirms earlier findings, with trainees continuing to be required to complete “non-core tasks” that divert them from patient-care and training, a poor use of this precious and expensive resource. The study also confirms earlier research which found that poor training and working conditions continue to be associated with an intention to go abroad and not return. The ‘level of stress in my workplace’ is worse or much worse, according to 65% of those who plan to leave Ireland for good, compared with 43% of those who plan to make their long-term careers in Ireland.

According to Professor Ruairi Brugha, Head of the Department of Epidemiology and Public Health Medicine at RCSI who has led the Research Group for the last six years, “the research has some good news about doctor emigration. Only 14% of trainees said that they planned to go abroad and not return; 42% said they planned to go abroad and then return to practice medicine in Ireland, 41% planned to remain here; and 3% planned to leave medicine. This new finding that 83% of Irish trainees wish to ultimately make their careers in Ireland is positive. However, once doctors leave to work abroad, they often establish roots and the window of opportunity for getting them back closes over time. In two of our earlier studies, Irish doctors working abroad reported that training, working and career opportunities are usually better in the countries to which our doctors go; and that Irish trained doctors are highly sought after in these countries.”

2014 STRATEGIC REVIEW
Professor Brugha said that implementation of the 2014 Strategic Review of Medical Training and Career Structure recommendations has produced some important wins. The six-monthly progress reports, produced by the Department of Health, show that an effective NCHD Lead initiative is in place, including a full-time National Lead and a lead NCHD in each hospital, which give NCHDs a real voice. Other achievements include flexible and predictable training schemes, reduced paperwork when NCHDs rotate to a new hospital; and better career planning information. However, these new findings show that progress in addressing some of the critical training and working conditions factors is at a standstill, or is getting worse. Underlying them is the lack of consultants to deliver training and to take a greater share of routine service work in hospitals, so as to allow NCHDs do the training they need to become specialists. Professor Brugha added that “other research has shown that stress and burnout are a reality for consultants as well as NCHDs, and some of the NCHDs in our research reported that the life of a consultant in Ireland was a disincentive to them considering making a permanent career here. Over the years, our work has shown that many of our doctors are also leaving because […] the permanent posts for which we train them are not there. Addressing the root causes, including establishing more consultant posts to implement the policy of a consultant-delivered health service, will ultimately come down to political commitment.”

SIX YEARS OF RESEARCH
The report summarises six years of medical workforce research from RCSI, supplemented by routine data from the HSE’s National Doctor Training and Planning Unit and the Medical Council. Most of the findings in this report, covering 2013-18, were presented by RCSI researchers to a meeting of national medical workforce stakeholders in November 2017. Those who attended included senior representatives from the Department of Health, the HSE, national training bodies and NCHDs.

The discussion threw new light on Ireland’s medical workforce crisis. The meeting concluded that one important root cause of the poor training, working conditions and career opportunities experienced by NCHDs is the shortage of consultants in hospitals. Ireland compares poorly in terms of numbers of consultants per head of population with countries to which our doctors emigrate, namely the UK and Australia.

Minister for State for Training, Skills, Innovation, Research and Development, John Halligan TD, John Gleeson, CTO, Surgacoll, Dr Aofie Gallagher, Head of Innovation, RCSI, Professor Fergal O’Brien, Head of TERG, Professor of Bioengineering & Regenerative Medicine and Deputy Director of Research, RCSI.

RESEARCH INNOVATION AWARD
RCSI and SurgaColl Technologies have won the 2018 Spinout Company Impact Award at the annual Knowledge Transfer Ireland Impact Awards. The award celebrates the company’s significant successes in 2018 and its heritage as a spinout company from RCSI.

SurgaColl Technologies is an innovative medical device company supplying novel tissue regeneration products for the surgical treatment of disease of the bone, cartilage and other human tissues, based on technologies developed by the Tissue Engineering Research Group (TERG) at RCSI, headed by Professor Fergal O’Brien, Professor of Bioengineering and Regenerative Medicine. SurgaColl™ Technologies’ products support the body’s own natural healing processes, using biocompatible, bioactive, and naturally-derived materials to promote faster tissue regeneration.

The KTI Impact Awards recognise knowledge transfer in Irish Higher Education Institutions and research organisations for the wider benefit of the economy and society at large. The award also recognises the instrumental role RCSI’s Office of Research and Innovation, particularly Head of Innovation, Dr Aofie Gallagher, has played in supporting the establishment and expansion of the company by assisting with commercialisation funding applications and IP portfolio development, protection, prosecution and licensing.
Publication of Trauma Steering Group report welcomed by RCSI

In February of this year, RCSI welcomed the publication of the report of the Trauma Steering Group following approval by Government, and endorsed the report's proposal that trauma care be centralised as the safest way to deliver care to patients with significant injury who require urgent treatment.

Almost one in ten people will die as a result of major trauma. Data from the National Office of Clinical Outcomes (NOCA), based at RCSI, shows poorer outcomes in Ireland in comparison to other developed countries. It also shows an unacceptable variability in outcomes amongst hospitals in Ireland. A Major Trauma Audit recently published by NOCA showed that 28% of trauma patients had to be transferred to another hospital for ongoing care as their care needs could not be provided by the initial receiving hospital.

Immediate Past President Professor John Hyland noted that "the best outcomes are achieved by patients receiving the right treatment in the right place by experienced trauma teams as rapidly as possible, yet the trauma system in Ireland is fragmented and under-invested. This is impacting on outcomes.” Professor Hyland said: “The Trauma Steering Group’s report highlights the need for investment in a reorganised national system, to improve outcomes and equity of care. The current lack of resources and fragmentation of trauma care in Ireland limits best practice in trauma management. The recommendations of this important report must be urgently implemented, with the establishment of Trauma Centres and investment in trauma teams, ITU beds, transport, pre-hospital care and post-injury rehabilitation. RCSI will promote best practice in coordinating the fragmented nature of trauma care in this country and will continue to provide the highest standard of training to surgeons in the relevant specialties.” Professor Hyland also said that the direct transfer of severely injured patients to trauma centres may free up resources in other hospitals and facilitate better care for patients with other conditions. He said that greater centralisation in the delivery of trauma care is an important first step in hospital reconfiguration and should be used as a catalyst to implement the rationalisation of 24/7 Emergency Departments.

A similar crisis in trauma care was addressed in the UK in 2010 through the centralisation of the delivery of trauma care. In London, regional trauma care for a population of ten million was reorganised in a process led by RCSI graduate and Fellow, Professor Lord Darzi. The adequately resourced system in London showed a dramatic improvement in outcomes for the majority of severely injured patients. Survival rates increased by 50% over five years, saving an estimated 610 lives.

Professor Hyland added: “Professor Eilis McGovern who chaired the Trauma Steering Group, should be acknowledged for bringing together the numerous stakeholders who examined the many issues in relation to prevention, transport and both acute care and rehabilitation, all of which need to be addressed to improve trauma outcomes.”

University Hospital Kerry completes National Theatre Quality Improvement Programme

University Hospital Kerry (UHK) has become the first hospital in Ireland to have successfully completed the National Theatre Quality Improvement Programme (TQIP), a new training programme which is a collaboration across the HSE’s Integrated Care Programme for Patient Flow, the National Clinical Programme in Surgery, the National Clinical Programme in Anaesthesia and RCSI.

Mr Kieran Tangney, Executive Director of the Quality & Process Improvement Centre at RCSI said: “RCSI’s Quality and Process Improvement Training Programme supports healthcare teams to design more effective ways of working together. Taking a multidisciplinary team approach is key to sustainable improvement. It enables participating hospitals to design safe, effective and efficient delivery of care for their patients. This approach directly benefits staff and their patients, as better designed work processes allows more time for direct patient care.”

Over the last year, as part of their ongoing onsite training, the TQIP team in UHK have worked on a series of patient flow and pathway redesign projects. This has led to a very significant improvement in theatre utilisation at the hospital. The multidisciplinary team consisting of nurses, surgeons, anaesthetists, porters, hospital management and administration staff were recently awarded their Quality and Process Improvement Certificates from RCSI at the National PAU conference in Tralee.

ST LUKE’S HOSPITAL IN KILKENNY RECEIVES FIRST ACUTE SURGICAL ASSESSMENT UNIT ACCREDITATION

The first site to be accredited as an Acute Surgical Assessment Unit (ASAU) in Ireland is St Luke’s Hospital in Kilkenny, which has successfully implemented an ASAU to its patient care pathway. This accreditation means that the unit at St Luke’s will now receive in-patient rates of pay under activity-based funding for the patients passing through their unit – similar to that of an Acute Medical Assessment Unit funding stream.

The ASAU aims to deliver a Senior Surgical decision maker early in a patient journey, aiming to reduce the patient experience time (PET) and reduce inappropriate admission. Additional benefits of this model are a reduction in the average length of stay, increased patient satisfaction and decreased time to diagnostics and surgery.

The development of Acute Surgical Assessment Units (ASAU) in Ireland is a key programme of work in 2018 for the National Clinical Programme in Surgery (NCPS). Since launching their minimum standards document for ASAsUs in Ireland in February this year, the NCPS has initiated an accreditation process with a number of sites nationwide.

More information on ASUs and on the work of the NCPS can be found at www.rcsi.com/ncps, on Twitter @SurgeryIreland, or by emailing surgeryprogramme@rcsi.com.
CODE OF PRACTICE

A copy of the recently published Code of Practice for Surgeons 2018 is included with this magazine. If for some reason you don’t receive it, please email us at fellows@rcsi.com and we will send you a copy.

This edition has been updated from the 2004 version to reflect changes in legislation, changes in Medical Council Guidelines and evolving surgical practice. The publication, led by Professor Sean Tierney FRCSI, Dean of Professional Development and Practice at RCSI, is intended to be useful to all Fellows of RCSI (regardless of their country of practice) but it is specifically focused on surgeons in practice in Ireland. RCSI has drawn on publications by other surgical colleges including Good Surgical Practice (Royal College of Surgeons of England, 2014) and the Code of Conduct (Australasian College of Surgeons, 2016) and from literature and international guidelines on ethical practice. We have consulted widely within the surgical community to ensure that this guide is as useful and practical as possible.

Surgical care is now being delivered in a very complex and rapidly changing environment. It is not possible to produce a rule book for practice that covers every situation. Rather, the Code articulates a straightforward set of principles that each and every surgeon can use to inform their own practice. Individual surgeons must exercise their own informed professional judgement on how best to meet the challenges that arise in clinical practice. Sections are included on good clinical care, maintaining competence, teaching, training and supervising, relationship with patients, probity in professional practice and surgical care in special settings and, very importantly, a section on your own health.

RCSI would like to acknowledge the contribution of all its Fellows and Members to the debate on Surgical Professionalism. We would also like to acknowledge in particular Professor Sean Tierney, and the members of the Working Group on Professionalism established by the Professional Development and Practice Committee, chaired by Mr Joe O’Beirne FRCSI.

Masters Programmes and Training Courses

Master of Surgery (MCh by Module)
The MCh by module is the first in Ireland to incorporate a taught component in addition to the research dissertation. Modules are designed to equip trainees with a versatile skill set that will help them better meet the demands of higher surgical training. The programme’s multidisciplinary structure will enable participants to build an understanding of the complex challenges and opportunities facing surgical professionals in the greater context of healthcare. Applications for candidates commencing in August 2018 will no longer be accepted, but applications will be accepted for 2019 from the beginning of next year. See www.rcsi.com/master-of-surgery-mch-course for more details.

Masters (MCh) in Surgical Science and Practice
This Masters programme is designed to give prospective students the essential knowledge, skills and behaviours required to maximise their competitiveness for entry to surgical training programmes anywhere in the world. The Masters is a one-year full-time programme delivered entirely in RCSI’s new state-of-the-art National Surgical and Clinical Skills Centre. The facilities of the new centre will be used to develop participants’ clinical skills and also the technical and non-technical skills required to optimise opportunities for their entry onto a structured programme of postgraduate surgical training. Applications for candidates commencing in Summer 2018 will no longer be accepted, but applications will be accepted for 2019 from the beginning of next year. See www.rcsi.com/masters-human-factors-patient-safety for more details.

Masters (MSc) in Human Factors in Patient Safety
The MSc in Human Factors in Patient Safety offered by RCSI is designed to develop participants’ knowledge of error, risk and safety in healthcare and to advance their practical skills and expertise to drive safety initiatives and quality improvement in the acute hospital setting. This is achieved through understanding sources of error and risk in healthcare, and strategies to manage them, and developing healthcare professionals’ non-technical skills: leadership, teamwork, communication, decision making, situation awareness and stress management. Applications for candidates commencing in September 2018 will no longer be accepted, but applications will be accepted for 2019 from the beginning of next year. See www.rcsi.com/masters-human-factors-patient-safety for more details.

MAKING THE CUT: SHORT COURSES

Care of the Critically Ill Patient
RCSI Dublin; September 18th/19th 2018
This informative, interactive course combines a variety of teaching and learning techniques to advance the practical, theoretical and personal skills necessary for the care of critically ill surgical patients. For ST1-ST3, SHO, Registrars, Specialists Registrars and Consultants. See www.rcsi.com/ccrisp-course for more details.

Basic Surgical Skills
RCSI Dublin; December 13th/14th 2018
Designed to introduce NCHDs to safe surgical practice in a controlled workshop environment, this course teaches, assesses and certifies safe, sound surgical techniques common to all forms of surgery – open, endoscopic and laparoscopic. See www.rcsi.com/basic-surgical-skills-course for more details.
Where are they now? ... we track the careers of Fellows and Members

CHRISTINA FLEMING
MB, HDipFPS, MCh, MRCSI

Current role: Research fellow completing a basic science MD at Cork University Hospital on utilising genomic and metabolomic characteristics of the perioperative period to improve outcomes in colorectal cancer. I will return to clinical practice in July as a colorectal SpR at University Hospital, Limerick. I am also vice-president of the Association of Surgeons in Training (ASIT) and am helping develop a trainee-led Irish Surgical Research Collaborative (ISRC) with fellow trainees. Career path so far: After graduation from UCC in 2011, I completed my intern year in medicine and surgery at Cork University Hospital followed by basic surgical training in the Mater and CUH. I have worked as a registrar and Specialist Registrar at Wexford General Hospital, St Vincent’s and the Mercy Hospital (Cork) and completed a Higher Diploma in Human Factors and Patient Safety and Masters in Surgery at RCSI. My main areas of professional interest are: Colorectal cancer and benign colorectal disease, especially robotic rectal cancer surgery, IBD with intestinal failure and complex abdominal wall reconstruction. I would love an opportunity to: Gain more experience in global surgery. Undertaking an elective in Kenya as a student, I was struck by the minimal resources but also the tireless efforts of all staff. This year ASIT will travel to Rwanda to deliver a course in Foundation Surgical Skills and Human Factors – I am really looking forward to this. I also had experience in colorectal surgery in Hanoi, Vietnam through the Atlantic Surgical Leadership Exchange Programme at RCSI. A goal I have for my career is: A legacy we should be proud of. With Irish data showing that trainees are completing my career is: A legacy we should be proud of. With Irish data showing that trainees are completing

ASAM ISHTIAQ MB, BS, FRCSI
Current role: Consultant surgeon and Clinical Director, UPMC Whitfield, Waterford. Career path so far: I graduated from Punjab University in Pakistan in 1990 and came to Ireland in 1991 to pursue surgical training and obtained Fellowship of RCSI in 1995. After broad-based surgical training and experience in various hospitals in Ireland, leading to specialist certification in 2005, I was appointed consultant surgeon in general and vascular surgery at UPMC Whitfield in 2006. My main areas of professional interest are: Provision of consultant-delivered surgical service in elective settings with almost 1,000 new patient referrals per year. My areas of surgical interest are management of GI diseases, lower limb venous disorders, venous access procedures and skin cancer surgery. I have also been involved in medical representation since 2000. I was President of the Irish Medical Organisation and have been a member of the Medical Council. In my current role as Clinical Director, I am responsible for accreditation, patient safety, clinical governance, quality and safety of systems at UPMC Whitfield. I would love an opportunity to: Get involved again in teaching and training of medical students and surgical trainees. A goal I have for my career is: To achieve excellence and maintain it to the highest standard, worthy of a Fellow of RCSI. It is a great privilege and honour to be a Fellow of such diverse and internationally recognised institution. On days off: I like to spend time with my wife and my two young sons, who aspire to follow in my footsteps.

SHANE CARR MB, BCh, BAO, MRCSI

Current role: First year, CST 1, surgical trainee with the plastic and reconstructive surgery service at Galway University Hospital. Career path so far: Having graduated from the Graduate Entry Medicine Programme at RCSI in 2015, I completed my intern year at Beaumont Hospital where I worked with the neurosurgical and upper GI surgical services. Following my intern year I made the decision not to apply directly to the surgical scheme. I took up two surgical posts in Santry Sports Clinic and St Michael’s Hospital in Dun Laoghaire while completing my MRCS exams and some clinical research and took time to travel. Having applied to the surgical scheme, last year I was offered my first year post in Galway with the General Surgery/Breast service and then with the Plastic and Reconstructive Surgery service where I am currently working. I will be taking up my CST 2 post in Cork next year, also doing Plastics. My main areas of professional interest are: I am hoping to pursue a career in plastic and reconstructive surgery so that is my main area of professional interest currently. I’ve enjoyed the paediatric element of the job so far and I would like to pursue this as a subspecialty within plastic surgery; cleft surgery would be of particular interest. I would love an opportunity to: Work abroad for a year or two as a surgical trainee. Having an opportunity to provide surgical care to patients in the less fortunate parts of world with an organisation like MSF would also be a fantastic experience. A goal I have for my career is: To progress through the core surgical training scheme on to the specialist registrar scheme. Looking beyond that, my long-term goal would be to obtain a consultant post at home in Ireland having completed a fellowship abroad. On days off: Do my best to spend time with my friends and stay active. On a few days off recently, I had the opportunity to cycle from Malin to Mizen head with a few friends which was a great experience. ■
Women in surgery

BARBARA LEE BASS, PRESIDENT OF THE AMERICAN COLLEGE OF SURGEONS, WILL BE MADE AN HONORARY FELLOW OF RCSi WHEN THE COLLEGE PARTNERS WITH THE ASSOCIATION OF WOMEN SURGEONS FOR THE INAUGURAL WOMEN IN SURGERY MEETING AT RCSi, DUBLIN THIS JULY. SHE SPOKE TO SURGEONS SCOPE ABOUT ROLE MODELS, OLD PREJUDICES AND NEW WAYS OF BEING A SURGEON ...

The theme of Barbara Lee Bass’s presidency of the ACS as she travels around the world over the course of her year in office is “joy and privilege”. “The joy of surgery,” she says, “is that it delivers immediate gratification: you are faced with a problem and you intervene and make a big difference, whether by repairing, replacing or removing. It’s very intense and there is an immediacy that I like, but it is not just the physical side, the act of surgery, that appeals. It’s the relationship with the patient too. The notion that you meet someone with a problem, and they place their trust in you … they are in a big dark room surrounded by strangers and they allow you to go into their body and you promise to deliver in the way that you have been trained. There is a lovely personal interaction from beginning to end, and then you send them back – hopefully – to a healthy life. It’s an incredible privilege for a surgeon to be able to focus on a problem at a time, and to work in a very complex environment as part of a high-performance team.”

Dr Bass initially went to medical school with the intention of it being a route to becoming either a scientist or geneticist, but found herself unexpectedly captivated by surgery. “Surgery was my last rotation in medical school,” she recalls, “and it was like a blow to the head, it felt right. I really liked the nature of the patient contact. Back then, only about 10-15% of students in medical school were women, and almost none went into surgery. So the challenge was to navigate a pathway without the assistance of any obvious role models; I had to find people who believed in me.”

During the course of her career, Dr Bass says that she was lucky to find great female mentors, such as Pat Numann (see panel overleaf) and Olga Jonasson, the American transplant surgeon who performed the first kidney transplant in the state of Illinois. According to her obituary in The New York Times, when Jonasson joined Ohio State University in the late 1980s, she was believed to be the only woman serving as head of a university department of surgery. [In 1978, Jonasson explained to The New York Times, “The decisions of the surgeon as team leader are final, and men have simply been unwilling to accept women in that role of the all-powerful decision maker.”]

But Dr Bass also gives credit to inspiring male teachers and mentors. “Most of the men who taught and mentored me never questioned my ambition or desire,” she says, “they were fabulous. Yes, there were some fools along the way … and there are still a few dinosaurs in the profession but not many in empowered positions. They are the ones who hang on to the ideals of a life that is ‘24/7 nothing-but-surgery’, and their personal infrastructure [presumably their wives] lives on supporting that. These are men who are still baffled that women would choose this pathway. Some of them have a eureka moment when their daughters are becoming surgeons and they realise that this is really hard for them; they can end up becoming wonderful, potent advocates for women in surgery.”

Now that she is herself a leader in her profession, greatly honoured, she
Leadership

surgeons cannot imagine that the job can be done by women who also want to have a family and home. "They ask: 'How can they be us?' The days of conscious bias – the blatant, 'We don’t want them!' – may largely be gone, but it is difficult to change culture, when there are still high expectations of sacrifice. We must not lower standards in terms of the product we deliver to the public, but there are more ways to get there than the ones that there have been over the past 50 years. Maybe it takes longer if you need to take breaks for life reasons – whether for having a family, or caring, or military service – but we must ensure not to assign stigma, and that alternative pathways are accepted. It is not necessary for the career of a surgeon to be the all-consuming discipline that it has been in the past; there are different ways to become ‘me’.

Dr Bass sees gradual and positive change coming to the profession says, to receive an honorary fellowship from RCSI, one of Dr Bass’s priorities is to help the young women surgeons who want to follow in her footsteps.

“It is getting better, we have no choice but for it to become better – we have to make the discipline more attractive in order to attract the best and the brightest into the pipeline. In the US many young women are entering surgical training – it’s up to 40% now, but I still think of the work of the socio-biologist, Virginia Valian and her seminal work on gender-imbalanced professions and ask, ‘Why So Slow?’ It’s still the case that women and other minorities are judged first on the basis of their minority, and only then on the basis of their performance.”

Some specialities continue to have more difficulty than others in attracting women into their ranks. Only 10% of orthopaedic surgeons, for instance, are women. “There may be a problem with micro-aggression,” says Dr Bass. "Many surgeons cannot imagine that the job can be done by women who also want to have a family and home.” They ask: 'How can they be us?' The days of conscious bias – the blatant, 'We don't want them!' – may largely be gone, but it is difficult to change culture, when there are still high expectations of sacrifice. We must not lower standards in terms of the product we deliver to the public, but there are more ways to get there than the ones that there have been over the past 50 years. Maybe it takes longer if you need to take breaks for life reasons – whether for having a family, or caring, or military service – but we must ensure not to assign stigma, and that alternative pathways are accepted. It is not necessary for the career of a surgeon to be the all-consuming discipline that it has been in the past; there are different ways to become ‘me’.

Dr Bass sees gradual and positive change coming to the profession of surgery in the US, with the introduction of new practice models and restrictions on working hours. “It’s now an 80-hour week, down from 24/7. People choke when we say that, but it is manageable for a five-year period after medical school when you are doing your residency. Most residents are aged between 24 and 35, so it’s an important time in life, the peak of young adulthood, and it’s easy to become isolated from the outside world. They can wonder if it is worth it. But many form a community within their training group to get them through, and most do get through it. It’s regarded as crazy but formative.”

What does Dr Bass see as the remaining barriers to advancement for women in surgery? “Women need mentors and sponsors, which is one reason that we still have the AWS which was founded by Dr Pat Numann in the early eighties. It started as a breakfast table meeting for eight women at the American College of Surgeons conference. Pat was tired of going to meetings and having no one to talk to; she felt ‘actively excluded’.”

Dr Bass says that personally, she did not experience the same level of active exclusion as Numann – “thankfully, instances of that were few and far between” – but notes that Numann was a pioneer, ten years ahead in career terms. “Each year the breakfast got bigger,” says Dr Bass. “It has a very distinct purpose: primarily it’s a place of optimism about your choice of career, an affirmation that you have made a great choice. And it’s a place to discuss the differences in our lives as surgeons – we can share experiences of family, and also of equity and compensation. We still make an average of 8-15% less than men, thanks to a series of ‘micro hits’ along the course of a career. There are residual inequities, which I call the ‘invisible obvious’ because of maternity and family. When it comes to being considered for leadership roles, if young women see more senior women batting for them it engenders great camaraderie. We are just people too, but by virtue of the pathways we’ve been raised in, the hope is

REGISTER NOW

RCSI is delighted to host the Association of Women Surgeons (AWS) for the inaugural Women on Surgery meeting in Dublin in July. Register online at www.rcsi.com/aws_meeting
that we have developed qualities as principled leaders. The network can help with referrals for hiring and search committees, as well as the personal and life aspects of a career in surgery, and with advocacy. Now that women are more visible in the profession, it is easier for young women to find role models.”

In addition to her presidency of the ACS, Dr Bass still plays an active teaching role and, as Chair of the Department of Surgery at Houston Methodist Hospital, she has a large administrative responsibility, and is in a position to influence recruitment and the culture of the institution. “Twelve per cent of the professors of surgery in the US are now women, and it has been a banner year with 24 out of 200-plus chairs of departments of surgery now women, but still there is nowhere near the rate of progression that we need. Critical mass is when 30% of these positions are held by women. It can be an extra burden to be a woman in a position of leadership; you are more scrutinised. There is always the: ‘Can she really do this?’ question. Men burn out all the time and the institution just says: ‘Let’s get a new chair!’ Visibility is unfairly borne by women leaders.

“One positive influence is that young men now are accustomed to gender balance so their expectations are different and they live their lives differently to previous generations; they are more inclined to think of women as partners so life will be more fair and balanced. That said, they still have intrinsic privilege and it is easier for them in some respects.”

Dr Bass is confident that things will continue to improve for women surgeons. “In the US, we teach professionalism and have embraced formal leadership training as a core competency. Leadership training starts to become important during the residency years. Once training is finished, the career begins and so does the sorting. There are many different venues for leadership and the AWS and ACS Women in Surgery committee run leadership training courses specifically aimed at women and these are having an impact.”

Three standout surgeons also appearing at the AWS/RCSI Conference

HILARY SANFELY, MD, was part of a team to complete the first liver transplant in Scotland in 1992. She is Professor of Surgery and Vice Chair for Surgical Education in the Department of Surgery at Southern Illinois University (SIU), in Springfield, Illinois. Dr Sanfey graduated from Trinity College Dublin in 1976, underwent surgical training at RCSI and spent three years as a research fellow at Johns Hopkins University (1981–1984). She worked as a consultant transplant surgeon at the Royal Infirmary of Edinburgh for four years before moving to the University of Virginia (UVA) in 1996. After attaining AST accreditation as a transplant surgeon she remained on the faculty. At UVA she served as the Associate Program Director and Clerkship Co-Director until she left for SIU in 2008. In 2009 she received a Master’s Degree in Health Professions Education from the University of Illinois, Chicago. Dr Sanfey is a past president of the Association of Women Surgeons (AWS), a former member of the American College of Surgeons Board of Governors, past chair of the American College of Surgeons Women in Surgery Committee and the recipient of the AWS Olga Jonasson Distinguished Member and Nina Starr Braunwald Awards. She is a past president of the International Society of Surgery US Chapter and a member of the American Surgical Association. Dr Sanfey is currently first vice-president elect of the American College of Surgeons.

Dr Sanfey recently spent three months as a Specialist Advisor in Postgraduate Surgical Training and Education in the Department of Surgical Affairs in RCSI.

In 2010, PROFESSION ELIS MC GOVERN was the first woman to be elected president of the Royal College of Surgeons of Ireland since its foundation in 1784.

As a student at University College Dublin, Professor McGovern excelled academically, winning the gold medal in surgery and silver medal in medicine. In 1982 she obtained her fellowship of the Royal College of Surgeons in Ireland, coming top in the fellowship examination.

Awarded a European scholarship, Professor McGovern studied in Paris, subsequently working at the Mayo Clinic, Minnesota, USA. On returning to Ireland, she was appointed consultant cardiothoracic surgeon at the Mater Hospital, Dublin, before moving to St James’s Hospital, where she established a new cardiac surgery unit.

Professor McGovern is currently national programme director for medical training at Ireland’s Health Service Executive. She has received numerous honours and awards recognising her outstanding work, including an honorary fellowship of the American College of Surgeons.

AWS founder PATRICIA J. NUMANN, MD, was the first female surgeon of the State University of New York, as well as the first female chair of surgery at the university.

Dr Numann joined the faculty of SUNY Upstate Medical University in 1970 as an Assistant Professor of Surgery and the university’s first female surgeon. She was promoted to associate professor in 1975. From 1978 to 1984, she was associate dean of the university’s college of medicine.

She became a professor of surgery in 1989 and was appointed the Lloyd S. Rogers Professor of Surgery in 2000, a position which she held until her retirement in 2007, when she became a professor emeritus. After her retirement, SUNY Upstate established the Patricia J. Numann Chair of Surgery, the university’s first endowed chair for a woman.

Dr Numann held appointments at Crouse-Irving Memorial Hospital, the Syracuse Veteran’s Affairs Hospital, and SUNY Upstate University Hospital. In 2007, she founded the Patricia J. Numann Breast & Endocrine Surgery Center at SUNY Upstate Medical University.

Dr Numann has been involved in numerous professional organisations. She became a fellow of the American College of Surgeons in 1974 and received its highest honour, the Distinguished Service Award, in 2006. She was appointed president of the college in 2011, making her the second woman to hold that position. She founded the AWS in 1982 and served as the Association’s president in 1986–1987. She was the first woman chair of the American Board of Surgery, a position that she held from 1994 to 2002. She co-founded the Association for Surgical Education, and her election as president in 1985 made her the first woman president of any national surgical organisation in the United States.
of course, living here takes a little getting used to,” says Professor Michael Larvin of Kuala Lumpur where he is coming to the end of his first year as Dean of the Perdana University-RCSI School of Medicine, “but we pinch ourselves every day. In addition to having a challenging, interesting and rewarding role, the wonderful lifestyle offers a real bonus. It’s summer all year round, Malaysian people are very welcoming, and food comes in an amazing variety.”

The cost of living and taxation are lower than in Ireland. He would urge colleagues in Ireland to be open to overseas opportunities with RCSI. “It’s well worth a visit to take a proper look, to appreciate the great set-up and support from RCSI and to be sure that you could accomplish something worthwhile.”

Professor Larvin is no stranger to an expat life. Descended from Irish heritage, he was raised in the UK and trained there and in the US, Sweden and Germany. In 2012, he left his position as Foundation Professor of Surgery at the Graduate Entry
Medical School at the University of Nottingham to take up the role of Head of Graduate Entry Medicine at University of Limerick. "In a sense, that was the bigger move for us as a family," says Professor Larvin, whose youngest daughter was still at school. With characteristic enthusiasm, he and his wife immersed themselves in Limerick life, even attending Irish classes. "Looking back, learning basic Irish was difficult compared to learning Malay whose pronunciation and structure is simple and mistakes are readily forgiven." Embracing a new culture is one thing, acclimatising to equatorial rainforest weather patterns another: "The daily afternoon showers are more intense than gentle Irish rainfall, although mercifully brief. The high humidity can be a greater challenge than the warmth, but you adjust quickly, wearing linen and knowing your destination (and car) will be air-conditioned."

Choosing to live in central Kuala Lumpur (or KL as it’s popularly known), rather than closer to campus, was a conscious decision. A former colonial city, KL’s mix of preserved historical buildings and modern skyscrapers is extremely attractive. Professor Larvin and his wife Keyna live in a 64-storey apartment block in the heart of the city, a great attraction for the couple’s five children and friends who visit often. As KL is the headquarters of Air Asia, it’s also a great jumping-off point for further travel. The apartment is only a 25-minute drive to campus where, since 2011, RCSI through its partnership with Perdana University (PU), licenses the same five-year undergraduate medical programme as delivered at its Dublin and Bahrain campuses. For clinical teaching, Hospital KL, the largest teaching hospital in SE Asia with 2,300 beds is just three stops from home on the iconic air-conditioned KL Monorail.

The programme is fully accredited by both the Irish and Malaysian Medical Councils. Professor Larvin is enthusiastic about driving its expansion. “The programme has 250 students, of which the first full-cycle cohort graduated in September 2016 with degrees awarded by RCSI and the National University of Ireland,” he says.

The programme is led mainly by Irish academic leads and delivered with Malaysian and international faculty teams and clinical adjunct staff. It closely matches the RCSI Dublin and Bahrain programmes, with joint examinations that are time synchronised and so held mainly in the early evening. “We liaise daily with Julie Creedon in the Programme Office in Dublin. Julie also visits campus several times each year along with the senior RCSI leadership team who are readily available for advice and support.

RCSI’s international experience has led to a truly global programme which is highly innovative in the Malaysian context. The aim is to produce patient-focused doctors and the talented leaders needed to transform Malaysian healthcare.”

There are alumni of RCSI in positions of leadership all over the globe and Malaysia is no different. The Deputy Prime Minister, Dato’ Seri Dr Wan Azizah binti Wan Ismail, the first female holder of the post, happens to be an RCSI graduate and gold medallist, appointed in May after Pakatan Harapan, the main opposition coalition in the Malaysian Parliament, won the majority of seats in the Dewan Rakyat, Malaysia’s lower house of parliament. This marked a historic defeat for the ruling Barisan Nasional coalition which has governed Malaysia since independence in 1957. "This represents a real change in direction," says Professor Larvin. “This was a truly massive political changeover after 61 years, accomplished quietly without demonstrations, riots or any big fuss and a real affirmation of the power of democracy.”
The role of Dean is a busy one, focused mainly on assisting academic leads to deliver the programme smoothly, and to recruit new staff.

An experienced pancreatic surgeon and former President of the Pancreatic Society of Great Britain and Ireland, Professor Larvin was thrilled to have recently assisted a Malaysian former student and graduate with the country’s first totally robotic Pancreatoduodenectomy (Whipple’s Operation), the surgical equivalent of “precision or personalised medicine”. Professor Larvin acknowledges that despite such technical advances, most pancreatic cancer patients present with disease beyond surgical cure. He hopes that some of his students might be inspired one day to develop more effective treatments, which will likely yield from laboratory research into genetic and biological therapies and less invasive therapy.

He says that for medical students and trainees to be inspired, they should experience positive as well as negative patient outcomes. “It is extremely difficult for most young doctors to deal only with patients and families experiencing a bleak outlook. For that reason, I have always balanced my practice and outlook. For that reason, I have always balanced my practice and outlook. That has allowed me to keep a positive perspective.”

Professor Larvin has always found teaching and training satisfying. “I also enjoy meeting with students, although often my role means that they are usually in need of help with academic or personal difficulties. I like getting out of the office and working ‘on the ground’ to try and improve the staff and student experience. Life is never boring here, occasionally a single day can involve visiting all of our main teaching sites: Hospital KL, Perdana University campus in Serdang and Hospital Tuanku Ja’afar Hospital in Seremban, some 60km south of KL.” He is building on the work of his predecessor Professor David Adams, who last year retired to his native Belfast, in increasing student recruitment. Professor Larvin attended an ‘Education Malaysia’ outreach visit in Qatar earlier this year, the first marketing event of its kind: “I welcome the chance to recruit more applicants as our programme matures. Although our focus here is firmly on the Malaysian intake, I believe strongly in the RCSI global view that the student experience is greatly enriched by peers from other countries and cultures. At present we have small numbers of international students from New Zealand, Singapore, Saudi Arabia, the USA and Canada, and we are now targeting Sri Lanka, India and Myanmar.”

RCSI Fellows and Members are invited to express their interest in international academic opportunities at RCSI campuses in Bahrain, Dubai and Malaysia by contacting internationalcareers@rcsi.com

---

**Postcards from Perdana**

**PROFESSOR RAGHU VARADARAJAN**

ASSOCIATE PROFESSOR; RCSI LEAD IN SURGERY AT PU-RCSI

“PU-RCSI is a great choice for an academic position. We have strong leadership, fantastic local and international staff and excellent support from Dublin. I must say the highlight of the entire experience is the interaction with our students who are highly engaging and motivated. We organise placements for our students and cultivate a relationship with local department leads and hospital directors. The clinicians here are creative and talented and very willing to share their experience with our students.

There is plenty of outdoor activity, the weather is great all year round. Diving, trekking and cycling are usual over the weekend. If you like music, KL is known for its live bands and different genres of music. There is a big expat population and you get an international cuisine that can be a delight. Malaysia itself has a multi-ethnic population and is known for its relaxed lifestyle.”

---

**PROFESSOR JOHN PRICE**

ACADEMIC LEAD, ASSOCIATE PROFESSOR IN OBSTETRICS & GYNAECOLOGY AT PU-RCSI

“Retirement was approaching when I accepted the post at PU-RCSI. I was not ready to walk away from medicine and I still had much to offer. This role is refreshing and allows me to continue in my specialty in a friendly, less stressed (for me) environment. The students are intelligent and dedicated and keen to succeed. This is an opportunity to share with them the knowledge and experience gained over 40 years in medicine.

KL is a lively, young, progressive city with a vibrant nightlife. The traffic is chaotic, so I have avoided getting a car and use trains to get to work and taxis for other journeys (travel is inexpensive). I take a lot of exercise including the gym and tennis. I also do hill walking and travelling, which is easy from KL. Malaysians love their food and there is a multitude of restaurants and bars throughout the city.

Malaysia is underrated as a country to visit. Local people are friendly and helpful and the students a delight to work with. Malaysia is a sophisticated, ambitious country yet for expats the cost of living and taxation is low. I feel very safe in KL (apart from the motorbikes!) – crime figures are low. With careful planning this can be a great experience.”
Behind the scenes of a Medical Council complaint

Facing an investigation by the Medical Council can be one of the most stressful times in a doctor’s career. Dr Sonya McCullough, Medicolegal Adviser at Medical Protection explains the Medical Council complaint process and how Medical Protection can help its members.

RECEIVING A COMPLAINT LETTER
Anyone can make a complaint about a doctor to the Medical Council – patients, relatives, patient representatives, fellow doctors, other healthcare professionals or hospital colleagues and even the Medical Council itself. If the complainant is a colleague, employer or the Medical Council, there is a much higher chance of the complaint proceeding to a Fitness to Practise (FTP) Committee hearing.

A case officer at the Medical Council will initially write to the doctor about the complaint. The doctor is normally provided with a full copy of the complaint, unless other doctors are involved – in which case their details will be redacted.

The case officer will carry out investigations which can include a request for the doctor’s comments about the complaint, statements from other individuals involved, or if the case is particularly complex, the instruction of an expert. The case officer will also, if necessary, obtain a copy of the medical records in the matter.

The Preliminary Proceedings Committee (PPC) generally meets monthly to review complaints. There is no obligation on the doctor to submit a full response upon receipt of the first PPC letter. A holding letter that acknowledges the receipt of the complaint will suffice. We strongly recommend that the doctor contacts Medical Protection, or their medical defence organisation, immediately to discuss the complaint and request assistance in drafting a robust response.

DRAFTING A RESPONSE
The PPC usually shares the doctor’s response with the complainant for their further comments. It is recommended that the doctor’s full response deals with all the issues that are alleged in the complaint and responds to each in turn. The following should be set out in the response:

- A short paragraph or two detailing the doctor’s background, experience and qualifications to date. This should be sent to the PPC separately from the main body of the response. Medical Protection has had feedback from the PPC that having to review the doctor’s CV at the start of the complaint response may only serve to inflame matters with the complainant.
- If relevant, a paragraph or two providing detail on the system in place in the unit in which the doctor works.
- Setting out what the doctor understands about the complainant’s concerns; each of the issues of concern should be identified and responded to in turn.
- The chronology of the doctor’s involvement in the case and justification for treatment offered.

OUR SUPPORT
If a doctor requests assistance from Medical Protection as a member, it is important that they send Medical Protection a full copy of all the correspondence that the doctor would have received from the Medical Council, including the complaint letter. A medicolegal adviser can support the doctor with the response.

It is important that Medical Protection know details of the doctor’s period of involvement in the case - i.e. the first and last date that the doctor saw the patient.

If a doctor and his or her colleagues all receive a complaint from the Medical Council, they should all seek assistance separately as individuals.

In 2016, 411 doctors were referred to the Medical Council. Of these referrals, 42 were passed to the FTP Committee.

WHAT HAPPENS NEXT?
At the end of the investigation, the PPC will decide if there is sufficient evidence (Prima Facia case) for the complaint to be referred to the FTP Committee for a ‘Public Inquiry’. Otherwise, the PPC will recommend to the Medical Council that no further action is to be taken, or may include mediation or referral to another body.

In our experience, only a very small number of cases are sent forward to the FTP Committee for a ‘Public Inquiry’ and the vast majority are resolved at the initial PPC stage.

A ‘Public Inquiry’ is a hearing similar to a hearing before a court or a tribunal in that sworn oral evidence is heard.

The hearing is opened by the legal representatives of the Medical Council, who are required to present the case against the doctor, including any evidence gathered during the investigation (for example, from expert witnesses). The doctor who is the subject of the inquiry is then entitled to give evidence and call witnesses or produce documentation in defence.

If the FTP Committee finds that one or more allegations are proven, the Medical Council can impose one of the following sanctions:

- Advice, admonish or censure in writing
- Censure in writing, and fine up to €5,000
- Attach conditions to a doctor’s registration
- Transfer a doctor’s registration to another division of the register
- Suspend a doctor’s registration for a specified period
- Cancel a doctor’s registration
- Prohibit a doctor from applying for restoration to the register for a specified period

If the Medical Council decides to impose any of the above sanctions, except for advice, admonishment and censure, there is a right of appeal against the Medical Council’s decision to the High Court.

In circumstances where the matter is particularly complex, or if the allegation is serious in nature, Medical Protection can instruct one of its local panel firm solicitors in Dublin to assist with the matter. For further advice, contact Medical Protection on T: +44 113 241 0200 or E: medical.edinburgh@medicalprotection.org

While many patients have the option of pursuing legal action against their surgeons, most do not. Emily Egan SC – a Senior Counsel with over 20 years’ experience in medical negligence defence, and legal assessor to the Medical Council – says it is important for surgeons to understand the litigation process, so that the risks of being sued are further diminished.

During Egan’s talk to surgeons on Charter Day in February, it was made clear that the best way to defend a suit is to make preparations before it is commenced. “If preparations for court only commence when one is sued,” Egan said, “this is already far too late.” Rather, it is important to always at least keep in mind the potential for such an outcome. The barrister made it clear that she is in no way advocating defensive medicine, but rather that there ought to be a meaningful engagement at all points in the process with the possibility, however remote, of a poor outcome for the patient. Doctors must have an awareness of the risks, coupled or balanced with what is realistically achievable for the particular patient in front of them.

Egan addressed the process in four steps – firstly the consent of the patient to surgery, secondly the surgery itself, thirdly the practical aftermath, and finally, the courtroom.

**CONSENT**

At the time of the consent discussion between the surgeon and the patient, Egan explains, what the patient requires in that moment is good communication and the surgeon’s judgment. The practical surgical and medical expertise only comes into the picture later in the process. Egan reminded the audience that it is not the test of Dunne v National Maternity Hospital (1989) that applies in informed consent cases, but rather the reasonable patient test. In other words the test is primarily “patient focused”, rather than “doctor focused”. For this reason, expert testimony is of far less relevance in consent cases. What is asked is: has the material risk – either known or foreseeable involving pain or further operative intervention – been disclosed to the patient in full? For such scenarios, Egan puts forward eight practical pointers.

Firstly, she dispels one tenacious myth. In Egan’s experience, medics often assert with great confidence that there is no need to inform a patient of a possible consequence of surgery if the risk carries a less than 1% likelihood of occurring. This is incorrect. There is no invariable rule to the effect. Based on the severity of its consequences, a risk can still be material regardless of its low statistical frequency.

Secondly, Egan mentions the nature of the surgeon’s discussion with the relevant patient. It is fair, she says, to be concerned about a certain kind question such as: “If I were your husband or your father, would you recommend this procedure?” Asking such a question is perhaps unfair to the surgeon as it ought to be irrelevant in terms of his or her clinical judgment. However such a question can be awkward to answer. A correct or safe response Egan suggests is to say: “If you were my husband or my father, I would send you to somebody else to carry out a more objective assessment!” However, Egan asserts that ultimately in such a situation the surgeon has no option but to answer honestly and fully. Even though the question is problematic in nature it cannot be avoided merely because the surgeon is concerned about worrying the patient.

The third point Egan makes is that it is easy and, indeed, habit forming, to talk in terms of “good” versus “bad” outcomes to surgery. What we don’t often see is an explanation as to what those words actually mean in practice for this particular patient. She gives the example of sinus surgery – it is important the patient knows that while such a procedure might improve their symptoms, it won’t cure their symptoms. They will continue to experience symptoms and they may need to continue taking medication afterwards. Unfortunately, such details of an imperfect outcome are rarely made explicitly clear. These practical details must be made clear, particularly to overly optimistic patients. What patients want to know, in real terms, is how this surgery will affect their lives. “I regret to say that in my experience these kinds of everyday conversations don’t take place nearly often enough,” Egan says. Fourthly, the timing of consent discussions is important. For elective procedures the consent conversation must take place well in advance of surgery, preferably by at least several weeks. “Trolley consents” are difficult to justify.

Fifthly, the duration of consent discussions is also relevant. How long should the consent meeting last? Egan points out that in a courtroom, a surgeon will be questioned not just on the content of the discussions but on how long they lasted. She stresses that while there is no prescriptive amount of time for consent discussions, if of only five minutes duration, then obviously the surgeon must be aware of this aspect being raised in litigation.

As a sixth tip, Egan recommends that it is important that a basic note of what was covered in the
A conversation is taken. It need not be lengthy, but must be concise, clear and comprehensive. Take one minute of your time between consultations or tasks to write down or type into the patient’s record what was covered in the conversation.

Seventh, smartphones: Egan recounts a scenario she has come across, whereby a doctor was unwittingly recorded on the patient’s smartphone as the consent discussion took place. The doctor was quite cross about this. But the patient probably had every legal right to do this. The medical consultation is of course confidential, but it is the patient who is entitled to waive their right to privacy in such a situation. The privacy of a doctor/patient relationship protects the patient and not the doctor. It is legally problematic to say to a patient that they are not able to record such a conversation, and surgeons need to keep this in mind. If a patient states that they wish to record a discussion and the doctor is uncomfortable with this, then he or she can say so. If the patient insists however, the doctor cannot safely refuse to continue with the consultation for this reason alone. There is still an obligation to advise and to treat.

Finally, regarding information leaflets, Egan reminds surgeons to keep these up to date and make sure that leaflets really only expand on information that has already been verbally given to the patient. In addition, when a surgeon gives a leaflet to a patient there must be an understanding that the patient may take the leaflet home with them and must be entitled to an opportunity to cancel or postpone the surgery at a later point, on foot of the information contained in the leaflet.

THE SURGERY
After consent has been established, Egan addresses the surgery itself. She offers the example of a cholecystectomy. “Consider a patient undergoing a cholecystectomy, and as does happen, let’s assume the common bile duct is injured,” suggests the barrister. This is a recognised and acknowledged risk of such a procedure.

“Let’s assume the patient was reasonably informed of the risk of such an injury and that there therefore was no question of informed consent. Let’s also assume the injury was diagnosed in a reasonable amount of time and steps taken to address it. In other words, it’s not a “missed injury”. The kinds of factors which might determine whether such a case is defensible are as follows: Firstly, the patient’s anatomy. Is there anything unusual

The best way to defend a suit is to make preparations before it is commenced. “If preparations for court only commence when one is sued,” Egan said, “this is already far too late.”
Discussing the practical aftermath of an adverse event, Egan firstly emphasises the duty of candour on surgeons... there is absolutely nothing to be gained by avoiding these difficult conversations.

The second issue is the location of injury – is it within the operative field? If not, then, arguably, you had no business being there. The third issue has to do with the surgeon’s choice of technique. What methodology have you employed to minimise the risk?

In many cases, Egan says, it will be possible for a surgeon to rely on his or her invariable practice, but to do so, these techniques must be second nature to you. You must be absolutely confident that you’ve taken such care to systematically go through these safety precautions and, better still to record them. When the case comes to trial years after the event, where you have only a blurry memory of what took place, this is difficult to show if it is not recorded.

Fourthly, the surgeon must demonstrate in the operative note that he or she knew of the relevant risk, and took care to identify and minimise the risk by, for example, identifying and retracting the relevant adjacent structures. If these structures couldn’t be identified, he or she must show that a decision to nonetheless proceed was based on clinical judgment, that the surgeon was balancing the risk of injury to an adjacent structure when uncertain of its location against the risk of damaging such structure by excessive dissection in the quest for certainty. This is the key point. What is terribly important is that the court understands that one is exercising one’s clinical judgement to elect between two unpalatable options; one is not in an ideal textbook scenario, one is choosing the lesser of two evils. “It is very difficult, I know, to make that clear, to achieve that level of subtlety in an operative note,” Egan tells the audience, “but you are expert surgeons. I have no doubt that you can capture and encapsulate that judgement process, that you can to express clearly the fine balancing act that can apply in even the most straightforward of cases.”

The Aftermath of an Adverse Event

Discussing the practical aftermath of an adverse event, Egan firstly emphasises the duty of candour on surgeons, as outlined in the Medical Council Guidelines. If something has gone wrong, there is an overriding ethical duty to acknowledge this and explain it to the patient. Although, perhaps it is human nature to do so, there is absolutely nothing to be gained by avoiding these difficult conversations.

Secondly, Egan urges that surgeons understand one point about second opinions. In her experience it is frequently the case that the initial injury was defensible – but that, unfortunately, a surgeon’s persistent attempts to repair matters ended up making the case indefensible. It is in re-operation that greater damage frequently occurs. There is a great value to be gained from getting a second opinion early on, Egan notes. She warns the audience to be very wary of re-operating and to always obtain a second opinion.

The Courtroom

Egan makes three brief points about what is perhaps the most daunting part of the process for a surgeon – the courtroom.

Her first note has to do with aggression in the courtroom. Judges will never welcome an aggressive environment. They will not applaud hostility, or the haranguing of witnesses. As a witness, when you find yourself at the receiving end of this, Egan declares, it is because you are doing well. The opposing counsel becoming aggressive only confirms this. Rather than the aggressive examination that is often shown on TV dramas, what Egan thinks occurs in most cases, and certainly most medical negligence cases, is that barristers will completely immerse themselves in the relevant medical literature in relation to the surgery. Ultimately though, this is the medic’s area of expertise, not the barrister’s. Understanding this will make it easier for a surgeon who is being asked these technical questions to feel more confident.

Secondly, how does a surgeon approach his or her answers to counsel’s questions? The advice is to keep in mind that the focus ought not to be on the black and white lines of the text – whether it be the text in the op note, the text in medical records or the text in the medical literature – but on what is in between those lines of text but the surgeon’s judgement? It is your task to try and explain how that judgement was reached and applied to the case before you. A judge quite properly will be reluctant to second-guess that judgement. Why? Because the judge is not a surgeon. Likewise, the expert, although presumably a surgeon, was not present at the time the surgeon made this decision that he or she is now defending. The expert is at one remove temporally and geographically. The judge’s task is not to decide what could have been done differently but to see if a reasonable decision was made in the circumstances as per the judgement of a surgical professional on the spot.

Egan’s fourth point is important. Remember not to allow pride to let you down while being cross-examined. By that, Egan refers to the fact that you will be examined in such a way that is bound to make you feel as if you have stumbled. You may feel you have dropped the ball, been led down a blind alley, allowed yourself to be tricked. In short, you may perhaps feel a fool. This happens nearly every time somebody is cross-examined. However, if you spend the next five or six minutes of your time in the witness box allowing this feeling to percolate, ruminating or replaying this error in your mind, mistakes will then surely be made. It is important for you to trust the judge. They understand that one can mis-speak in this process, they are human and they are not unforgiving. Move on from your error (if error it is) and focus on answering the questions as best and honestly as you can. You can ask no more of yourself than that.
A surgeon in... Sligo

SURGEONS SCOPE SETS OUT TO EXPLORE THE EXPERIENCES OF SURGEONS AROUND THE WORLD AS THEY DESCRIBE THEIR PRACTICES. WE TALK TO MR NAISHADH PATIL, CONSULTANT ENT SURGEON, ABOUT HIS PROFESSIONAL LIFE IN THE SLIGO COMMUNITY

Naishadh Patil is a consultant ENT surgeon at Sligo University Hospital, (part of the Saolta University Healthcare Group), and President of the Irish Institute of Otorhinolaryngology. This year Mr Patil will be offered Fellowship Ad Eundum by the College, an acknowledgment of his contribution to the surgical profession. It's a privilege earned through hard work and commitment to excellence.

Back in 1986, when Naishadh Patil graduated second in his class from KEM Hospital in Bombay, now Mumbai, it was the done thing to go abroad. As a very good student, his ability caught the eye of one of his professors who arranged for him to travel to Germany to train in Tuebingen. Mr. Patil was fortunate in having the support of his parents, who put together the funds to make this dream come true. With this prospect on the horizon he quickly signed up for German language classes so that when he arrived he would have the edge over most of his non-German colleagues. At the time, Germany was a mecca for academia, he says, particularly in his chosen field of otorhinolaryngology. While doing his first year’s attachment in that country, he applied for a scholarship for aspiring researchers. (He continued his language learning three evenings a week and, although there are few opportunities to deploy it in Sligo these days, Naishadh says that knowing the language was instrumental in assisting his early progress). He was successful in procuring a DAAD Scholarship to undertake an MD in neurotology at the University of Wuerzburg for his second year. He returned to Mumbai in December 1987, and applied to various UK hospitals. He was offered a post at Tyrone County Hospital, and while preparing for his move to Northern Ireland, met his wife, Anita, who was working for a pharmaceutical company. They married in 1990, and moved to Sligo in 2004 where a 35-page in-patient list awaited him.

Having entertained the idea of a move to the US, even applying for a Green Card, in the end his choice was to become an Irish citizen. He believes the Irish healthcare system is "socialistic. It has a compassionate face. By that I mean it is less robotic than, for instance, the German system. It is inherently human, I think."

He and his wife and two sons made their home near Rosses Point in Sligo. It's a close-knit community, he says: "It's not an anonymous life. The number of my patients I meet just going about my business is quite large." Nowadays, the workload is shared by a senior consultant – Niall Considine, and a husband and wife team, Mary Bresnihan and Marcus Choo. The impression is of a trusted community-oriented partnership that serves its patients well. They operate a one-in-three rota, which up to a few years ago was a one-in-two (24 hours on call, 24 hours off – challenging by most standards!). The week is spent between theatre and teaching as well as seeing patients in Letterkenny, a feeder clinic for Sligo. Procedures are mostly routine/intermediate – sinuses, tonsils/adenoids, salivary gland surgery, otology, staging cancers (oncology cases are transferred to Galway University Hospital). "We don't have image guidance, but what we offer patients is not radically different from the major hospitals."

While his specialty rarely results in life-or-death outcomes, he finds it's not easy to switch off. Walking is a stress-reliever as is spending time with family. Mr Patil also travels in his role as President of the Irish Institute of Otorhinolaryngology and as an examiner for RCSI. One of his keen interests is in e-health and virtual medical education. "I can't see why Ireland can't be a beacon for online training. There is huge potential for this in India and globally where doctors with ambition want to be trained by an authoritative external source."

It's a close-knit community...

“The number of my patients I meet just going about my business is quite large.”
The well clinician

THE NEW STRATEGY FOR DOCTORS’ HEALTH AND WELLBEING AIMS TO SUPPORT DOCTORS AT WORK IN CHALLENGING AND STRESSFUL CONDITIONS. NATIONAL CLINICAL LEAD OF THE HSE’S HEALTH AND WELLBEING UNIT, DR LYNDA SISSON EXPLAINS...

hat doctors need to be well, to deliver high-quality healthcare seems obvious. But, is it unreasonable to ask doctors to cope effectively and to develop resilience when thus far the access to a set of standards, relevant tools and resources to support them have not been available? The new HSE Strategy for Doctors’ Health and Wellbeing aims to change all that.

Wellbeing may be described as a bio-psychosocial aspect of health and happiness and relates to our physical, social and mental state. Multiple definitions of wellbeing are available, although there are minimum factors that comprise wellbeing, including the presence of positive emotions and positive mood and, additionally, the absence of negative emotions. In plain terms, wellbeing can be described as judging life positively and feeling good.

In the healthcare sector, objective surrogates of wellbeing might include absenteeism data, turnover statistics, and measures of the number of injuries and incidents for staff. More subjective measures were captured in the National Staff Survey and in the National Patient Experience Surveys of 2016 and 2017.

The importance of teams in health and social care has been emphasised in numerous reports and policy documents. One such study, undertaken in 2014 to assess the wellbeing of doctors across Ireland involved representatives from RCPI, RCSI, College of Anaesthetists, College of Psychiatry, Irish Association of Emergency Medicine and Dublin City University. Data was collected on doctors’ lifestyle choices, interpersonal relationships, mental health problems, anxiety and substance misuse. The report highlighted unacceptable levels of distress and dissatisfaction in both trainees and consultants with the working environment.

The best outcomes for patients are shown when there is evidence of doctors, nurses, allied health professionals, and support staff working, learning, and auditing together to enhance engagement and innovation. Maintaining the health and wellbeing of doctors and the extended interdisciplinary team is essential for a healthy workplace environment.

Studies also revealed links between clinician burnout and increased rates of medical errors, malpractice suits and healthcare-associated infections. In addition, the recruitment and retention of doctors is a key human resource priority for the Irish healthcare system, and doctors were citing poor health and wellbeing as a reason to leave it. It was clear that a key priority was to address the challenges faced by the medical profession which lead to so many doctors experiencing distress and exhibiting manifestations of stress. Doctors were saying that they were stressed, burnt out, and leaving the system as a result. An intervention to manage this situation was required.

The research that was being published in Ireland was very concerning. The Strategic Review of Medical Training and Career Structure (McCraith report, 2014) recommended the implementation of initiatives to achieve three key targets for junior doctors:

- The improvement of graduate retention in the public health system
- Planning for future service needs
- Realising maximum benefit from investment in medical education and training

The most recent implementation review from December 2017 clearly states that while some of the the recommendations of the report have been implemented, a significant number have not. There has been no implementation of the mentoring programme, no improvement in stressful working environments and the workforce plans, and ongoing bullying of NCHDs by peers and staff/supervisors. The lack of progress in this and other areas suggest that the change of culture necessary to provide a more supportive working environment for junior doctors is a slow process and that the implementation of necessary improvements is challenging. A recent publication from RCSI (Crowe and Clarke 2017) explores the relationship between power and emotion and questioned how effective relations between senior and junior doctors are patterned on the hierarchical structure of medicine. Through a number of qualitative structured interviews, this study showed that respect for hierarchy, anger, fear, intimidation and delusion were key themes in relations between junior and senior doctors in the health system.

Dr Lynda Sisson, MB MPH
ACOEM FFOMI, was appointed National Clinical Lead in Workplace Health and Wellbeing in the Health Sector in Ireland in 2016. In this role she has published Standards for Occupational Health Services and a Strategy for the Health and Wellbeing of Doctors and rehabilitation standards for injured workers and is currently working on a Healthy Workplace Framework for healthcare workers which will include a Mental Health Strategy for staff. She currently lectures at the Institute of Leadership at RCSI. A graduate of TCD, Dr Sisson trained in general practice in Ireland before specialising in Occupational Medicine in the US. On her return to Ireland in 1998, she became a Fellow of the Faculty of Occupational Medicine in the the Royal College of Physicians in Ireland and is currently Vice Dean Elect in the Faculty of Occupational Medicine in the RCPI.
“Doctors were saying that they were stressed, burnt out, and leaving the system... An intervention to manage this situation was required.”

The Organisation for Economic Co-operation and Development show that 36.1% of Ireland’s doctors in 2014 were trained abroad. The Irish Medical Council confirms the significant reliance (34.3%) on international medical graduates. Historically Ireland’s health professionals migrated to developed countries for multiple reasons. It was in this context that a large group of stakeholders gathered last year to discuss what could be done. This meeting proved to be the first step in the development of the new Strategy for Doctors’ Health and Wellbeing 2018-2021, launched in April. The strategy comprises a set of standards to safeguard and improve the health and wellbeing of doctors. Its mission statement “To ensure that doctors in Ireland can continue to be physically and emotionally well throughout their working life”, underpins the set of national standards for all healthcare workers that must be adopted at all levels – medical students, NCHDs, consultants, senior medical personnel and GPs. These stakeholders, and others, among them nurses, nursing staff, support staff, government representatives, were invited to provide feedback during the document’s progress and will continue to provide input as part of the implementation plan. Our hope is that current doctors, along with the next generation of medical students, will be healthy and equipped to deal with demanding working conditions and the inevitable challenges that they will face and to be “physically and emotionally well throughout their working life.” These standards are the first of a series of national standards for all healthcare workers that will address the unique challenges of managing health and wellbeing for those who care for the sickest and most vulnerable in society. Consultation and stakeholder engagement was a key part of this project. Multiple stakeholders were invited, over a two-month period, to provide feedback on the document and changes were made to it based on the feedback received. In line with continuous quality improvement methodologies, stakeholder engagement and consultation will continue as part of the Strategy’s implementation plan. For healthcare settings, the most relevant current standard to promote wellbeing is the the National Institute for Health and Care Excellence (NICE) publication: Healthy Workplaces: Improving Employee Mental and Physical Health and Wellbeing Quality Standard (see www.nice.org.uk/guidance/qs147). The Workplace Health and Wellbeing Unit obtained a licence from NICE to adapt the content for use in the Irish healthcare setting. The standards are specific to four grades of doctors:

- Medical Students
- Non Consultant Doctors
- Consultants/Senior Medical Personnel
- General Practitioners

Supplemental considerations are outlined for those in the above categories who may also be international graduates, retiring doctors, doctors not in training and/or locum doctors and also include considerations to enhance family friendly workplaces. The criteria for all parties involved are clearly set out, and include the individual doctor and medical student, employers, medical schools and training colleges, as well as government bodies and key decision makers. The NICE Standards define four quality statements that can be applied to a workplace:

- Making health and wellbeing an organisational priority
- The role of line managers
- Identifying and managing stress
- Employee involvement in decision making

The next stage is the implementation of the standards. I am meeting with third-level colleges and professional groups as well as individuals who are championing the standards in their local area. A distributed leadership model appears to be the most practical and suitable approach to progress the implementation of the standards, in order that they become embedded in the system. The WHWU will run Training Workshops in the autumn. The standards will also be supported by the framework for improving quality in the health sector, the Quality Assurance plus Improvement process. Follow us on Twitter @whw_hr and at hr.wellbeing@hse.ie
From the beginning

Dr Robin Tattersall

FROM ENGLAND TO THE BRITISH VIRGIN ISLANDS, RCSFELLOW DR ROBIN TATTERSALL’S CAREER, FUELLED BY A PASSION FOR MEDICINE, HAS BEEN FULL OF ADVENTURE

In his fast Bertram boat, he became known as the “flying doctor”, whizzing between islands, diagnosing and treating the islanders.

CAREER PATH

Bachelor of Medicine and Bachelor of Surgery at Cambridge University, Cambridge and St George’s Hospital Medical School, London.
1957 - 1965
Post-Graduate Surgical Training in General Plastic Surgery at St George’s Hospital, and Westminster Hospital and associated Hospitals, London.
1965 - 1976
Government Surgeon for the British Virgin Islands and Anguilla. Founder and director of the Bougainvillea Clinic, BVI
1976 - 2010
Licentiate in Medicine and Surgery, Society of Apothecaries of London Fellow, Royal College of Surgeons of Ireland Member, General Medical Council of Great Britain Awarded an OBE for medical service in the BVI Member of the Endoscopic Society of North America Faculty Member, Annual BVI International Plastic Surgery Workshop

On the final day of racing in the British Virgin Islands Spring Regatta in April this year, there were 70 boats registered to race. The weather was warm and bright, with a pleasant breeze, typical Caribbean conditions. In this little piece of paradise, little has changed in the 47 years since the first Spring Regatta. Certainly not the prowess of the BVI’s most famous sailor, 87-year-old Fellow of RCSF, Robin Tattersall. As well as taking home two of the most important Regatta awards – the International Yacht Club Challenge and the Best BVI Boat award – Dr Tattersall went on to win all six races in which he sailed. He has competed in sailing events in the Olympics for the British Virgin Islands twice. He was for 20 years a judge for the International Yacht Racing Union.

Dr Tattersall’s life story is one of adventure and gentle ambition, underpinned by a deep love of his adopted home in the British Virgin Islands and a huge regard – which is mutual – for the islanders who call him “Beloved” and who have relied on him for healthcare over several decades.

Dr Tattersall was born in 1930 in Cheshire. Both his father and grandfather were sailors, and sailing played a huge part in his childhood, some of which was spent in a small village in North Wales. After secondary school at Manchester Grammar and two years as an infantry officer, he entered Cambridge where he completed his Bachelor of Medicine and Bachelor of Surgery (and played a lot of rugby) before entering St George’s Hospital Medical School in London to continue his training. It was while at St Georges that he worked as a male model to earn a little money. Working with the legendary American fashion photographer Richard Avedon, he was paired on a shoot with supermodel of the day Suzy Parker. The resulting shoot catapulted him to the pages of *Vogue* and *Harpers & Queen*. Brief but exciting, his modelling career yielded to his real love – medicine. He knew he wanted to be a general surgeon but also had an interest in reconstructive surgery,
having been introduced to this form of surgery by the well-known plastic surgeon, Henry Elliott Blake.

Just as he was finishing surgical training, he saw an article in the British Medical Journal which encouraged young doctors in specialties to spend two years abroad before settling down at home in the UK. When the opportunity arose to become Government Surgeon in the British Virgin Islands, his interest was piqued. He could spend time abroad while practising general surgery, among other medical duties. By this time married to Jill, and with three small children in tow, he left Britain. “We crossed the Atlantic to St Lucia on a ‘Banana Boat’, with our 28-foot sloop as deck cargo and spent a month sailing up the island chain to Tortola, dodging hurricanes along the way.” It was October 1965.

The government gave him a $100 horse allowance in his first year. ”I soon had this converted to a boat allowance, as 80% of the population lived within 200 yards of the sea.” In his fast Bertram boat, he became known as the “flying doctor”, whizzing around the islands, diagnosing and treating the islanders and the ex-pat community. Patients were scattered across many islands – all were his responsibility, 24 hours a day, seven days a week, 365 days a year. The medical budget was small and resources were tight but Dr Tattersall found it stimulating, fascinating, and satisfying. He did his own anesthesiology – and almost everything else. He had to improvise and make his own instruments and creatively cope with a shortage of blood. He read an article that suggested that coconut water (a natural isotonic beverage with the same level of electrolytes as we have in our blood) could be used in place of IV fluids. He used it and it worked. His dashing James Bond-like demeanour was coupled with ingenuity and resourcefulness. He was awarded an OBE in 2001 in recognition for his public service as a doctor in the British Virgin Islands. ”The OBE was presented by the Queen,” he remembers, ”who in 1966 spent 20

minutes with me, one-on-one, cooling down in my operating theatre, the only air-conditioned room in the country.”

Life was challenging and interesting, and Dr Tattersall and his family stayed after the end of his first contract. Although still working for the government, he also set up his own clinic, which later evolved into the Bougainvillea Clinic, called “The Purple Palace” by locals, which had been a hotel, then was abandoned for 20 years. When a locally born surgeon returned to Tortola in 1976 to take up the post of Government Surgeon, Dr Tattersall decided to stay on the island. His Bougainvillea Clinic grew. His own practice also developed from general surgery towards more aesthetic and reconstructive surgery.

In 2007, the Clinic began a transformation into a general hospital with a focus on the surgical specialties, when a relationship was forged with the doctors of Eureka Medical Clinic. In 2010, Dr Tattersall transferred ownership of the clinic to Dr Heskith Vanterpool of Eureka. The hospital is now served by specialist surgeons and physicians from hospitals in the UK, Ireland, Europe, USA, and in modern facilities in other Caribbean islands.

“Regrettably, I did have to retire at 85,” says Dr Tattersall, “but I am still called upon by friends and former patients for advice.” Sailing apart, he enjoys life with second wife Martha, an artist, and many friends. A life lived in the service of others, with some quality downtime strikes the perfect balance – one every surgeon might aspire to.
Cancer, genes, risk and us

Dr Siddhartha Mukherjee is asking serious questions about the future of genes, risk and precision in medicine. Dr Claire O’Connell met him in Dublin.

As we learn more and more about the genetic risks of developing cancer, what will that mean for our bodies, for our societies and for ourselves as humans? Where will we draw the lines for monitoring and intervention? And could we become a society laden with ‘previvors’ who have to deal with knowing they are genetically susceptible to particular illnesses?

Those are some of the difficult and fascinating questions that Dr Siddhartha Mukherjee explored in his recent talk at RCSI. The following day, he received an Honorary Doctorate from RCSI, celebrating his contribution to human health, medicine and science.

The talk, ‘Three Visions of a Medical Future: Genes, Risk and Precision,’ was a panoramic view of cancer and genetic risk, and Sid is well placed to speak on that topic. As an oncologist, he treats patients with cancer; as a scientist, his research is uncovering how bone and cartilage are generated in the body and as an author he has penned two best-selling books: The Emperor of All Maladies: A Biography of Cancer, which earned Sid a Pulitzer Prize in 2011, and The Gene: An Intimate History, which explores our understanding of genes and the impact of being able to read and write genetic information.

BACKWARDS INTO CANCER

Sid admits he came into the field of cancer backwards. After he had studied biology at Stanford University, he moved to the University of Oxford for his Doctorate in Philosophy, which looked at how viruses interact with the immune system. “I was looking at how infection with a particular virus, the Epstein Barr virus, can become chronic,” he says. “That is the problem I took on.”

The Epstein Barr virus is associated with a higher risk of some cancers, and through his work on the virus, Sid developed an interest in malignancy. “I began to think about getting out of the microscope and thinking about the larger issues of human cancer,” he says. “That is when I started to train in medicine.”

He was awarded an MD from Harvard University, and since 2009 Sid has been an Assistant Professor of Medicine at the Columbia University Medical Center in New York City. There his areas of research include blood cancers and how blood, bone and cartilage are generated in the body.

“I treat and I work on leukaemia and I am particularly interested in the microenvironment of the cancer,” he explains. “We showed about ten years ago that if you change the microenvironment you change the behaviour of the leukaemia.”

That line of work has led Sid to delve more deeply into the impact of hormones, the immune system and even diet on leukaemia. “It is a very unexplored area,” he says.
His lab also has an interest in stem cells and has made important strides in discovering how the body makes cartilage and bone.

“We didn’t know where bone comes from properly and what maintains bone,” he says. “We now think there are at least two completely separate sources of cells that are the stem or progenitor cells for the bone. One of them forms cartilage and bone, the other one forms bone and the fat cells that live inside bone. Why that is the case no-one knows.”

BRINGING MEDICINE TO BOOK

Sid’s curiosity and his fascination with his work are evident when he speaks, and readers of his books will be familiar with his elegant turns of phrase.

His first book started out as a journal and grew into The Emperor of All Maladies, which looks back at our millennia-long history with cancer. “Emperor” as Sid refers to the work, charts discoveries and shifts in thinking that inform how we tackle cancer today.

“There is a frustration around how slow progress can seem, but the shifts [in thinking] are towards the understanding of truth, understanding nature in a deeper way, and with each shift comes a new direction,” he says. “You understand there are many unknown unknowns, but even demarcating those spots is a move to understanding cancer better.”

Part of the inspiration for Sid’s second book, The Gene: An Intimate History, came from his own reflections on cancer. “If cancer is the abnormalcy of genes what is normalcy?” he asks. “How do our bodies build a repertoire of cells without every cell becoming cancerous?”

Again, Sid’s experience as a researcher was another key to unlocking that second book. “We were getting all this new knowledge about genetic engineering, gene editing, and new technologies such as CRISPR” [Clustered Regularly Interspaced Short Palindromic Repeats, a family of DNA sequences in bacteria and archaea. The CRISPR/Cas systems confers resistance to foreign genetic elements to provide a form of acquired immunity], he says. “We were using it in the lab and we were shocked by how easy it was.”

ENGINEERING NEW GENETIC FUTURES

The emergence of such genetic and genomic technologies offers many potential advantages for human health and society, but there are serious ethical questions to be considered too.
“The most important and most neglected [in public discourse] use of CRISPR in all other organisms, for example to change crops and food,” says Sid. “But there are biohazards and environmental hazards to consider there.”

Genetic engineering in somatic cells, which are not involved in reproduction, also offers an enormously powerful technique for understanding and perhaps even treating disease, he adds.

“You can use that to change stem cells in human beings and you can potentially cure diseases such as sickle-cell anaemia,” says Sid. “And you can use it to understand the biology of cells in the lab and ask why do cancers behave like cancers.”

The application that probably gathers the most attention, though, is human gene editing in embryos, which is fraught with ethical issues.

“It is understandable that so much of the CRISPR debate gets preoccupied with that idea,” says Sid. “It’s the one that people have a very visceral and ethical reaction to and it’s the one that is most talked about, the barriers are high and hazards are huge.”

THE RISKS OF CANCER RISK

Our better understanding of genes and cancer have helped to fuel the move towards more personalised or precision therapies for cancer patients, which again opens up new avenues and questions for society and medicine to tackle.

“One of the things we have understood about cancer is that the application of personalised cancer therapy early in cancer is often successful but later in cancer is often not successful,” says Sid, citing breast cancer and Herceptin as an example. “The advantage there is that we have started looking more deeply at earlier times when cancer can be diagnosed, but that raises important questions about surveillance and what it feels like as a human being to be constantly under surveillance for cancer. I think it is going to become much more continuous and we need to think about what that does to our bodies and our societies and ourselves.”

A more tested society could be one more burdened with more anxiety. We don’t want to become a society of ‘previvors’.”

With the tsunami of genetic and genomics technologies on our way, what do researchers and physicians need to do to ameliorate the risks of knowing the risks? “I think we need to understand what risk looks like,” says Sid. “And we need to understand that for many diseases we were previously blinded to in terms of genetic risk we will now begin to understand the genetic risk. For anything that is heritable, you could have a number that is ascribed to you, and I think physicians need to figure out how to think about this genetic report card of the future. What is that magic number where you want to make a difference, and what kind of intervention are you willing to take, how much intrusion into their life is an individual willing to accept.”

BALANCING FOR THE TRILOGY

With such a busy work life, seeing patients and leading active research, Sid found it a challenge to write books too, but their urgency carved out the time to write them.

“I did a lot of juggling,” he says. “But the books grow out of questions and when the questions are important enough they take so much precedence that the book writing fits itself into everything else. When you have a sense of urgency you make time for the project.”

And what’s next? “This was conceived as a trilogy,” says Sid. “I am figuring out the third part.”
THE OPENING OF 26 YORK STREET, CONFERRINGS AND MEETINGS

26 YORK STREET IS OPENED BY MICHAEL R. BLOOMBERG

On June 5, 26 York Street was officially opened by Michael R. Bloomberg, WHO Ambassador for Noncommunicable Diseases, philanthropist and three-time mayor of New York. Guests gathered in the Desmond Auditorium for the ceremony, which was followed by addresses by Professor John Hyland, Immediate Past President, RCSI, Professor Cathal Kelly, Chief Executive, RCSI, and an interview with Mr Bloomberg. The Rt Hon Lord Darzi, an alumnus and Fellow of RCSI, made closing remarks.
Students, alumni, Fellows and Members view an operation on SimMan in 26 York Street’s mock operating theatre; inside the National Surgical & Clinical Skills Centre; birthing simulation.

TOUR OF 26 YORK STREET

The reception which followed official proceedings at the opening of 26 York Street gave alumni, Fellows and Members the opportunity to meet and reconnect. For many, particularly those visiting from abroad, it was the first time they had seen the National Surgical & Clinical Skills Centre, where tours were conducted by staff and students.

FROM LEFT TO RIGHT: Students, alumni, Fellows and Members view an operation on SimMan in 26 York Street’s mock operating theatre; inside the National Surgical & Clinical Skills Centre; birthing simulation.
CONFERRINGS

We congratulate the 22 Fellows and 74 Members conferred at RCSI Dublin last December and those conferred at Fellow, Member and Diplomate Ceremonies that took place in Bahrain and Penang in November. A total of 310 Fellows and Members across 23 countries were welcomed into the RCSI Fellows and Members Community in 2017. Over 200 Fellows and Members will be admitted to the College this July at two ceremonies in Dublin and Penang.

INAUGURAL CONFERENCE ON PROFESSIONALISM

More than 450 healthcare professionals attended the inaugural conference on healthcare professionalism in Ireland which highlighted the importance of professionalism in improving patient outcomes and experience, and in promoting clinician wellbeing.

The conference was opened by Dr Philip Crowley, HSE National Director, Quality Improvement, demonstrating the collaboration taking place between educators and health service providers to increase awareness of the importance of professionalism in healthcare.
BELFAST REGIONAL MEETING

More than 30 of our Fellows and Members based in Northern Ireland joined us for a discussion and dinner on April 19th at the Crowne Plaza in Belfast. Topics discussed on the night included cross-border training initiatives and engagement opportunities for Fellows and Members.

CHARTER DAY

The RCSI Charter Day Meeting brings together over 500 members of Ireland’s surgical community annually, in a series of events commemorating the foundation of RCSI by a Royal Charter granted by King George III in February 1784. The 2018 Abraham Colles Lecture, “How Inequality Kills,” was delivered by Dr David Ansell, Senior Vice President, Community Health Equity, Rush University Medical Center, Chicago, while the annual Johnson & Johnson lecture was delivered by Professor Shafi Ahmed on “The Future of Surgery.”

> Events
OBITUARIES

THE LATE PROFESSOR EDWARD GUINEY AND
PROFESSOR TOM HENNESSY WERE PIONEERING SURGEONS

Professor Tom Hennessy (1933 – 2018)
Tom Hennessy was born in 1933 in Graiguenamanagh, Co Kilkenny. At school in Knockbeg College, Tom's ambition was to study medicine: he passed the Matriculation and entered Pre-med in UCD. Even before graduation he knew he wanted to be a surgeon. When it came to "walking the wards", he approached Professor Eoin O’Malley at the Mater to ask to be his intern. His surgical progress took him to various hospitals in Ireland and Liverpool. He passed the Fellowship Examination of the London College of Surgeons. He returned to work again with Professor O’Malley as Surgical Tutor at the Mater where the seed of his interest in oesophageal surgery was sown. A period of research took him to Minnesota. Tom was now not only an accomplished surgeon but also had a strong research pedigree. On his return, working with George Fegan, Professor of Surgery in TCD allowed him to concentrate his interest on oesophageal surgery.

After graduation he had married Maura Hayden and daughter Anne was followed by twins, Kathy and Lisa, and son, Michael. He adored his family.

Cork University was Tom’s next port of call, as Senior Lecturer in Professor Michael Brady’s department at St Finbar’s hospital, followed by the Chair of Surgery at TCD. The specialist department he established in St James’s was arguably, the most productive academically of any surgical department in Ireland. A landmark study was the six-year clinical trial that compared surgery alone for the treatment of oesophageal cancer with surgery plus chemotherapy and radiotherapy, published in the New England Journal of Medicine.

Election to the Council of RCSI was followed by the Presidency in 1994, during which he oversaw RCSI expansion in Bahrain and Penang. He conferred honorary fellowships on Nelson Mandela and Mother Teresa. Election to the Council of RCSI was followed by the Presidency in 1994, during which he oversaw RCSI expansion in Bahrain and Penang. He conferred honorary fellowships on Nelson Mandela and Mother Teresa.

Professor Edward Guiney (1931–2018)
Professor Edward (Eddie) Guiney was described as a “quick, superb technical surgeon, who showed great humanity in dealing with parents”, characteristics which led to a very successful career as a paediatric surgeon.

Eddie was born in 1931 in Dublin and educated at Belvedere College before studying medicine at UCD, graduating in 1962. He spent his postgraduate years working in St Vincent’s hospital in Dublin before moving to the Regional Hospital Galway in 1957 for two years as senior house officer and registrar. In 1958 he moved back to Dublin as senior registrar and tutor in surgery in St Vincent’s. Then, awarded a two-year travelling Fellowship in surgery by the NUI, he went to St Thomas’s hospital in London between 1960 and 1961 as a lecturer in surgery, before becoming Research Fellow in Massachusetts General Hospital and Harvard Medical School. On his return from the US, he lectured in surgery in UCD until 1965.

Moving into paediatric surgery, he became senior surgical registrar in the Alder Hey Children’s Hospital in Liverpool before returning to Dublin as a consultant paediatric surgeon in Our Lady's Hospital for Sick Children and Temple Street Hospital, the National Children’s Hospital, Harcourt Street and AMNCH Hospital Tallaght.

Eddie was involved in research, culminating in his appointment as Director of Research at the Children’s Research Centre in 1976. In 1972, he led a experimental liver transplant surgery on pigs at the UCD Research Centre, which led to his involvement in the national liver transplant programme in St Vincent’s Hospital, Dublin. His other clinical interest was the management of children with spina bifida and hydrocephalus.

Eddie was a firm believer in the importance of post-operative care and communication saying, “Post-operative care and communication are essential, especially when it comes to working with children. When you have a child as a patient, you actually have three patients; the mother, the father and the child itself. Children have their own way of communicating and you have to learn this.” Eddie was President of the British Association of Paediatric Surgeons. He was also President of the Society for Research in Spina Bifida and Hydrocephalus and of the Irish Paediatric Association.

In 2006 Eddie’s wife Sheila passed away. They had three children, Eddie, Michael and Carina. Eddie continued to work as a Surgeon Prosector in RCSI until 2014, following on from his role as RCSI Professor of Paediatric Surgery (1991 – 1997) and later became Professor Emeritus at the College. He never took his position for granted. “Working as a surgeon was a great career and I feel very privileged.”

Edited from a piece by Barry O’Donnell. ■
When and where are you happiest? Operating, uninterrupted.

What is your ideal evening? At home with my wife and our cats, with some good coffee and a record on the turntable. What relaxes you most? Cycling along the north Dublin coast from Clontarf to Howth.

What is your greatest fear? Not being able to work or provide for my family. When did you decide you wanted to become a surgeon? A memorable Final Med rotation with Professor Liam Kirwan at Cork University Hospital sealed the deal for me. His enthusiasm for teaching and for surgery was infectious.

Do you have any advice for your younger self? Do what you want to do, not what others think you should do. Don’t worry if it takes you time to find the right path, you will find it eventually. Where would you be if you had not become a surgeon? Behind the desk at a record shop somewhere.

What issues do women in medicine face today? Women are pre-judged. Most people think a woman in scrubs is a nurse. As a man, I will never have to face that prejudice at work. There are also issues around pregnancy and maternity leave which the medical profession, and surgeons in particular, have yet to address in a meaningful way.

What has been your proudest moment? Graduating from medical school with my family present. Who have you learned the most from in your life? My parents. A cliché, I know, but true nonetheless. How does a surgeon in 2018 cope with pressure? With difficulty, but with a calm mind. What is the best thing about the system of training young doctors in Ireland? The camaraderie among NCHDs is what gets us all through. We are also fortunate to work with consultants who have worked at top institutions around the world and brought knowledge back home to pass on to the next generation.

What is your greatest extravagance? Vinyl. I now have a collection of over 1,500 records. Do you have a mantra to live by? “The best way to not feel hopeless is to get up and do something.” (Barack Obama). What do you consider your greatest achievement? Representing the medical profession in Ireland as IMO President. Who is your hero? I have two. Barack Obama, whose grace and dignity in the face of racism, and instinct for the right words at the right moment, remains an inspiration. And the late Joe Strummer of The Clash, whose positive energy and principled righteousness drives me forward every day.

What is your favourite book series? The Game of Thrones. My titles of choice would be “Radiator” by the Welsh group Super Furry Animals or “I Am Kurious Oranj” by The Fall. What is your favourite writer? JG Ballard. He masterfully combines a “complete and serene ordinariness” of suburban life with a dystopian vision of the modern world which is closer to reality than is comfortable.

If you could invite any historical figure to dinner, who would it be? Michael Collins. He achieved so much in a short time and understood the importance of compromise as well as revolution. I’d be interested to hear if modern Ireland matches the vision he had for a new republic. Why did you create the hashtag 24NoMore? As a shorthand for the public to understand the campaign’s aims. Most people did not fully understand doctors regularly worked more than 24 consecutive hours. Once that message had gotten through, public support for the campaign was overwhelming.

Name one virtue all surgeons ought to have. Patience. Name one vice no surgeon should have. Greed.
We are currently inviting applications from College Fellows who wish to become Examiners. The RCSI’s Court of Examiners was established in 2014 to acknowledge the essential contribution made by our Examiners to Fellowship and Membership examinations.

**Court Members**
- Contribute to the assessment of junior colleagues
- Examine in Overseas Centres
- Network with colleagues
- Participate in Annual Meetings / Postgraduate Conferrings

**Upcoming Events**

**CONFERRINGS, MEETINGS AND EVENTS ... SEE WWW.RCSI.COM FOR FURTHER DETAILS, OR EMAIL FELLOWS@RCSI.COM**

**MILLIN MEETING**
The annual Millin Meeting 2018 will take place on November 9th 2018. Please note that applications for the 41st Millin lecture have now closed.

**CHARTER DAY**
The annual Charter Day 2019 will take place at RCSI Dublin from February 5th-9th 2019. Information in relation to the programme and registration will be available at www.rcsi.com in due course.

**Congress of the Hong Kong Academy of Medicine**
The 25th Anniversary Congress of the Hong Kong Academy of Medicine, Hong Kong has as its theme this year “Beyond 25: New Paradigms in Healthcare”. The David Todd Oration will be delivered by Professor Yuen Kwok-yung on “Emerging Infectious Diseases and Beyond” and the Halnan Lecture by Dr Humayan Chaudry, on “Regulators and Clinician: Making a Difference in Medicine Worldwide.” Several multi-specialty sessions include Advances in Cancer Screening and Management, Medicine in the Digital Era, Trauma and Sports Medicine, Paediatric Metabolic Diseases and many more. The deadline for early bird registration is August 31st; the Call for Abstracts deadline is September 15th. Visit www.hkamonline.hk/25congress for more details.

**FELLOWS, MEMBERS & DIPLOMATES CONFERRING**
We look forward to hosting over 250 newly-admitted Fellows and Members at two ceremonies in July. On Sunday, July 1st, a Fellows, Members & Diplomates Conferencing Ceremony will take place at Penang Medical College in Malaysia. The Fellows, Members & Diplomates Conferencing at RCSI Dublin will be on July 10th, with registration at 3.30pm. In November and December of this year, three Conferencing ceremonies will take place in Bahrain, Penang and Dublin.

**NORTH AMERICAN CHAPTER MEETING**
The North American Chapter of Fellows Meeting will take place on October 22nd in Boston, USA. Further information along with official invitations will be sent to Fellows and Members based in North America in August 2018. If you are not based in North America but would like to attend, please register your interest by emailing fellows@rcsi.com.

**FFN Global Congress 2018**
The 7th Annual Fracture Fragility Network Global Congress is due to take place at RCSI, Dublin from July 5th to 7th 2018. This international congress addresses the full pathway of care for fragility fracture patients, and consists of contributions from invited international experts, plenary discussions, update sessions and free papers. This year’s motto is “Patient-Centred Multidisciplinary Care,” and the congress themes include perioperative care, surgical treatment, rehabilitation, secondary prevention, research and policy change. For further information and to register, please visit http://fragilityfracturenetwork.org/our-organisation/7th-ffn-global-congress-2018.

**Sir Peter Freyer Memorial Lecture & Surgical Symposium**
The Sir Peter Freyer Memorial Lecture & Surgical Symposium is hosted annually on the first weekend of September by the Department of Surgery, NUI Galway. Professor Sean O’Beirn established this conference in 1975 and was succeeded by Professor Michael Kerin. It is the largest surgical conference in Ireland and is open to all surgical disciplines both nationally and internationally.

Each year the Sir Peter Freyer Memorial Lecture and Surgical Symposium are eligible for CPD credits. See www.freyer.ie for more details and registration.

**Regional Events**

**JULY 2018**
- Wednesday 11th - Association of Women Surgeons (AWS) Meeting for Women in Surgery, RCSI, Dublin

**SEPTEMBER 2018**
- Tuesday 25th - Regional Meeting, Waterford

**NOVEMBER 2018**
- Friday 9th - Millin Meeting, RCSI Dublin
- Thursday 22nd - Regional Meeting, Galway

**DECEMBER 2018**
- Monday 10th - Fellows, Members and Diplomates Conferencing Ceremony, RCSI, Dublin

**FEBRUARY 2019**
- Tuesday 5th - Saturday 9th February - Charter Day 2019, RCSI Dublin

**GLOBAL EVENTS**

**JULY 2018**
- Sunday 1st - Fellows, Members and Diplomates Conferencing Ceremony, Penang Medical College, Malaysia

**NOVEMBER 2018**
- Fellows, Members and Diplomates Conferencing Ceremony, RCSI, Bahrain

**DECEMBER 2018**
- Friday 7th – Saturday 9th - 25th Anniversary Congress of the Hong Kong Academy of Medicine, Hong Kong
OLYMPUS IRELAND
Supporting Irish Surgical Training

To register your interest in attending an Olympus Surgical Training course, speak to one of our territory managers or contact info@olympus.ie