UCC
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Coláiste na hOllscoile Corcaigh

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Alumni and Faculty

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Introduction

Welcome to the 11th newsletter of the UCC Medical Alumni and Faculty Association.

This year we had an excellent Scientific Conference on September 13th combining for the first time contributions from faculty and alumni. A highlight of this year's meeting was the unveiling of the Dr. John Danis Memorial Plaque, listing the name of those distinguished Alumni awarded the Medical School Medal for outstanding contributions to the advancement of knowledge and for outstanding public service in Ireland and abroad since the award was introduced in 2001.

You will see here in the newsletter a summary of the many and varied contributions to the conference from wide and far. This time we are glad to bring to your attention a few particular awards to our Alumni deserving of mention and our congratulations as we all bask in their reflected glory. Pat O' Leary in New York received a lifetime achievement award for his contribution to the development of spinal surgery in the Special New York Hospital for Orthopedics, the top ranked hospital in the US for orthopedic surgery. Barry O'Donnell has been invited to give the Thomas Vickory lecture at the Royal College of Surgeons in London, and Conor Duggan, Professor of Forensic Psychiatry in Nottingham has been awarded the OBE, while John Ryan at The University of Chicago, has won the Cournand and Comroe Young Investigater award at the annual scientific sessions of the American Heart Association in Los Angeles. Professor Cillian Twomey received the Medical School medal for 2012, and Surgeon Rear Admiral Frank Golden will receive the Distinguished Medical alumnus award for 2012 in the coming days.

We have had two outstanding invited lectures during the last year, The Joe O'Donnell Memorial Lecture given by Professor Michael Maher, Professor of Radiology, outlined the importance of minimising radiation while optimising image quality in Radiology. Much of the evidence presented was the result of collaboration between the Department of Radiology and the Alimentary Pharmabiotic Centre in UCC and CUH. Another outstanding lecture was the DePazzi Lecture given by Dr Kevin Horgan from Philadelphia, outlining the pioneers who have blaised the trail in Technology over the last 100 years. It was reassuring to see many had and have Munster and Cork connections. Surely this augurs well as we prepare for the Boole Sesquentenial celebrations in 2014.

Professor John Higgins has outlined his plans for the development of Academic Medical centres in tandem with the reconfiguration of clinical services countrywide. One can see their energy and enthusiasm continues to increase with remarkable changes and progress in UCC and in clinical services countrywide, recession not withstanding (as always "when the going gets tough, the tough get going!")

This year we have to congratulate the first graduating class from the Graduate Entry Medicine programme and welcome, the second class of 52 students from Malaysia in the Alliance Medical College of Malaysia, co-sponsored by UCC and NUI Galway. This class will complete preclinical training in UCC and commence clinical studies in Taiping in Spring of 2014. Next year we invite all graduates and faculty to come together and reunite with Faculty and old friends on Thursday 12th September.

We are enclosing details of the appeal for the Gerry O'Sullivan endowed Chair in Cancer Research and we very much appeal to you to make possible this most fitting tribute to Gerry.

We again would like to challenge all alumni to consider supporting your Alma Mater in whatever way you can, financially, and no sum is too small, or by facilitating contacts for our students and graduates, wherever you are. Just keep in touch and please ensure that we have your up to date email address. ■

Prof George Shorten

Welcome Medical Alumni 2013

I wonder how Ireland 2013 looks to someone interested in making or extending a career in medicine. In healthcare, we seem to have reached bare bone without eliminating the redundant or superfluous. In general, we survivors of the Celtic Tiger era are necessarily practitioners of the simple life. The Greek philosopher, Diogenes would have approved; he exemplified the simple approach to life by living in a tub. (Perhaps we have not yet reached the nadir of the Irish property market).

Diogenes is also reputed to have wandered around in broad daylight with lamp lit in search of an honest man. Like it or not, we recognise the power of perception. In the increasingly competitive world of higher education, branding is important and progress requires both style and substance , the former preferably delivered in bite-sized easily digested soundbites matched to the demands of a carefully profiled marketplace. With your help, we can do better than that. As medical alumni and faculty of UCC, you are the most impressive, accurate and widely distributed manifestation of what the School of Medicine does. We are grateful for all that you contribute and ask that you continue to serve as our ambassodors. You define, in a sense, you are the UCC medical brand.

We will look forward to welcoming you to the 2013 Annual Scientific Meeting of the Medical Alumni and Faculty Association. ■

Reformation Man – Prof John Higgins

Dr Bridget Maher reports on the School of Medicine Grand Rounds presentation on October 10th, 2012 by Professor John Higgins, Professor of Obstetrics and Gynaecology and Head of the College of Medicine and Health, UCC.

Professor John Higgins has a number of items on his opening introductory slide, each crucially important, each of interest to the diverse audience of clinicians and educators who have come to listen to him at this Grands Rounds meeting. Professor Higgins is going to discuss the new hospital groups and how previous experiences of reconfiguration have helped in this process. He is going to outline the College of Medicine and Health's strategic plan. He is going to explain how we need to adapt our mindset, indeed, change the culture of how we interpret healthcare evaluation so that we value all the items encompassed in the healthcare spectrum. And finally, he is going to tell us about the exciting new capital projects within the College of Medicine and Health.

Role of the university in reforming healthcare

Professor Higgins explained that key to reformation and realignment and the main challenge, is to bring the different agendas together - delivery of clinical care (the prime focus), teaching, training, research and innovation. Not a small challenge by any means, but one which Professor Higgins is undaunted by. He quotes Dr William Plested, a past president of the AMA – 'No country can afford to provide for every citizen all the treatments that are now available and goes on to explain that Ireland's economic challenges are not unique and that countries all over the world face similar challenges. Indeed, Ireland has a lot to be grateful for on a global level. 'Even though resources are affected, we still have huge resources'.

Hospital groups – the process

Professor Higgins explained the background to the fundamental change about to take place in hospital governance in this country. On March 28th, the Government issued a formal communication (Section 10 letter) which outlined in great detail exactly how it is envisaged that new hospital groups will come about. The first step will be the formation of administrative groups, and this will be followed after a few years by the development of these groups into actual legal entities with their own board. The year 2013 will be a transition year, and there will be a non-executive advisory board on hand to provide expertise and advice. The Hospital Groups Strategic Board, of which Professor Higgins is chairman, was set up in June 2012 and membership includes many international experts. A project team has been extremely busy during the summer and has held 75 formal meetings since July. This group has engaged with hospitals throughout the country and will shortly bring recommendations to the Minister. The Hospital Groups Strategic Board was also asked to provide information on hospital university linkages. Professor Higgins sees this as a welcome addition to the Board's remit, and one which facilitates his 'big picture' approach, allowing the opportunity for linkage and fusion of the different agendae and promoting synchrony and harmony in the re-alignment of hospital systems and the universities. Professor Higgins repeatedly stresses that the patient is central to any reconfiguration or change in the healthcare system and how we deliver healthcare. Careful realignment will allow hospital groups to connect with the people they serve, and it is this live connection between those who deliver care and those who receive healthcare that is integral to optimal healthcare, something Professor Higgins feels has been diminished in recent years.

What lessons have been learned from previous projects?

• ***Hard work***

Professor Higgins admits that there is no easy solution, no quick fix. Processes like this require a lot of work and there will be lots of problems along the way.

• ***Clinical leadership***

While Professor Higgins welcomes the growth in clinical leadership, he thinks that clinical leadership encompasses far more than just managing resources - clinical directorship also needs to provide a philosopical guidance – it needs to direct the culture within the hospital to rise above all the usual challenges to succeed in improving healthcare. 'Delivering care is how you score goals in healthcare gain.'

• ***Multi-phased process***

Professor Higgins stresses that realignment and change are multi-stage processes, beginning with planning, something he feels in this country we are very good at, and moving on to implementation, which traditionally has posed more challenges. One important lesson he has learned from previous experiences is that you can't give up when the going gets hard, you don't lose heart, you don't abandon ship, you keep on going. Stopping, giving up, is not an option. You have to see the process through to completion.

• ***Changing the Culture***

The last lesson Professor Higgins brings from reconfiguration is the vital importance of the culture of an organization. Ideally, this culture needs to embrace basic human characteristics – openness, honesty, trust, integrity and respect. Professor Higgins feels that some of these fundamental characteristics may have been eroded in recent years and we need to bring them back. Without these culture traits, staff become demotivated and healthcare suffers.

UCC Strategic Plan 2013-2017

The current UCC 5 year strategic plan is nearly at an end. Professor Higgins explains that the College of Medicine and Health has successfully created a school system within the College of Medicine, helped by organizing the schools around individual professional groups.

• Of the 3000 students in the College of Medicine and Health, 500 of these are post-graduate students. This is a smaller post-graduate representation than other sections of the university and something which needs to be improved.

• Staff numbers at the College of Medicine and Health have decreased (core staff decreased by almost 20%), in line with the rest of the university.

• The good news, and a key marker of success, is that the number of PhD students has risen from 47 in 2006/07 to192 in 2012. Professor Higgins would like to increase this number by 50%.

• Research income (17 million) provides a significant portion of CoMH's budget and Professor Higgins paid tribute to the hard-working research staff, many of whom are without tenure.

• The state grant for university students has more than halved in the past 4 years (currently 1832 euro per student) and this shortfall has to be made up for by the university.

College of Medicine and Health – 5 year plan

Research is core to the College's 5 year strategic plan and Professor Higgins discusses the '5 in 5' research plan of CoMH (5 major research themes to be developed to reach Institute status within the next 5 years). This, he stresses, is number one priority for the College of Medicine and Health.

The 5 in 5 Research agenda – the five research themes

• ***Alimentary Pharmabiotic Centre***

Top of the list, unsurprisingly, is the world-renowned, heavy-hitting Alimentary Pharmabiotic Centre, one of UCC's most successsful research stories. The APC is shortly to become an accredited Research Institute, testimony to a multude of demonstrable metrics and consistent excellent performance over many years. Professor Higgins wants to learn from the experiences and successes of the APC, and study the structures and organization that have led to the tremendous success of this organization. This he hopes may help fast-track research output in other UCC research centres.

• ***Women and Children's Research Institute.***

With research income topping 3 million, Prof Higgins considers this a very attainable goal.

• ***Public Health Institute.***
The Western Gateway Building is home to the Public Health National Health Service Research Institure and was recently awarded 1.2 million euro for a national study on the benefits of reconfiguring the emergency services in hospitals (Professor Joan Browne and Orla Healy).
• ***Cancer Research Institute.***
Three cancer groups will come together in the Western Gateway Building as part of an 8 million investment.
• ***Simulation Research Centre***
This new research area is what Professor Higgins reckons will put CoMH 'ahead of the curve' in research and innovation. The UCC finance committee recently agreed to build a new purpose-built building for simulation training and research on the grounds of Brookfield Health Sciences Building at a cost of 8 million euro.

College of Medicine and Health – 5 year plan Lifelong Learning

The second item in the College of Medicine and Health's strategic plan is the pivotal importance of continual professional development and re-training for healthcare professionals, whom Professor Higgins suggests need to retrain 2 or 3 times over 40 years of practice. He explains that the university has the infrastructure and expertise to co-ordinate and organize CPD training and education and that all of the schools will have a role to play in ensuring that the university delivers this agenda for all healthcare disciplines.

College of Medicine and Health – 5 year plan Academic Healhcare Centre

The third item on the 5 year strategic plan was the delivery of an academic healthcare centre. While not yet realised, the formation of an academic healthcare centre involving the university and the hospitals is CoMH's main priority for the next 5 years.

The Healthcare Spectrum – bringing it all together

Professor Higgins views healthcare as a spectrum of activities and not just confined to clinical service. Teaching, training, research and innovation are all part of the healthcare spectrum and he suggests we need to look beyond clinical services provision and look at these areas. These are all areas that we perform exceptionally well in. The manufacture of pharmaceuticals is one of these and Professor Higgins points out that Ireland is top of the list when it comes to choosing a country to manufacture a new drug, especially for highly-regulated complex drugs that are difficult to manufacture.
Medical devices are another of Ireland's great successes – only Germany manufactures more medical devices than Ireland and we may soon surpass Germany in this ranking.

We have a lot to be proud of, Professor Higgins reassures, when we look at the entire spectrum of healthcare. There are elements of the healthcare spectrum that we are very successful at and puts this country top of the world league. Well-trained medical professionals are another of this country's assets. Professor Higgins points out that Irish nurses, midwives and doctors have an excellent reputation in hospitals across the world and are top of the recruiting list. All that's missing is to get the systems and the organization right. This would allow the country to provide much better healthcare.

Aligning the different agendae – an inclusive approach

To bring about the regional policy framework, Professor Higgins has included a range of interested parties, from county councils to Government agencies, and these are enthusiastic about being part of the longterm plan for healthcare delivery in the region.

Capital developments

While the need for a second hospital in Cork has been agreed upon, this site has not yet been chosen. Professor Higgins considers that we need to look 10 to 15 years ahead if we want to make really important changes. We must look at all the projects together and relative to each other, rather than working on capital projects in isolation without understanding where they fit into each other. Ideally, Prof Higgins suggested that a new hospital could be built gradually, in modular format, and the new Dental School and Hospital could be the first unit to occupy the site.

Cork City Council has signed off on a site plan to completely rebuild Cork University Hospital and Professor Higgins is very pleased about the large designated space for education, research and innovation 'as big as Brookfield Health Sciences Complex' and referred to as a Health Technology and Innovation. He stresses the importance of the hospitals and university working closely together to develop these strategic capital projects.

Health Innovation Hub

This exciting new facility is a multi-agency, multi-disciplinary project where commercial companies have access to three hospitals in Cork to develop and refine diagnostic or other healthcare products. Cork was chosen as the national site for this facility (Western Gateway Building). Six Irish companies will use the hub to fast-track their products for the marketplace. This innovative new facility is a perfect example of how a change in culture can kickstart an entire process leading to successful outcomes and demonstrates how embracing research and innovation as part of a spectrum of activities may lead to the better delivery of healthcare.

Reformation Man

Professor Higgins is an expert on how to effect change, how to bring people on board, how to realign services, how to look to the future and learn from the past. His vision is about joining the dots, connecting people, linking hospitals and universities, government agencies and local authorities. It's not about making a circle – it's about making a straight line – onwards and upwards. A new culture, a new philosophy, a new era in healthcare, which will see huge benefits for carers and patients alike. These are real plans, already in action. Culture, mind-sets, and attitudes are already changing. The future of Irish healthcare is unfolding in front of us. There will be challenges and it will not be easy. But it can happen. ■

Logic of Medicine in the 21st century

I was honored to be invited to deliver the De Pazzi Lecture for 2012. Sister De Pazzi made significant contributions to Irish society by her work at the Mercy Hospital. She served as an excellent role model as we confront the challenges of providing humane, ethical and rational healthcare in the midst of conflicting priorities.

Having been asked to be both provocative and forward looking in my lecture, I was prompted to consider the logic of current medical practice. I wondered if adopting a retrospective vantage point at some time in the future might enable enlightening insights into our current approach to medical practice. I suspect the verdict would be that we are now overwhelmed with data - thousands of clinical trials published annually - but we are lacking the tools and wisdom to practice medicine in a way that optimally reflects our current knowledge. We have a serious deficit of wisdom.

Bluntly, we as a profession are doing a lot of things that don't benefit our patients and we are reluctant to confront that reality because of a reluctance to perturb existing systems and dogmas. That much of contemporary medical practice is of dubious merit is appreciated by some very sophisticated patients with backgrounds in technology, who are able to critically and accurately assess the available scientific evidence. An example is the founder of Sun Microsystems, Vinod Khoshla, who recently said that "contemporary healthcare is just like witchcraft, just based on tradition".

Our current medical practice is centered on a model of medicine best explained and advocated by the great Canadian physician William Osler a century ago. Osler's renown was based on his clinical skills and superb writing with a focus on diagnosis and short-term prognosis. He was renowned for his clinical acumen and his ability to draw clinical pathological correlations. Osler asked the question what disease does the patient have and how do I treat it? Though he was an enthusiastic advocate for bedside teaching, he was in no sense an innovator.

A contemporary of Oslers's was Ernest Amory Codman. Codman was a Boston surgeon who was remarkably innovative with multiple important contributions. He was a virtuoso shoulder surgeon and author of a monograph on shoulder surgery that apparently reads well even today. As a medical student, together with Harvey Cushing who subsequently became a neurosurgeon of note, Codman introduced the first approach for monitoring vital signs for patients undergoing anesthesia. Codman also was a pioneer in the use of radiology and he provided a framework for the interpretation of radiographic images. Codman was keenly aware that the outcomes of medical and surgical interventions were not always positive and that the best way to ensure that mistakes were minimized and improved outcomes were sustained was diligent routine record keeping with candid discussion of outcomes. Codman introduced the very first disease specific registry:- for osteosarcoma. He also introduced the concept of the morbidity and mortality conference. Codman also formulated the general "end-result" principle that required the outcome of each patient to be followed to ensure that the outcome of therapy was known. Without this follow-up, Codman regarded practice as negligent as interventions could be resulting in harm without the awareness of the treating physician or surgeon. Codman tried to advocate that his end-result idea be introduced into routine clinical practice but not only was his idea rejected, his colleagues were appalled by the approach he took and in 1915 he was forced to resign from the Massachusetts General Hospital and the Massachusetts Medical Society.

The fate of Codman is instructive, as unfortunately a century later, we have not appreciated the wisdom of his end-result concept. The vast majority of clinical encounters do not result in any dividend to the corpus of medical knowledge; the practice of medicine is in essence a huge clinical trial, with all the data currently produced left in obscurity. Why is this? The insights of Danny Kahneman, a psychologist and recipient of the Nobel prize for economics are instructive as he has helped clarify the psychologic evasions that allow us to avoid uncomfortable truths. As medicine has become increasingly reimbursement based rather than evidence based there is great inertia to be overcome.

What can be done? UCC engineering graduate, author and Observer technology correspondent John Naughton is one of the best people on the planet at bridging technological hyperbole and cant into practical wisdom. Naughton recently emphasized the significance of Thomas Kuhn's classic book on "The structure of scientific revolutions." Using the terminology that Kuhn used, there is a need for a new paradigm for the practice of medicine. A paradigm is a "a set of theoretical beliefs, methodological principles and values to which a mature discipline collectively subscribes." Naughton states "what has been scarce is a professional wisdom informed by a rich knowledge of psychology, institutional structures and historic precedents." The necessary reassessment of how we approach medicine should reflect an integrated assessment of the impact of technology, human behavior and psychology: a new paradigm.

Rather than Osler, the architect and patron of 20th century medicine, we should first look to Osler's successor as Regius Professor of Physic at Oxford – Archibald Garrod to provide guidance on the new paradigm. Garrod is known for coining the term "inborn error of metabolism" but more importantly he had a more sophisticated approach to medicine than Osler, one that is more relevant to our current situation. When evaluating a patient, Garrod would ask why did this patient, get this disease at this point in time? Unlike Osler, Garrod did not regard the patient as simply a broken machine, but a less well adapted product of evolution with a disease that was a consequent of a unique individual's encounter with an environment for which he/she was uniquely unfit.

Though many would regard the discovery of the structure of DNA as being the pivotal scientific discovery of the 20th century, a strong case can be made that the most important discovery was the discovery of software 2 decades earlier by Turing and von Neumann. In fact, DNA can be defined functionally as biological software. The pervasive importance of software in our lives is recognized to some extent, but its transformative effect is perhaps only beginning to be appreciated. When the increasing importance of software is debated, it is frequently in the context of a binary choice: will it render human input and expertise obsolete?

An excellent illustration of how data and computers may impact medicine comes from the world of sport: specifically American baseball over the last 10 years. Entertainingly chronicled by the author Michael Lewis in his book Moneyball, the manager of the Oakland Athletic's Billy Beane realized that the traditional metrics used to assess the value of a baseball player were unequivocally wrong. By applying more relevant metrics with the assistance of computer savvy statisticians, Beane was able to attain a competitive advantage over other teams reliant on the traditional approach of recruiting potential talent using seasoned scouts. Beane's competitive advantage however, was transient since all teams quickly acquired computer savvy statisticians to help their recruitment decisions. Has that meant that the traditional baseball scouts have been made obsolete? No, all the teams still retain their scouts but now their work is combined with the statistical data driven perspective. The marriage of both approaches has resulted in raising the standard of decision making in recruitment decisions.

An analogous outcome can be anticipated in medicine when we have software tools developed that can mine clinical encounters for insight on the best treatment outcomes

for our patients. Such tools will help sort out the signal from the noise and allow doctors to focus on the signal and more effectively address the patient's primary needs. This will amplify the ability of the physician to focus on the critical human elements of the patient interaction that are essential for managing important medical decisions.

As we are on the threshold of the introduction of the driverless car, the prospect of effective software tools to complement medical practice is not at all farfetched. Physicians will benefit from alleviation of information overload and patients will benefit from having less apparently distracted physicians.

As usual Steve Jobs had the right insight: "you've got to start with the customer experience and work back toward the technology - not the other way". Substitute patient for customer and you have a manifesto for personalized medicine that the profession needs to deliver.

Cork born Tim O'Reilly studied classics at Harvard. His father was from Killarney and graduated in medicine from UCC before practicing neurology in London, San Francisco and Washington DC. Tim runs a very successful business, O'Reilly Media, that specializes in publishing and conferences related to technology. O'Reilly has been dubbed Silicon Valley's leading intellectual.

His career advice is instructive: "work on something that matters to you more than money, create more value than you capture and take the long view."

The challenge for the medical profession is to implement a new paradigm of medical practice in harmony with the resources and needs of the 21st century that fulfills the wise advice of Tim O'Reilly inspired by the dedication of medical pioneers like Sister De Pazzi. ■

Dr Tom Aherne

Remembering my Friend - *Mr Aonghus O'Donnell (1961 - 2010)*

The Writer Bern Wolfe had Aonghus in mind when he wrote "if you observe a really happy man you will find him building a boat, writing a symphony, educating his son, growing double dahlias in his garden or looking for dinosaur eggs in the Goby desert. He will not be searching for happiness as if it were a collar button that has rolled under the radiator. He will not be striving for it as if it is a goal in itself. He will have become aware that he is happy in the course of living life twenty four crowded hours of the day".

I first got to know Aonghus around the time of his appointment as Consultant Cardiothoracic Surgeon to Cork University Hospital in April 1996. I was immediately struck by his eloquence and wit, his keen intellect and his passion and commitment to his new post in Cork. I thought we had chosen well. It quickly became apparent that he was more than a big personality but was a gifted and talented surgeon, quick to assess and incorporate new innovations in a rapidly changing field of cardiothoracic surgery.

Somewhat unconventionally for the time, he always introduced himself as Aonghus and was thus known to both staff and patients alike. His practice was always patient centered and egalitarian. He was tireless in his support for all his patients especially the seriously ill where his availability and reassurance was appreciated by both families and staff.

He had immense organisational and leadership ability and was the natural choice for Chairman of the division, a position he retained up to the time of his death. His talents were put to good use in an area of medicine where innovations frequently require expensive technology and highly skilled staff. During the final two years he devoted much energy and time to shaping and planning the Cardiac Renal Centre which he happily lived to see open. All the cardiac services in CUH have now been transferred to this new building and this will include the greater Cork area before the end of the year. Aonghus also worked at a national level in association with the Royal College of Surgeons in Ireland to organise and regulate the training of future cardiothoracic surgeons in Ireland.

Just a year ago, the speciality of cardiothoracic surgery was robbed of this remarkable man at the height of his creative powers. His leadership is greatly missed nationally at a time of change and retrenchment. At a personal level, his sense of fun, ability to entertain, repertoire of stories - especially those embellished after one of his fishing trips - will be sorely missed.

Aonghus lived life to the full, celebrated it in equal measure and his abiding love was for his wife Miriam and his five children who were always uppermost in his mind. His loss to them and his wider family is immeasurable. I have no doubt that we will all meet Aonghus again by which time his store of stories will be sufficient to entertain us long into eternity.

I don't think we could say that Aonghus went in the words of Dylan Thomas "gently into the good night", rather his life was packed down, shaken together and flowing over. ■

Bronzino's Allegory

When next in London, go to see Bronzino's Allegory in the National Gallery.

Bronzino's Allegory, the Exposure of Luxury, or Allegory of Venus and Cupid, was commissioned around the mid-1540s by Cosimo I de' Medici, Duke of Tuscany and was subsequently given by him to Francois I, King of France.


Fig. 1

Bronzino's intentions regarding the exact meaning and significance of every detail of the painting's brilliant imagery are unknown. Several interpretations have been advanced over the centuries.

The central theme is undoubtedly a moral one and concerns illicit sex [1]. The two central figures, Venus and Cupid, are mother and son. Their excitement is palpable as they prepare to abandon themselves to incest. Cupid, as he presses himself against his mother, is clearly no child. His mother, with her open lips and emergent tongue, is equally not averse to his approaches.

Venus and Cupid are framed by five others. A variety of ideas regarding the significance of these figures has been put forward. One persuasive scenario proposes that the other figures framing the couple comment on this particular act of illicit sex. They give it a dimension in time and embody its pleasures as well as its potentially unremitting and merciless consequences. The Putto on the right signifies Pleasure. The intent on gratification is such as to be regardless of the consequences. He rushes headlong forwards as he prepares to scatter roses over the shameless pair. Such is his obsession with gratification that he fails to notice the thorn which has impaled his foot [2]. This hint, that pleasure might not be undiluted, and that there might be some unexpected price to pay for it, is embodied more forcefully in the figure which is partly hidden behind him. At first sight the face which gazes into the distance from behind his right


Fig. 2

flank seems to be that of a beautiful young girl. This, however, is far from being the case. She is a chimera. She has a serpent's tail, visible near the lower, right border of the painting, and her hindquarters and feet seem to be those of a lion. The contradictions thus embodied are highlighted through her hands: in one she holds a honeycomb, representing the sweet pleasures of love. It is counter balanced, though, by the vicious-looking double sting in her tail, which she holds in


Fig. 3

the other hand. This contradiction is given further physical expression in her hands. These transgress one of the fundamental rules of symmetry: They are transposed, with the right on the left side and the left on the right. She represents Deceit. Her quite unnatural form is an unequivocal intimation that there may be in the long run a price to pay for breaking a fundamental social taboo through abandonment to untrammelled pleasure. The price is embodied in the anguished figure on the left [3]. He has lost some of his fingernails and many of his teeth; his eyes are reddened and there seems to be arthritis of the finger joints. These signs have recently been convincingly identified as representing advanced syphilis (Conway 1986; Cole 2006), the real sting in the tail of careless sex in the sixteenth century. Syphilis undoubtedly existed in Europe in the mid-16C. Outbreaks had been unequivocally described in the 1490s. It may have been there, unrecorded, for many centuries before, perhaps even confused with leprosy. Alternatively, it may have been brought to Europe from America in the late 15C. Whatever the reality, syphilis had become a sentence of death. The greyish tinge to the skin could well be a side effect of treatment for this with mercurial compounds, which was apparently the practice at that time when the Allegory was painted. The figure is likely to be male, signified by the near absence of fat under the skin, which allows the muscles to show clearly through. It was formerly considered to represent Jealousy (traditionally female).

The two other figures near the top of the painting comment further on the chilling sequence of events. Oblivion on the left urges suppression of thoughts of any possible unpleasant consequences of sex. She tries to draw the blue veil of forgetfulness over the proceedings. As if to emphasise this, she is eyeless and she also lacks most of her brain, where any memories or uneasy forebodings might be stored. However, on the right the massive figure of Time, with the hour-glass on his shoulder, effortlessly holds back the veil, insistent that events will take their inevitable course. The increasingly ominous chain of events is traced out in an almost full circular sequence over the painting surface.

The figures display the near-faultless anatomical realism to be expected in the High Renaissance, as they depict male and female, young, mature and old. The exact details of Time's powerful arm muscles, even in places of their internal subdivisions, are clearly visible through the skin. The smooth contours of Venus's elegant body are equally typically female. The covering of fat provides a flawlessly smooth surface which gives her a cool and graceful allure.

Bronzino

Bronzino (1503 – 1572) was Court Painter to Cosimo I de' Medici. Many of his paintings of Cosimo I, his family and his Court are images of incomparable elegance, and are in the octagonal Tribuna in the Uffizi gallery in Florence. Interestingly, the face of Fraud appears in one of these portraits. She was referred to as Bia de' Medici, a greatly loved illegitimate child of Cosimo's, who died at the age of six. Bronzino painted a number of Allegories of Venus and Cupid, one of which, much less lascivious and less complex in its message than the London painting, is in the Budapest Museum of Fine Arts. ■

References

Cole, Michael Wayne, Ed. (2006) Sixteenth Century Italian Art. Wiley-Blackwell

Conway, J F (1986) Syphilis and Bronzino's London Allegory. Journal of the Warburg and Courtauld institutes 49, 250 – 255.

Kids Do The Darndest Things

It was after lunch and time to kill before the resumption of afternoon classes when I detected a buzz of excitement progressing down the school corridor. Leo, trailing a small band of happy camp-followers, was making his way to the secluded area beneath the stairs from where the soccer and rugby balls were signed out. Standing between two assistants, he turned to face us. Then, with little preamble, he assumed a crouched position and started to hyperventilate. After a minute of that he suddenly stood up, grabbed his nose, blew out against pursed lips and crumbled to the ground like a towel slipping off a bathroom rail, his two assistants ensuring that his head did not hit the cast-iron radiator behind him. And just as quickly as he had fallen to the tiled floor he regained consciousness, stood up and, with a nonchalant air, acknowledged the acclaim that was his due.

It had all the magic of a circus act. I remember thinking to myself: I could do that. But I was not going to do that. What was it that made it acceptable to Leo to take the risk and the rest of us to hesitate? Yes, life necessitates taking risks, hopefully calculated risks, but what makes some embrace risky behavior? The adrenaline rush? The temporary release from the grip of reality?

What brought all this to mind more than a half century later was a sudden flurry of test results appearing on my office computer. A telephone call to the hospital emergency room was just in time to learn that one of my patients had been defibrillated twice, intubated and transferred forty miles north to an ICU in Boston. Three days later he regained consciousness with a serious case of short term memory loss. And the etiology of his cardiac arrest? An aerosol canister found in his pocket provided the diagnostic clue: huffing.

Huffing is a more advanced form of glue sniffing, which I was also familiar with from my boarding school days, where the expected output of model airplanes from the Aero Club was always strangely disappointing. The concept behind huffing is to replace the normal gas in the lungs, the familiar mixture of oxygen, nitrogen, carbon dioxide and water with an inhalant and in the process induce a sense of dizziness and disassociation with reality. The subject continues to breathe because of the accumulation of carbon dioxide within the blood while oxygen progressively declines. However, the exercise can come to an abrupt end with either the development of acute hypoxia and cardiac arrest or vomiting with aspiration. Any aerosol or solvent will do, depending on what is in mode, ether when ether was in common use to nitrous oxide today which, for convenience sake can be bought in balloons at concerts.

Huffing has always been an occupational hazard amongst anesthesiologists, they having easy access to inhalant gasses. Heavier than air gases pose the most serious threat since they are the most likely to replace the normal gas mixture in the alveoli leading to acute hypoxia. Computer cleaners are particularly lethal. In general, the average teenager resorts to common household solvents or aerosols and a plastic bag. Clues to this activity include secretive behavior, an odor of petrol, turpentine or whatever and a facial rash consistent with a contact dermatitis.

The combination of addictive self-injurious behavior and secrecy can be a fatal combination and is not confined to huffing. The mixture of masturbation and strangulation, auto-erotic asphyxiation, can be fatal, risking as it does compression of the blood supply to the brain, the trachea and the vagus nerve. The subject is found strangled in his closet, naked, surrounded by erotic material and some form of ligature around the neck. Family members may remove the incriminating material and the deceased signed out as suicide, which is perceived as less upsetting than auto-erotic strangulation. This is usually a solitary activity but not necessarily so. Nor does it cease with adolescence as evidenced by the death of David Caradine at the age of 72 years. My single case, being an only child, was doubly distressing; his mother, unable to live without him, committed suicide.

Another distressing, addictive, secretive, self-injurious behavior is the practice of cutting. This involves the taking of any sharp object, whether it is as obvious as a razor blade or as innocuous as a paper-clip, and making superficial cuts on the skin. This usually involves the arms, which are well covered by loose sleeves, even in warm weather. The subject, at least in my experience, looks waif-like and depressed. This behavior is mostly seen in serious mood disorders. Though these patients have an increased incidence of suicide the latter has little to do with the act of cutting. However, when a patient such as one of mine comes in with multiple such cuttings on his torso and arms from a combat knife, it gets your attention pretty quickly. The theory behind the practice is that the pain involved functions as a diversionary tactic from the psychic pain they are experiencing but are no longer able to tolerate. And since it works it is repeated. And like most things that predictably produce a desired effect it is addictive. The cuts themselves are superficial, linear, multiple and in varying degrees of healing. They are usually discovered, often incidentally, by either the parent or the doctor and necessitate immediate psychiatric intervention.

Another more common serious, secretive, self-injurious and addictive behavior is bulimia. Eating disorders can be divided into your classic anorexia nervosa, binge eating and bulimia. These conditions are more likely to be found in girls involved in dance (ballet in particular), ice skating and gymnastics and boys who participate in competitive wrestling, where the impetus is to gain an edge in a lower weight bracket. When the object of the behavior is to avoid the normal weight gain associated with adolescence the body is stressed, resulting in an increase in the secretion of catecholamines. These, in turn, suppress the secretion of estrogen, which is responsible for normal sexual development, menstrual periods and bone calcification. In anorexia the results are obvious and are achieved by a combination of dieting and excessive exercise. Amenorrhea is common and in the case of women who engage in excessive running, addicted to "the runners high" and its release of endorphins, they develop a more masculine gait. In binge eating the subjects are more likely to be overweight and because of this more difficult to diagnose. Food begins to disappear; the subjects tend to disappear after meals and despite their impressive consumption of food their weight remains unchanged. The anorexic nervosa patient enjoys losing weight, is consumed with losing weight and will never be satisfied with their weight loss, while the bulimic nervosa patient hates and is ashamed of the whole process. The explanations for bulimia vary from sexual molestation, controlling family dynamics, an inability to deal with normal sexual development or a release from whatever psychic discomfort they are experiencing. Its practitioners tend to be high achieving girls whose intention is not just to do well but to be the best. But, no matter how well they do, it is never satisfying. (The classic New Yorker cartoon of the statue to a famous woman is illustrative of this. The inscription reads: Graduated magna cum laude from Harvard, First woman college president, US Senator, internationally recognized diplomat, skilled horsewoman but sadly a disappointment to her mother). The practice is quite common especially in women's colleges. Some years ago, in one such college in Boston, the plumbing was completely blocked by plastic zip-lock bags. The explanation was that the girls were regurgitating their meals into the bags when they ate out and to avoid detection dumping them down the toilet when they got back to their dormitories.

Detection of eating disorders is not easy especially when there is no ostensible weight loss as in bulimia and, when detected, not easily treated. Not only is the patient's resistance to intervention a problem but frequently the family do not welcome the medical recommendations especially in the case of an

athlete where performance may be compromised, the latter being the patient's ticket to a premier college education. However, even in families totally committed to medical intervention, success may be thwarted by chat-rooms on the internet where practitioners exhort each other to resist, stay strong and provide techniques on how to avoid detection. The chronic habit of sticking the middle finger down the throat can result in a number of tell-tale signs such as abrasions on the soft palate, enamel decay of the maxillary incisors from contact with gastric acid and a contact dermatitis on the dorsum of the hand where the incisors rub against the skin. The overstimulation of the salivary glands results in enlargement of the parotids and the glands around the corners of the mouth. The subjects usually go to the toilet immediately after meals, close the door, run the water, place the seat down to deaden the sound, and vomit. Examination of the underneath of the seat may reveal particles of food. Like all addictive behaviors this is carried into adult life where it may continue or be replaced by alcoholism only to be finally stopped by suicide. The use of SSRI antidepressants may help the occasional patient. Recently, encouraging results have been seen using the newer second generation anti-psychotics. Since bulimia is usually incurable the object of treatment is control, not unlike that in alcoholism (a frequent natural progression) where the alcoholic is never cured but always in recovery.

Subjects with eating disorders are thought to have a distorted self-image. However, a distorted self-image is common amongst teenage girls. A famous study of this involved having girls draw simple pictures of their body-types and the body-types they would prefer. Girls tend to see themselves as fatter than they are and would like to see themselves as thin. This is thought to be one explanation for their fascination with dieting. However, the vast majority accepts their perceived body image even if it is a disappointment; others, it is thought, go on to develop eating disorders. But, this may be a too convenient explanation. People with eating disorders who commit suicide in adulthood (a well described occurrence) are found to be of normal weight at time of death. So it is clearly not all about weight, which would explain why some patients seem to respond to medications that modify moods.

Another variation on the theme of distorted body image is Body Dysmorphic Disorder. This is a condition where the patient loathes some aspect of their physical appearance; the size of their nose, their thighs are too big or their abdominal muscles not suffiently ripped. Contrary to what one might expect it rarely involves sexual anatomy. The individuals are often quite attractive and because of this are believed to be excessively vain. However, this is far from the case since they see themselves as ugly. (Some will fall into the hands of unscrupulous plastic surgeons who will comply with their repeated requests for correction of their perceived anatomical defects, and end up addicted to plastic surgery.) Attempts to dissuade them of their distorted perceptions are frequently futile. While it can be said that they don't get it, unless the doctor recognises the disorder the same can be said of the doctor. Recognition is vital but having identified it treatment is unclear. Plastic surgery is certainly not the answer.

Other less serious compulsive self-injurious behaviors include trichotillomania and dermatillomania. Trichotillomania involves either constantly twirling or plucking ones hair or eye-lashes. It can result in bald patches or loss of eye-lashes. Interestingly enough evidence is appearing that it may respond to the newer atypical antipsychotics. Dermatillomania is compulsive picking at ones skin, scabs, suture lines etc. It is often the unthought-of explanation for suture lines that become repeatedly infected or, as in a recent patient of mine, ingrown toenails unresponsive to standard treatment. (He liked to tear his toenails while watching television).

Though these conditions may be fascinating in their own peculiar way, the question remains how relevant are they? Some may be inconsequential, trichotillomania for example, but others such as bulimia can be fatal. (The daughter of a former colleague of mine died of a cardiac arrhythmia while in flight on her honeymoon, while a university president once explained to me his wife's absence at a formal dinner as their reluctance to leave their adult, bulimic daughter home alone). Huffing and auto-erotic strangulation are clearly flirting with the next world. Cutting may raise the alarm to a more serious and deeper problem. Detection of these practices, that are cloaked in secrecy and shame, poses serious challenges for the doctor since the patients rarely if ever volunteer information that might aid diagnosis. Any time I have made the diagnosis, it was because the parent had already made it for me. Once recognized, however, they necessitate immediate medical intervention and should not be dismissed as a passing phase. The distraught parents may be sadly misguided but that is not grounds for the physician to feel superior since we have little concrete information as to why these children engage in such bizarre, compulsive and potentially fatal behavior.

It is said that knowledge is power. Certainly knowledge is vital for recognition and as parents we are afforded a front seat to our children's lives. I have always maintained that there are clues before the fact that are either not recognised or not acted upon. However, having said that, I have to concede that there are times when one must agree with Banquo, who famously said before Macbeth stuck the knife in him: "There is no art to find the mind's construction in the face." A year after I left boarding school an exemplary student who had graduated the year before me was pronounced dead on arrival at a London hospital, victim of a drug overdose. It seems trite to have to admit that it was the absolute last thing we expected of him. This extraordinary event 50 years ago reminds me of an answer a mother once gave me when I asked if there was any addictive behavior in the family. "Isn't there in every family?" The impact of secret compulsive, self-injurious behavior cannot be underestimated. More often than we care to admit it is what makes the Earth, and those of us who cling to its surface, spin.

Centre for Gerontology and Rehabilitation

Established September 2010, the Centre for Gerontology and Rehabilitation (CGR) is led by Prof David William Molloy, Chair in Clinical Gerontology, and based in St Finbarr's Hospital. The CGR is funded by Atlantic Philanthropies with a specific remit to establish interdisciplinary teaching and learning in Gerontology, Rehabilitation and End of Life Care in UCC and to raise the standard of care of the elderly in the South of Ireland. Clinical Gerontology and Rehabilitation is now an established discipline in UCC. It is embedded in the undergraduate medical curriculum and the postgraduate programme in Older Person Rehabilitation (commenced in September 2011). The programme is co-ordinated by Dr Suzanne Timmons, Senior Lecturer.

Currently, the focus of our research is in the areas of dementia, delirium, advanced care directives and palliative care. The importance of this area of research is demonstrated by the government's commitment to develop and implement a Strategy for Dementia for Ireland. A team of researchers are involved in screening approximately 650 older people admitted to acute hospitals in Cork County for dementia, in order to determine, for the first time, the prevalence of dementia in older people admitted to Irish hospitals, and the associated costs. A longitudinal follow-up of these patients in hospital will determine rates of adverse events, delirium, behaviours that challenge, discharge to long-term care, and death. Data is also collected from patients, carers and families, and attending acute hospital staff, as to the problems encountered in providing acute care to patients with dementia, and the experience of the patient with dementia in the acute hospital.

Delirium, although common, reaching a prevalence of almost 50% in elderly hospital inpatients, is under-researched in Ireland and is poorly recognised in clinical practice. It is associated with increased dependency, mortality and higher rates of dementia. A multicentre prospective study is underway to determine the in-hospital incidence and risk factors for delirium in older people hospitalised in the acute care setting with a view to identifying an objective test for early warning signs of delirium in older people. This hopefully will prevent the development of full-blown delirium and its resultant severe cognitive injury to the person.

Although older people are living longer and in better health, Ireland will face substantial extra demands for care of older people every year. As people age they are less likely to die at home and more likely to die in private nursing homes and public HSE residential care. Approximately 25% of all deaths each year occur in long-term care (LTC). A major aim of the CGR is to improve end-of-life care for older people in LTC. End-of-life care also overlaps with the research interests of the CGR in Advance Care Directives (ACDs) and palliative care.

Advance care directives (ACDs) allow patients to provide instructions about their preferences regarding the care they would like to receive if they develop an illness or a life-threatening injury and are unable to express their preferences. ACDs can also designate someone the patient trusts (proxy) to make decisions about medical care if the patient becomes unable to make (or communicate) these decisions. A study on "the simultaneous implementation of advance care directives and a palliative care programme in long term care" is currently underway and focuses on the educational and resource needs pertaining to end-of-life care, in the long term care sector in Ireland.

Currently six nursing homes and community hospitals are systematically implementing ACDs and palliative care in Cork and Kerry. The staff have been trained and are offering the "Let Me Decide" advanced care directive to residents and families. It is planned to extend the programme to nursing homes and to offer ACDs in a community setting next year in a pilot study.

CGR researchers are vastly experienced in the development of cognitive screening tools e.g. the recently published Quick Mild Cognitive Impairment Screen (Qmci). The Qmci differentiates mild cognitive impairment from normal cognition and dementia. A shortened and refined version of the Qmci, the Caregiver Cognitive Screen (CCS), has also been developed to allow families and carers to screen family at risk for cognitive impairment at home. A referral and screening pathway, RAPCOG (Rapid Community Cognitive Screen) is being developed, utilising both tools.

Another exciting tool developed by CGR researchers is the Community Assessment of Risk Tool (CART), a risk assessment tool for community dwelling older adults. This comprehensive, integrated programme provides a series of different tools to a) screen older adults at risk of adverse outcomes (hospitalisation, institutionalisation and death), b) triage people into high, middle and low risk groups, c) have a more comprehensive assessment to describe the factors that are putting them at risk and d) design interventions to target the factors that are placing them at risk. To date, over 800 community dwelling older adults have been screened and are being followed to see who is admitted to hospital or long term care over the next year.

The CGR is actively developing collaborations both nationally and internationally and is involved in FP7 multicentre studies e.g. NILVAD (nilvadipine in Alzheimer's dementia).

Improved Outlook for Pre-Eclampsia

A consortium led by Professor Louise Kenny of UCC has secured €6 million euro in FP7-health framework research funding to combat pre-eclampsia, a condition which accounts for as many as 24% of maternal deaths in Europe each year and over 500,000 infant deaths annually across the globe.

This award by the European Union will bring the likelihood of a readily available predictive test for pre-eclampsia closer to fruition, a development that would revolutionise prenatal care. The IMPROvED (IMproved PRegnancy Outcomes by Early Detection) project is coordinated by Professor Louise Kenny, who is Professor of Obstetrics and Consultant Obstetrician and Gynaecologist at Cork University Maternity Hospital.

Professor Kenny is a principal investigator on the project, which is also driven by two other companies, Metabolomic Diagnostics Ltd of Ireland, a UCC spin-out company, and Pronota NV of Belgium. Both companies are industry leaders in the discovery and development of novel blood-borne biomarkers for disease prediction. The four-year IMPROvED project will establish a multicentre clinical study to assess and refine two innovative prototype screening tests for this common late pregnancy complication. One of the two tests was developed at UCC and funded by the Health Research Board and Science Foundation Ireland. Professor Kenny comments: "Pre-eclampsia affects almost one in 20 first time mothers and globally causes approximately 70,000 maternal deaths each year. We were therefore extremely pleased to see that researchers from different fields, centres and countries were enthusiastic about the IMPROvED project. Our ultimate goal is to develop a robust predictive test for pre-eclampsia and to improve the outcome of pregnancy for both mothers and their babies."

Katleen Verleysen, CEO of Pronota says: "currently no clinically useful screening test exists for pre-eclampsia; consequently clinicians are unable to offer targeted surveillance or emerging preventative strategies. We are excited to be part of the consortium. The IMPROvED clinical trial will allow Pronota to progress its proteomics based risk stratification test."

The IMPROvED project will establish a high quality pregnancy biobank with blood samples collected from 5,000 first-time pregnant women recruited from at least five countries including Ireland, the United Kingdom, Germany, Sweden and the Netherlands. All recruitment centres involved (UCC, Erasmus University Rotterdam, Klinikum der Universitaet zu Koeln, the University of Liverpool, Karolinska Institute and University of Keele) are major obstetric centres with a proven track record in the research and management of pre-eclampsia. The scientific value of the biobank will be enhanced by the collection and storage of comprehensive clinical data along with the samples (Medscinet AB, Sweden).

Charles Garvey, CEO of Metabolomics Diagnostics adds: "Metabolomic Diagnostics is delighted to be involved in this innovative consortium: "We believe that an early pregnancy -screening test can make a major contribution to maternal safety and this project, once completed, will help accelerate its adoption."

Prof Phil Baker (Keele University), co-principal investigator, says: "an effective screening test will allow antenatal care to be tailored to an individual woman's risk, such that at risk women receive the best possible care. The approval of IMPROvED is a strong endorsement of European researchers and recognises the importance of enhancing maternal and fetal health." ■

UCC Alumni Awards for Medical Graduates

Two UCC medical graduates were honoured at the 2012 UCC Alumni Achievement Awards Gala Dinner on the 23rd November for their outstanding achievements and voluntary work for UCC.

Dr Frank "Gully" Golden MB '60 was honoured by the College of Medicine & Health for his distinguished work in providing a better understanding of the body's response to the various threats associated with survival at sea and saving countless lives. Dr Golden is a physiologist who spent thirty years with the British Royal Navy in a series of senior postings, including Surgeon Rear Admiral, Support Medical Services. Dr Golden has published over 70 research articles for medical and scientific journals and has co-edited 'Essentials of Sea Survival' in 2002 which is internationally recognised as the definitive guide to survival at sea. Frank was honoured with an OBE in 1981 and has been honourary lecturer at the Universites of Leeds, Sheffield and Portsmouth.

To acknowledge the great support and loyalty of alumni to their *alma mater*, an Alumnus Award for Voluntary Service to UCC was introduced in 2010. This year's award is dedicated to Cork couple **Mary Jane and Dr Dick Kenefick** for their remarkable voluntary contributions to UCC Ladies' Hockey Club and UCC Rugby Club respectively. Dr Dick Kenefick MB 77 has been an active member of UCC Rugby Club since 1985 where he has held many senior positions, including Club President, senior team selector and Chairman of the Rugby Committee. Dick has been at the forefront in improving structures within the Club in response to the challenges of professional rugby. He is one of a dwindling number of medics who look after the injured players at his surgery. He also established the annual UCC RFC Sports Medicine Conference, now in its eighth year. Mary Jane Kenefick BA '77 HDE '78 has dedicated her life to developing Ladies' Hockey in Munster. She is President of UCC Ladies' Hockey Club and is an active member of the Munster Schoolgirls' Council since 1996, as well as coaching a number of school teams. Under her stewardship, the Club has had some notable successes; most notably winning two Chilean Cups, sharing the Munster Senior League on one occasion and being runner up twice. ■

Dr Frank "Gully" Golden

Dr Dick Kenefick

The Professor Gerald O'Sullivan Memorial Appeal

Dr. James Watson – *Nobel Laureate*

"He was so unique, standing strong above those who first worshipped his surgical skills and then his determination to move from treating, to truly curing cancer. His passing creates a gap that will not go away – in Cork, in Ireland, in Europe and throughout the world."

Prof. Tom R. DeMeester, *MD*

"Professor Gerald O' Sullivan was known and loved by many surgeons and physicians. His investigative studies, creative thinking, and provocative lectures had a profound impact on Irish, European, and American surgery. He achieved his objectives with indefatigable energy, innovative thinking, and collaboration with colleagues."

An Invitation . . .

Today you are asked to help us preserve and honour the memory of the late Professor Gerry O'Sullivan as a pioneer of ground breaking research leading to new treatments for cancer. You can do this by subscribing to the Professor Gerard O'Sullivan Memorial Appeal.

The funds that are raised will be used for the immediate creation of The Gerald O'Sullivan Chair in Cancer Research at the Cork Cancer Research Centre, University College Cork (UCC). The chair will initially lead the Centre's immunotherapy programme and contribute to its important and innovative efforts to develop new treatments for poor prognosis cancers and micro-metastatic disease.

The Gerald O'Sullivan Chair in Cancer Research

In the last ten years many results have emphasized the remarkable potential of the immune system to eradicate cancer, even when the disease is widespread. Professor O'Sullivan, driven by his own clinical experience, knew the significant impact on survival that the patient's own immune reaction to their cancer can have. Thus, he strongly believed that an immunotherapy approach was the best hope in solving the most difficult clinical challenge for cancer surgeons and physicians: to develop efficacious treatments when cancer has already metastasized throughout the body. The immunotherapy research area was led by Professor O'Sullivan and was complemented by other highly innovative groups within the Centre.

The establishment of a Chair for Cancer Research, would allow us to continue our pursuit of safe and durable treatments, including the use of the immune system to recognize and eradicate widespread cancer. This approach is underpinned by extensive experience in multiple delivery mechanisms for gene delivery, an area where initial results are also extremely promising.

The cost to launch The Gerald O'Sullivan Chair is €250,000 per year for five years, with a fund total of €1.25 million. After the five years have elapsed University College Cork have committed to supporting the continuation of this named Chair.

Contributions can be made to Cork Cancer Research Centre, UCC in a tax effective manner in Ireland, the UK and the USA.

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Cork Cancer
RESEARCH CENTRE

Entry and selection Criteria for Medical Students - Dr Siun O'Flynn

Dr Siun O'Flynn is Head of Medical Education at University College Cork and is a Consultant Physician in Cork University Hospital. Within the School of Medicine she leads a cadre of specialist medical educators from a diverse range of backgrounds in the Medical Education Unit, who teach and coordinate modules at all levels in the undergraduate Medical programme and actively participate in post graduate training also. She has a research interest in entry and selection to medicine and has recently authored a preliminary review of the revised entry and selection methods to medicine introduced in Ireland in 2009. She coordinates a National Research Group Evaluating Revised Entry Mechanisms to Medicine which involves a multi-institutional collaboration between all the medical schools in Ireland and the Central Applications Office. Her talk focussed on some of the main preliminary research findings of this group, 3 years after the post Fottrell entry and selection reforms.

In particular, she noted that the changes introduced gave a highly valued opportunity to approx 40% of medical school entrants in the past 3 years as these students previously would not have secured a place. Acknowledging that, due to the high demand for places, 85% of highly committed applicants will be disappointed regardless of selection mechanisms used. The data she presented revealed that those who perform well in the Leaving Certificate also tend to perform well in the HPAT but that the new adjunct test does appear to measure domains not currently assessed by the Leaving Certificate. She noted that candidates are repeating the HPAT and those who do tend to improve their scores and the various reasons for this were presented. This has had the unintended consequence of triggering exits from other third level courses. She also presented data suggesting a possible benefit to candidates who access commercial coaching and reasons for this were outlined.

These preliminary findings have led to recommendations which have been sent to the Higher Education Authority. ■

Medical School Attrition in UCC: *Beyond the Statistics.* - Dr Bridget Maher

Dr Bridget Maher, Lecturer at the School of Medicine, UCC discussed the results of a recent 10-year retrospective study on medical school attrition in UCC.

The aim of the study was to determine medical school attrition rate (2001-2011) and to examine factors associated with dropout. Data sources included student files, examination records, admissions records, staff interviews and exit interviews. Ethical approval was granted by the Cork Hospitals Research Ethics Committee. The overall attrition rate (completed cohorts 2002-2007) was 5.7% (45/779). This is relatively low compared to other studies (a recent meta-analysis found an average attrition rate of 11%). Similar to other studies, more males than females dropped out, but this was not statistically significant RR=1.58(95% CI:0.82,3.05);p=0.165. Irish and EU students were at low risk of dropout. There was an increased risk of dropout in Kuwaiti and UAE students combined (RR =5.70 (2.65,12.27);P <0.0001). Over 60% of dropouts occurred in first year students, 15% in year 2, 16% in year 3, 13% in year 4 and 5% in Final Year. The year with the highest dropout was 2007/08 and the cohort who started that year also had the highest dropout rate.

Associated factors were academic difficulty, 48% of dropout students repeated at least one year while 65.7% were required sit at least one autumn repeat exam. There was documented physical ill-health in 14% students and psychological ill-health in 40% (higher than other studies). Depression was documented in 16%, homesickness in 20%, social isolation in 20%, family/ personal problems in 18%, financial problems in 14%, and English fluency problems in 10%. There was documented absenteeism in 30% of students and 20% took leave of absence. Only 34% of these students attended the Student Welfare Services. This is a cause for concern as these are the very students who need help. There was a transient increase in dropout (1%) in 2005/06, the year the new curriculum was introduced. Dropout fell the following year (5.38% in 2006/7) but rose to a high of 7.74% in 2007/8 (majority first years). Dropout rate is declining. It is too early to say if the introduction of the HPAT (2009) has contributed to this and if Graduate–Entry students are at lower risk of dropout. However, our study is a valuable platform on which to evaluate the effect of these institutional changes. Important red flag symptoms that should prompt early interview include: academic underperformance, social isolation, overseas origin, depression, leave of absence, English fluency problems and absenteeism. We need to consider the active promotion of Student Welfare services to students at risk (first year students, students who have failed exams, overseas students). Above all, we need to remember that dropping out of medical school can be a very traumatic time and these students need our understanding, support and advice. ■

Never cease to be surprised: *the challenge of rising demands of working in different situations* - Sr Miriam Duggan

Sr Miriam Duggan's paper dealt with some of the challenges faced in working in a developing country and shared some of the experiences gained.

Many surprises awaited Sr Miriam:

- There was great celebration and jubilation around childbirth.
- The head was rarely engaged at 36 weeks, and mostly after labour pains had begun due to the forward prominence of the sacral promitory.
- Many of the cases coming to the hospital were after they had failed to deliver in the village and were often exhausted, dehydrated from being days in labour, and ruptured uterus was common with the added complications of vaginal fistula or rectal and vaginal fistula, due to the head being impacted in the pelvis.
- Local medicine to enhance labour was frequently administered by a grandparent so that there would be a good outcome, causing strong uterine contractions. This local medicine also turned the liquor green. Too much caused sustained contractures and often led to a rupture of the uterus and foetal death.
- Multiple fibroid uterus was common and sometimes the tumours were very big. The biggest tumour Sr Miriam removed was 21 lb in weight.
- The theatre team consisted of a nurse with some skills in anaesthetics, a nurse or two to assist at the operation or Caesarean section – somehow all the responsibility fell on your shoulders.
- Electricity came and went, water was frequently in short supply.
- There was no shortage of patients, and once you were a doctor you should be able to treat everything.

One of the operations that most enhanced ones reputation was the Shirodkar stitch. Incompetent cervix was a common disorder, and women would come having had multiple miscarriages and being convinced that they were bewitched. Often you do not have the nice fancy tape you have in Ireland but a double strand of thick nylon suture did the trick. One reads about abdominal pregnancies but they are rarely seen. Ectopic pregnancies were a common occurrence and women often arrived after many hours of travel on bad roads and very exsanguinated. Auto transfusion was frequently used, whereby blood within the abdomen was ladled out and passed through a funnel lined with gauze to filtrate any clots, into a glass bottle, and transfused into the patient.

There was no back up Paediatric surgeon, so one was left coping with Hare Lips, Cleft Palate, Spina Bifida and Meningocoeles.

During the years of political upheaval one had frequently to deal with emergencies such as severed arteries, shattered bones, chest injuries as well as coping with the lack of basic supplies but with the aid of some text books one coped. Despite what is said in Ireland, symphysiotomy had a place in cases of obstructed labour when the patients were brought in in very poor condition after being in labour in the village for days.

Another issue was dealing with the pandemic of HIV/AIDS and the strain it put on medical resources and families. The challenge was to tackle the root causes for the spread of the disease and to promote abstinence among the young and faithless among married couples.

Working in a developing country one has to be prepared to be flexible, to work outside the box so be sure to carry a few good text books with you.

There is a great challenge but also great satisfaction and people who are very grateful. It has also been very satisfactory to pass on skills to other junior doctors and to see them now in responsible positions and treating their own people. There possibly is stress in dealing with things you feel you are not an expert in, but I think the stress is less than the kind of stress may undergo in Ireland with the demand that the doctor always has to be successful and the fear of litigation. I think I would choose the stress of being stretched beyond ones capacity. Wherever you are in these days you need that extra wisdom, guidance and help so keep God on your side. ■

Pharmaco Economic Challenges - Prof Michael Barry

Pharmacoeconomics is that branch of health economics that deals with the costs and benefits associated with drug therapy. The National Centre for Pharmacoeconomics (NCPE) was established in 1998 and supports the Health Service Executive and the Department of Health on aspects relating to drug expenditure. Spending on medicines under the Community Drugs Schemes (GMS, DPS, LTI & HTDS) increased over 5 fold for the decade 2000 – 2010 and now accounts for over € 1.9 billion per annum (approx 15% of total healthcare expenditure). The double digit percentage year on year increase was amongst the highest in Europe. This growth rate was considered by many as unsustainable and had implications for the availability of new (expensive) medicines. Not surprisingly, the issue of value for money arose. Pharmacoeconomic assessment or Health Technology Assessment (HTA) determines the added value for the increase in expenditure associated with new (and existing) medicines. The assessment process (initially for high cost medicines or those with a significant budget impact) was formally introduced following the IPHA agreement in 2006. Since September 2009 the value for money associated with all new medicines is considered prior to reimbursement. Pharmacoeconomic assessment is a two step process with all medicines undergoing a 'rapid review' to determine which products require a more detailed assessment. If a detailed review is deemed necessary the Pharmaceutical Company submits an economic dossier to the NCPE.

The assessment determines the incremental cost effectiveness ratio (ICER) for the product i.e. the added value for the increased cost, which is usually expressed as cost/quality adjusted life year (cost/QALY). For products with an ICER greater than €20,000/QALY the likelihood of a positive recommendation and reimbursement is less than products where the cost/QALY is below €20,000/QALY. Recent assessments have seen new expensive therapies with ICERs well above €100,000/QALY e.g. Ipilimumab, Abiraterone and Vemurafenib. One of the many challenges is providing access to products which could not be considered cost-effective for the majority of patients but which may be beneficial for a small number of patients. This has led to concepts such as value based pricing and/or performance based risk-sharing schemes.

In addition to being cost-effective, new medicines must also be affordable. Therefore drug expenditure needs to be contained to enable us to afford these new high cost drugs.

The Health Bill 2012 will see the introduction of reference pricing and generic substitution in an attempt to reduce drug expenditure and facilitate access to newer expensive drugs. These and other challenges were discussed. ■

ASSERT Centre

The ASSERT (Advanced Southern Simulation Education Research and Training) Centre is a state-of-the-art, simulation-based medical and healthcare training centre located in University College Cork.

The School of Medicine (UCC) in partnership with the Health Service Executive and the Higher Education Authority, launched the ASSERT Centre to promote clinical learning, through the use of simulation, by undergraduate and postgraduate health professionals in the southern region of Ireland.

The overriding aim of the ASSERT centre is to improve patient safety and reduce avoidable clinical error by training our healthcare professionals to the highest standards in procedural skills and incorporating human factors science in our team training.

Simulation offers a safe environment to refine clinical skills relating to rare clinical events and medical emergencies. Simulation is an additional environment to train multidisciplinary healthcare professionals communication, leadership and teamwork.

The ASSERT Centre also provides simulation and patient safety training to undergraduate medical students, interns, industry, armed forces, dental practitioners and postgraduate healthcare professionals across all disciplines including paramedics and the ambulance service. The ASSERT Centre is a registered Irish Heart Foundation Training Site offering a wide selection of Resuscitation Courses from the basic to the most advanced.

Additionally, the centre provides a wide variety of Procedural Skills courses using basic part-task trainers to the most advanced and powerful haptic and virtual reality simulators. Advanced task training simulators include the Mentice VIST endovascular simulator, the Haptic Promis minimal invasive surgical simulator, and the Simbionix GI Mentor endoscopic simulator. Our patient simulators include METI HPS, METI iSTAN, TDCK, Laerdal 3G, Laerdal SimBaby and a variety of BLS and ACLS mannequins.

The simulators are housed in specially adapted rooms that replicate clinical environments such as theatre, CCU, ICU, A&E and ward areas. All the necessary clinical equipment is to hand to allow accurate replication of real life situations. The ASSERT Centre is also equipped with mobile simulation and audio-visual technology to provide high quality off site mobile simulation training in both the clinical environment and the pre-hospital setting.

The ASSERT Centre uses sophisticated audio and visual equipment to record simulation training to support formative and self directed learning opportunities to course participants. Participants are able to review, reflect and learn from their performance with the assistance of trained facilitators.

The ASSERT Centre collaborates extensively within and outside the university with simulation centres, universities, industrial partners, postgraduate training bodies, the health service, interest groups, charities and standard and regulatory bodies. The ASSERT Centre works closely with the TEL for Health Research Group at UCC and collaborates and is a partner in training, grant and research opportunities.

It is envisioned that the ASSERT centre

- will be integral to the current and future teaching and research agenda of the UCC Centre for Medical Education.
- will ensure that UCC has incorporated best practice into UCC healthcare education and training; ie the evidence that health care workers who have been trained to proficiency on appropriate simulators carry out their first procedures on real patients with fewer errors than healthcare workers performing these procedures for the first time on patients without the benefit of prior simulator training.
- will facilitate that deliberate practice, ie training that is configured and incorporates formative metric-based feedback, is extended in medical and healthcare workers' education and training in healthcare practice.
- Will facilitate medical students, interns, more advanced trainees and healthcare workers to have the opportunity to train in a skills laboratory thus enabling them to demonstrate the required level of proficiency and competency before applying their skills to patients. ■

Appreciations

Dr Dermot Crean

On August 27th this year, a memorial service was held in the Honan Chapel, UCC, for the late Dermot Crean, who died in Gosport, UK, on May 29th 2012. The service was attended by Dermot's wife Terry, his two sons and four daughters, many friends and rugby supporters (including ex-international players) from Dermot's years as a medical student and as an avid rugby supporter in UCC.

His son Damien gave a moving account of his father as a family man, (including his unexpected skill as a talented cook), and a colleague recounted Dermot's exploits in his college years. He was a larger than life character, a wonderful raconteur who, it was remarked, never let the truth get in the way of a good story. He was extremely witty and he loved to perform at the Philosophical Society debates where, with his booming voice and uppercrust English accent, he was a match for all comers. He was funny, sarcastic and fearless, especially adept at thinking up clever and scholarly nicknames. Two nuns who were classmates of his, one tall and one small, were promptly re-named Pollicis Longus and Pollicis Brevis, names that are remembered to this day! One contemporary described him as having a copious thatch of black hair, with a long thin face giving him a look of grave composure, but his severe horn-rimmed glasses concealed eyes with flecks of merriment and mischief, and this was the Crean who provided us with so much fun and entertainment during the UCC years.

Although he did not play, Crean was a great rugby aficionado, famous for parading a coffin bedecked in UCD colours around the Mardyke during the annual Colours match. In 1962-3, the year of Paddy Kiely's captaincy, Dermot was the bagman responsible not only for UCC jerseys, but for the morale and spirit of the team, which was the most successful in the history of UCC rugby.

Dermot was extremely bright and had a fine intellect. He was known as a resource to his classmates in study groups where he could summarise the salient issues in clear concise terms. However he was also able to adapt quickly to the demands of clinical work, and was very popular intern when he started his medical career in Bantry in 1965.

Following in his father's footsteps, Crean spent most of his medical career in the British Naval Service, including service on nuclear submarines. He trained as a rheumatologist and was responsible for setting up a Rheumatology service in the Portsmouth Royal Naval Hospital. During his career, he rose to the rank of Surgeon Commodore, and Medical Officer in charge of the Institute of Naval Medicine. When he retired from the Navy in 1996, he was appointed as a referee on the Armed Forces medical tribunals, and then to independent tribunals in London. In recent years, he suffered from a long illness, and any account of Dermot is not complete without referring to his beloved wife, Terry, who he referred to as his rock, and who coped with the family singlehandedly during Dermot's long absences at sea and kept a steady hand on the rudder of the Crean family. Dermot – thank you for all the fun and laughs we had. Ni feichimid a leithead aris.

PG / HOM

Dr Barry Duggan (1932 - 2012)

As a scientist in the field of medicine, Prof Barry Duggan, who has died aged 79, played a major role in laying the foundations of clinical biochemistry in Ireland. Academically brilliant, he gained national and international distinction and was president of the Association of Clinical Biochemists in 1975 and again in 1986, 1987 and 1988.

A member of the Royal Irish Academy, he was also awarded a DSc by the National University of Ireland, an extremely rare honour reserved for scientists who have published a large volume of seminal documents on a particular area of research.

A Fellow of both the Royal Society of Chemistry and the Institute of Chemistry of Ireland, he was also a member of the Cork Scientific Council.

A talented amateur footballer in his day, he founded the soccer club at University College Cork which famously had its home in a muddy quarry on the campus, now the Boole Library, where generations of students played in fiercely fought, inter-class competitions for the coveted "Quarry Cup". Sixty years, on it is still going strong on an all-weather pitch at the Mardyke.

With an exceptional capacity to look at scientific processes, ask questions and design experiments to answer those questions, he is regarded as making a significant contribution to scientific thinking in this country.

An educationalist at heart, in the competitive world of academia he was not afraid to ruffle feathers at UCC by extending educational bridges to the Cork Institute of Technology, thus starting what is now an excellent joint Biomedical Sciences programme involving students from both CIT and UCC.

Duggan grew up near the Lough, a quiet suburb surrounding a lake in the heart of Cork city. Educated at Presentation College, he was a graduate of UCC and gained a PhD at UCD. He went to the US in 1960, doing research work at the National Institute of Health in Washington DC, returning to UCD as a researcher and lecturer for a 10-year period punctuated by a sabbatical visit to the US in 1968 where he worked at St Louis University in Missouri.

In 1971, he joined St Finbarr's Hospital in Cork, and established a department of biochemistry, an aspect of medical science concerned with the metabolism of human health and disease. It was transferred in 1978 to Cork University Hospital, where two of his daughters work – Cleona as a consultant haematologist and Jennifer as a medical scientist in haematology. In a personal tribute, Dr Paule Cotter, consultant haematologist, who worked closely with him at the hospital's pathology department for 20 years, said "the vastness of his support and the paucity of his complaints, made him an absolutely wonderful colleague".

Dr John O'Mullane, who succeeded him as head of the department of biochemistry at CUH, described him as "a very complete practitioner – whether you're talking about the teaching of scientific biochemistry, its practice in a hospital setting, or his contribution to fundamental research as evidenced by the awarding of a DSc".

Despite his academic achievements, he carried his learning lightly and had a lifelong interest in humour and philosophy. With a ready Cork wit, he had an ability to defuse difficult situations with a humorous remark.

A social golfer, between bouts of chemotherapy he continued to join old friends for a Sunday afternoon four-ball at Muskerry. Finally opting out through illness, he loved nothing more than to join them after the game for a glass of wine and the customary banter.

He is survived by his wife Ursula (nee Russell), daughters Jennifer, Cleona and Naomi, son Jason, sisters Mona, Breda, Berna and brother Joe.

Dr Patrick (Paddy) Kieran FitzGerald (1920 - 2011)

Dr Paddy FitzGerald, born on January 10, 1920, died on March 15, 2011, at the age of 91 RIP. The seventh of ten children, his parents were Richard FitzGerald and Ellen Mullins. He was born and reared in a thatched cottage in Glenroe (the Red Glen), in the shadow of the Galtee mountains. His very happy memories of a traditional, rural Irish childhood in the 20s and 30s gave him a lifelong love of Glenroe. Despite the harsh economic times, his industrious parents and very supportive family, including emigrants to America, ensured an excellent education with the Christian Brothers in Mitchelstown, for whom

he had enduring respect and admiration. His movement to UCC came at a challenging time in his life. His father had died and despite a permanent shortage of money and rationing, the rigours of academic life were offset by a passion for Gaelic Football, and great friendships, Paddy Fuller, Tom Mc Elligott and Jim Hurley standing out for particular mention .

He qualified as a doctor in 1946. At that time it was very difficult to get a medical job in America. He therefore spent 6 months in the North of England, prior to crossing the Atlantic. Cousins and the related Irish Diaspora supported him initially in America until a chance encounter with a stranger, landed him a job in Connecticut. A subsequent very harsh winter there directed him to the warmer climate of Texas. He worked in two hospitals, one for white people and another for African American patients, such was the racial discrimination at that time. As Texas was a dry state, and aware that kindness and decency appear in unusual places, he and some Sisters of the Incarnate Word Order, would cross the Orange River into Louisiana raising $3000 from casinos and taverns for the African American hospital.

He loved Texas but Texas medical licencing rules precluded non US graduates from applying for permanent positions, so he moved to New York. In New York he was involved in negotiations with New York State Board to accept the legitimacy of the UCC medical degree and UCC graduates. Having passed his New York State licencing exams, he was appointed as a General Surgeon in Central Islip State Hospital, Long Island. During this time he met and married Mary O'Donnell (a UCD graduate) from Tralee. Both were very active in the Irish community and helped set up the National University of Ireland club in New York.

They returned to Ireland in 1962, settling in Cork, where he took up a post in UCC as Lecturer in Anatomy. Jim Hurley, who persuaded him to return, also wanted help coaching the Gaelic Football team. He enjoyed the slower easier pace of life back in Ireland but was very active in University life . He enjoyed research and published 24 papers and 2 books at the time. He won a Council of Europe scholarship in Surgery to Sweden and was regularly invited back to America for various teaching and academic events in the University of Texas, University of Missouri and George Washington University. In 1969 he found himself in Leningrad, Russia at the World Anatomical Society at the request of the Royal Society of London.

The Gaelic football interest led him to be Chairman, Coach, Selector and Medical Adviser for the UCC team from 1964 to 1977 during which they won 5 Sigersons and 2 Munster club championships. Many famous Cork and Kerry players passed through his hands and these years were amongst the happiest of his life. He was actively involved with the Cork Football team as doctor, and for 3 years as selector, in the early 70s, during which time Cork won the All Ireland Championship in 1973. He maintained a passionate interest in Gaelic games right to the end of his life.

When not actively involved in football, academic and family life, he regularly engaged in volunteer work, including 12 trips to Lourdes and one to Kenya. In all his endeavours, Paddy was hugely supported by his wife Mary, to whom he was happily married for 55 years. Mary also worked in UCC as a demonstrator in the department of Chemistry. She was very involved in the National University Women Graduates' Association, where she helped forge links with Northern Ireland Universities. Mary predeceased Paddy in June 2009. They are survived by six children, Richard, Patricia, Margaret, Alasdair, Brian and Desmond, all UCC graduates, and by their 10 grand-children, to whom they were devoted and who miss them greatly. Dr. Paddy FitzGerald will be remembered very fondly by his students as a fair and practical teacher, who excelled in the discipline of Clinical Anatomy and was a wise mentor to many in their medical careers.
CV

Dr Michael Herlihy (1921 - 2012)
Dr Michael Herlihy passed away on February 22nd 2012 in the presence of his family at home in Georges Street, Mitchelstown where he practised from 1956 to 2012 without interruption. Michael was born on March 2nd 1921 in New Square, Mitchelstown. His father Tom was the Principal of Gortroe National School and his mother was also a teacher. He proceeded from Gortroe National School to St. Colman's College in Fermoy and he graduated from UCC in 1946. He worked in the United Kingdom for about a decade in hospital surgery training posts proceeding to the first part of his fellowship but returned to Mitchelstown in 1956 when his mother became unwell. He initially started practice on his own and soon joined Dr. Batt Hutch in Kings Square, Mitchelstown and after Dr. Hutch's death, continued in solo practice with the help of his wife and nurse, Maureen. There they built up the practice from their home and he had the satisfaction of having his son Declan join him in practice many years later in 1989. It was described as an old fashioned practice where the patient would come and ring the door bell and Maureen would go out to them and bring them in. Each person was greeted individually. It is a far cry from the modern state of the art primary care centre in Mitchelstown replete with computers and extensions. It must have been a great satisfaction for both Michael Herlihy and Tom O' Callaghan to be joined in their practices by their sons and to see the evolution of individual practices in Mitchelstown proceed to what is now the country's showpiece primary care centre.

Another big difference was the maternity care offered. During his early years, he was responsible for antenatal care right through to delivery and he delivered hundreds of babies in his time. These were delivered in the patient's home, at the top of the Galtees and even on the roadside on occasion. Behind a very shy quiet façade was a very hard worker and superb clinician. He died just 9 days short of his 91st birthday party from carcinoma of the pancreas. He had worked and seen patients until 2 weeks before his death.

He was an enthusiastic sportsman with an enthusiasm for golf and together with his wife Maureen was instrumental in the development of Mitchelstown Golf Club, where he served as President and Captain. He drove a sports car until the age of 89 when he had his hip replaced and then had difficulty getting in and out of the bucket seat! His passing was much regretted in the greater Mitchelstown area. However, Dr. Michael also had the satisfaction of seeing his daughter Olive become a Consultant Endocrinologist, Karen a Physiotherapist, Ann a Clinical Nurse Specialist in addition to Declan joining him in his practice. In keeping with the family tradition, his grandson Tony is now in the United Kingdom also practicing medicine and two of his grandchildren David and Maeve are studying medicine in his old Alma-Mater.

Dr Barry Kennedy(1932 - 2012)
Dr Barry Kennedy died peacefully at home on September 14th 2012. Barry graduated from UCC in 1958. He was born in Jerusalem but his family relocated to Jersey soon afterwards and he spent his first 12 years in Jersey before going to Clongowes Wood College. Following his enjoyable years there, he came to UCC for his medical studies and graduated in 1958. He interned in the North Infirmary where he met his wife Mary (Ryan) who was a theatre sister. He subsequently joined the RAF and saw service in Northern Ireland, England and Malaysia. He returned to Buttevant in 1967 and set up in general practice. He was joined by his son Michael in 1990 and they worked together until 2008 when he retired. He was the deputy Coroner for North Cork from 1988 until 2000 when he became the Coroner and retired at age 70 years in 2002.

He was a founder member of the vibrant North Cork Clinical Society with Dr. Tom O'Callaghan and Dr. Pat Casey. This was a forerunner to the local chapter of the Irish College of General Practitioners. He was a founder member of the Buttevant soccer club and the Buttevant soccer team formed a guard of honour at his funeral. He was also very active in the setting up the Boy Scouts locally and always maintained a keen interest in scouting activities.

He had a great interest in all things mechanical, loving to take engines apart and putting them together again whether it was a watch, a clock, a boat or a car. Shortly before his death, he celebrated his 80th birthday with his family and friends and Dr. Michael Hyland recalls a vivid and long conversation recounting many great experiences and mutual friends shared. Always a Francophile, in the last few days he reverted to his native tongue.

His passing was much regretted in his local community whom he served so well for over 40 years.

He is survived by his wife Mary, his children Michael, Veronica, an Otorhinolaryngologist in Bolton, Helen, a Nurse Oncologist in Sydney Australia, Finnbarr, a geologist, John, an Engineer, Anna, a Biochemical Scientist and Kevin, an Engineer and 10 grandchildren.
WF

Dr Seamus O'Donoghue (1934 - 2012)

Dr Seamus O'Donoghue, died peacefully on March 13th 2012. He was born in Killarney on August 21st 1934, the fifth of nine children to Dr Paddy and Kitty O'Donoghue, of whom he was predeceased by Michael and Dr Kathleen. He is survived by his wife Margaret, daughter Ollie, son-in-law Seamus, grandsons Shay and Darragh, brother Fr Paddy, sisters Dr Peg, Maura, Eileen, Frances and Finula.

Seamus qualified in UCC in 1959 when almost all graduates emigrated. Seamus went to the midlands and passed "the test" – the London MRCP in 1965. He became senior registrar in the prestigious Birmingham Children's Hospital and remained there until appointed Consultant Paediatrician in 1967. Cork Paediatricians agreed in the seventies to have all children with leukaemia treated in the Mercy Hospital. Seamus was keenly aware of the need to keep abreast of this rapidly developing sub specialty. His unit led the way in cooperating with the UK Medical Research Council leukaemia trials. The best available treatment was delivered close to home, whilst the results were monitored by international experts. Seamus and his colleagues opened the self contained Children's Leukaemia Unit in 1981. This splendid service is a tribute to Seamus and the staff of the Mercy University Hospital.

Seamus is fondly remembered by his contemporaries as a man who was passionate about sport, especially Kerry football. His sporting prowess moved to golf on returning home. He was captain of Cork Golf Club in 1984 and president in 1998. Seamus was a member of the Royal Cork Yacht Club and a keen sailor. He had a great love of horses and joined a syndicate that owned national hunt and flat racers. The question arises of how Seamus coped with all his interests. His clinical brilliance was matched by his prodigious energy. Golf, sailing, horse racing, football matches were all on the agenda and playing cards every Tuesday evening. It seemed that if ever there was a man who would have a fulfilling retirement – it was Seamus.

In 1998, Seamus noted a tremor in his arm when examining a newborn baby. It was the first symptom of a slowly progressive neuromuscular disorder. He took early retirement. It seemed that he was going to be sidelined for the rest of his life. Seamus remained unfazed and stayed totally involved with his family and close circle of friends. His daughter Ollie said that his illness was the best kept secret in their house. He never made a word of complaint for nearly fourteen years, and only one comment of regret when he noticed his grandson swing a golf club. If only, he said to Margaret, I could show him how to do it.

Seamus had a very fulfilling retirement and as Margaret said in the end he just ran out of steam. He was one of the last great all round paediatricians before specialisation began to hive off different aspects of care. He witnessed the shift in neonatal care from exchange transfusions and minimal handling to maximal monitoring and skilled interventions. He welcomed these skills in young consultants and gracefully encouraged their input to care. Seamus contributed easily to a congenial atmosphere in Cork Paediatrics which facilitated inter hospital cooperation and cross cover at weekends. An important outcome has been the smooth amalgamation of the neonatal units from the Bon Secours, the Erinville and St Finbarr's Hospitals into a world class neonatal intensive care unit in the Cork University Maternity Hospital. As a talented sportsman he instinctively knew the importance of teamwork in a competitive medical world where the consequences of his dedication endures.
PK

Prof Gerry O'Sullivan (1946-2012)

Blessed with a rare blend of academic brilliance and a practical approach to medicine, Prof Gerry O'Sullivan, who has died aged 65, was an internationally renowned surgeon, a distinguished clinician and a world authority in the field of cancer research.

Regarded as one of the outstanding surgeons of his generation, he was president of both the Royal College of Surgeons in Ireland and the European Surgical Association.

On graduating from University College Cork in 1969, he did postgraduate studies in Ireland, America and Canada, returning to Cork in 1985 as a consultant at the Mercy University Hospital. Of West Cork farming stock, he was one of the first "outsiders" to break into a medical scene dominated by dynastic families.

A straightforward man, he never lost sight of his roots at Milleenahorna in the parish of Caheragh near Skibbereen. Despite receiving an array of lofty international accolades, his elevation to the West Cork Hall of Fame and the Muintir Skibbereen Credit Union Award for exceptional achievement were every bit as pleasing to him.

In her eulogy, his daughter Orla described him as "an extraordinary ordinary man".

Though he had huge hands, his surgical work was remarkably delicate. An original thinker, he founded and directed the Cork Cancer Research Centre at the Mercy Hospital in 1999. Though ill for some time, he continued working at the centre, which investigates major issues in the development and treatment of cancer at both primary and secondary stages. It has held internationally important clinical trials.

When awarded an Honorary Fellowship of the American College of Surgeons in 2008, the citation referred to his "profound impact on Irish, European and American surgery" and also mentioned that he was "known and loved by many surgeons and physicians".

A research pioneer, he held several patents and created new techniques and cancer treatments, including minimally invasive and gastrointestinal surgery. He was also involved in the early discovery and development of probiotic bacteria as therapeutics. Stressing that laboratory and clinical experience were closely intertwined, he observed: "I think that makes our research much more meaningful."

Quick to praise others, when a young medical researcher discovered that molecules found in turmeric, a curry spice, were shown to kill oesophageal cancer cells in the laboratory, he said her research had opened up the possibility that natural chemicals found in turmeric could be developed into new cancer treatments.

Appointed a Professor by UCC, he was instrumental in the university's conferring of a doctorate of laws on the Navan-born actor and benefactor, Pierce Brosnan, whose wife, Cassandra, had died in 1991 of ovarian cancer. Brosnan is patron of Unicef Ireland, Downs Syndrome Ireland and the Cork Cancer Research Centre.

From 1983 to 1985, O'Sullivan worked with the Park medical organisation in the Middle East and was founder and director of surgery at Baghdad Hospital. His ready collaboration with colleagues was recognised in visiting professorships to the University of Southern California and Royal College of Surgeons, Glasgow.

A generous mentor, several of his proteges went on to distinguish themselves internationally as scientists or consultant surgeons. A provocative lecturer whose awards are too numerous to list here, he also authored or co-authored more than 200 academic papers. Besides being on the Council of Surgeons of Great Britain and Ireland, he was president of the Irish Society of Gastroenterology, chairman of the British Oesophageal Group, and a member of the Council of the European Association of Cancer Research.

In 2009 he was honoured with a Lifetime Achievement Award, known as the "Medical Oscars", by the Irish Journal of Medical Science in conjunction with the Royal Academy of Medicine in Ireland.

He is survived by his wife Breda, daughter Orla, sons Gearóid and Eoghan, brothers Con, Donal and Seán, and sisters Joan and Breda. ■

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UCC Annual Scientific Conference

September 12, 2013

Contact Rachel Hyland
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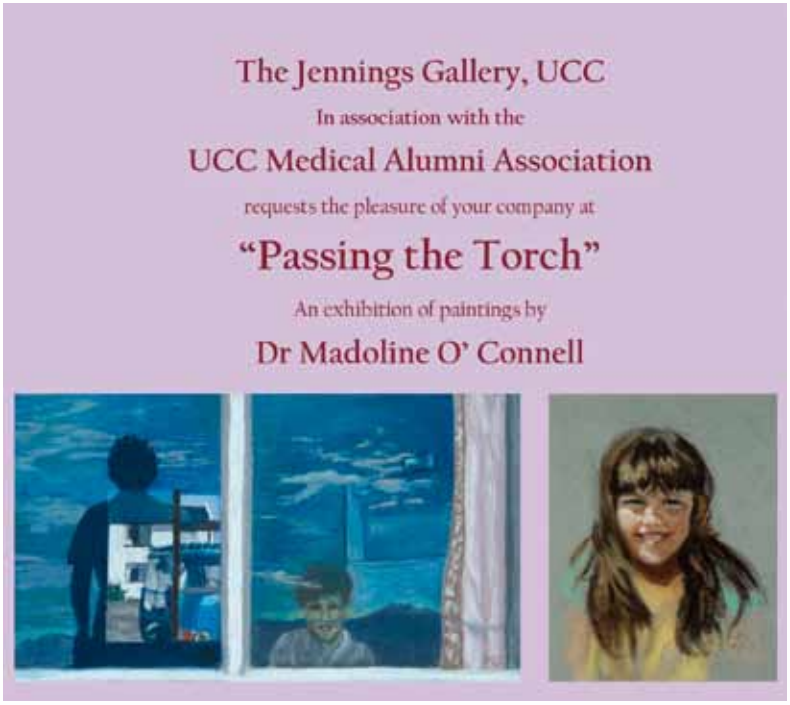
Diary of Alumni Events

23rd Dec '12 @ 5pm
UCC Christmas Homecoming, Aula Maxima, UCC
Tickets €10
http://www.eventelephant.com/universitycollegecork christmashomecoming2012

6th Feb '13 @7pm
Dublin Alumni Event, Irish Management Institute (IMI)
Email: alumni@ucc.ie

1st March '13
Cork Dental School Centennial Alumni Dinner, UCC
http://www.ucc.ie/dentalschool/

Jan- March '13 - Weds@ 8pm
Faculty of Science Annual Public Lecture Series, Boole Lecture Theatre 4
http://understandingscience.ucc.ie



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