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Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

Medical **Alumni**

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Diary in Pictures

UCC Medical Alumni Scientific Conference 2009

Dr Mike Henry, Dr John Coulter

Prof Paul Finucane, Prof Brendan Buckley

Dr John Casey, Dr Brian O'Mahony, Dr Eamonn Shanahan

Dr Pat Sullivan, Prof Noel Caplice, Dr Dan O'Mahony, Dr Paula O'Leary, Dr Liz Kenny

Dr Paddy Ryan, Dr Sheila O'Neill, Prof David Kerins

Prof Noel Caplice, Dr Mary Cahill

Dr Denise Deasy, Dr Pat Cogan, Dr Hilda Fennell, Dr Helen McGrath, Prof Gerry O'Sullivan, Dr Pat Devlin

Dr Margaret Lynch-Nyhan, Dr Donal Nyhan

Dr Will Fennell

Introduction

Welcome to the eighth Newsletter. We are grateful to our many contributors who have shared their experiences with us. We also should acknowledge the outstanding presentations at the Annual Scientific Conference last year – one could not ask for a more interesting programme and we hope as many as possible will gather again in September (16 and 17) for this year's get together, which also marks the Inaugural Joe O'Donnell Memorial Lecture.

You will also see the continuing efforts done on the international scene by Prof Eamon Quigley and Prof Fergus Shanahan recognised by their peers in the award of the David Sun Lecture. Eamon was the recipient of the Medical School Medal and Distinguished Alumnus Award for 2009.

Dr Con Murphy was recognised for his outstanding voluntary contributions to UCC and Irish sport in general. You will enjoy the interview with Con and Paddy Crowley.

Katy Keohane recounts for all the memorable reunion for the Class of 74 held in St John, Newfoundland and hosted by Benvon and Pat Parfrey and their colleagues who have left their indelible mark on the Canadian scene and as our ambassadors we have basked in the reflected glory.

Frank Golden recounts the memories of an Applied Physiologist where new frontier research has led to benefits for humanity in improving survival after cold water immersion. I don't think John Sheehan could have asked for more from one of his outstanding students.

Gerry O'Sullivan has detailed for us, with typical understatement, the remarkable ten year journey of the Cork Cancer Research Centre. It is an outstanding story of innovation and hard work inspired by one man with vision and determination, of whom all in UCC can be justly proud.

Fergus Moylan brings us up to date from the US and down to earth with his insightful piece on bipolar depression and its potential role in suicide in the young, an ever increasing problem in our student population. A better insight will hopefully lead to improved recognition of the problem and lead to better preventive strategy.

John Good recounts his experience as a delegate in the International Red Cross (and as our silent ambassador). It is a long way from academic centres of excellence and private practice but one cannot but stand back and admire the work done by so many under difficult circumstances and follow the ideals of Albert Schweitzer for the betterment of mankind.

Carol Dundon has revisited the North infirmary ("North Cha") and will bring back happy memories to many.

Michael Hanna has outlined the daunting task of reconfiguring services within our acute teaching hospitals in Cork and Kerry to better cope with the challenges of today and hopefully provide a better service to our patients in the future, I personally hope we can have a united university hospital on three sites bringing the best of the old and new together, under the banner, United Colleagues of Cork.

Pat Gaffney and classmates have combined to "rereview" the Textbook of Surgery of Prof Patrick Kiely, first released 50 years ago, and reached a second edition. In the absense of word processors, PubMed, interuniversity library loans, etc and with his busy workload one can only marvel at this achievement of a remarkable man, whose example led to an extraordinary number of UCC graduates following a surgical career in Ireland and overseas.

We also include obituaries on recently deceased and much loved and respected colleagues, Pat Beausang, Cal Condon, Derek McCoy and Fred Moore.

We will also welcome contributions from Alumni or friends of UCC for future editions and will look forward to welcoming as many as possible to Class Reunions in UCC in September (to coincide with our Annual Scientific Conference on September 16 and 17) or at any other time of year.

The College and Faculty is grateful for the very generous response to the recent Ainsworth appeal. To date €9,000 has been raised.

I will shortly contact all Alumni to appeal for your support to our Alma Mater in whatever way you can contribute now or in the future to nurture further development of our proud heritage in these difficult times and repay our debt to our teachers and those who sacrificed so much to give us such an outstanding preparation and opportunity.

Two Outstanding Medical Graduates Honoured by UCC

Last December, two outstanding medical graduates were honoured by UCC and the College of Medicine & Health at the annual Alumni Awards Evening.

Professor Eamonn Quigley was recognised with an Alumnus Achievement Award, as a leading international expert in the field of gastroenterology. On the night, Professor Fergus Shanahan, Head of UCC's Alimentary Pharmabiotic Centre (APC) delivered the encomium for his friend and colleague.

UCC President, Dr Michael Murphy presented Dr Con Murphy with the inaugural Alumnus Award for Voluntary Services to UCC for his outstanding voluntary contribution to UCC GAA and to Cork GAA over the past forty years.

PROF EAMONN QUIGLEY is Professor of Medicine and Human Physiology at UCC and is Principal Investigator at the Alimentary Pharmabiotic Centre (APC), UCC. He serves as President of the World Gastroenterology Organisation (WGO-OMGE) and is the immediate past President of the American College of Gastroenterology. His major research interests include motility, functional gastrointestinal disease, eurogastroenterology, gastroesophageal reflux disease and probiotics in health and disease. He has published over 550 original papers, reviews, editorials and book chapters, and has received numerous awards and accolades for his work. The Alumnus Achievement Award from the College of Medicine and Health was sponsored by Boston Scientific.

DR CON MURPHY combines his busy general practice in Cork City with his commitments to UCC GAA and his deep involvement with the Cork County Board GAA Inter-County Teams. He has been Doctor to Cork Senior Football and & Hurling Teams since 1976. He has a national reputation for excellence as a volunteer in Sports and his commitment to County teams is unequalled throughout the country. He is currently President of the UCC Gaelic Football Club and has been involved with the Club either as a selector or medical officer since the early 1970's. Highlights with the Club include being team selector in 1973 and 1999 when UCC won the County Championships. The 2009 Alumnus Award for Voluntary Service to UCC was sponsored by Henry Ford & Son Ireland Limited.

Dr. Catherine Keohane

UCC Medical Alumni Meeting St John's Newfoundland Aug 26th 2009

(Combined with class of 1974 reunion)

A group from the class of 1974 celebrated their 35th reunion combined with a Medical Alumni Scientific meeting in St. John's, Newfoundland, Canada. Our hosts were Pat and Benvon Parfrey who organised what can only be described as an outstanding and memorable trip, with the strong support of their UCC colleagues in St John's, Brendan Barrett, John Harnett and Eilish Walsh.

The meeting started officially on Wednesday August 26th with the Scientific Session at St. John's Hospital, where the Hospital and Medical School of Memorial University are combined. Coming from the cramped conditions in CUH, the layout of the hospital with loads of car parking and plenty room for expansion, one was jealous of the feeling of space. The meeting included local and Irish speakers on a variety of topics. We started with a talk by Adrian Honan on the organisation and running of a Primary Care Centre by the Primary Care Team in Portarlington. The role of the Multidisciplinary team with Doctors, Practice Nurses, Physiotherapist, Pharmacist and Dietician and the need for frequent team meetings for good communication were stressed. In Portarlington, this has resulted in a successful venture for both those providing and receiving the service.

Gary Lee, Pat Parfrey. Dan Burke, Barry Oliver, Kathy Honan, Adrian Honan, Benvon Parfrey, Katy Keohane, Judy Burke, Mary Lee, Donna Oliver, Charlie Mc Carthy, Marie Rabette.

The next talk by Pat Parfrey described the multidisciplinary approach which had been taken to study a number of diseases affecting the populations of Newfoundland and Labrador. This relatively stable population is capable of being traced back to a small number of founders, so that the kindreds affected by a number of genetic disorders can be accurately screened both clinically and genetically. This has led to identification of certain target genes, clinicopathological correlation of genotype and phenotype and monitoring of treatment and intervention. Pat used a familial cardiomyopathy to illustrate the type of approach taken by the research teams in Newfoundland, and illustrated his talk with beautiful paintings, many from his own collection, of scenes depicting life in the region, where many people lived in small settlements clustered along the coast. Their livelihoods depended largely on the sea, including sealing, whaling and cod fishing, now largely diminished.

Brendan Barrett then gave the results of a very large regional Canadian study to assess the significance of biochemical markers of early renal failure in apparently well individuals in the community. The focus was to assess the need or not to refer to a nephrology service.

My own contribution was next on an Update on Brain Tumours with emphasis on the still very bad prognosis in High Grade Malignant Gliomas which are increasing in incidence as the population ages, and the role of molecular markers in targeting chemo and radiotherapy. There was a very timely interruption by Gary Lee, who told the group that his internet phone had just informed him that Ted Kennedy had just died of a malignant glioma.

The difficult management of an unusual case of recurrent hypercalcaemia due to parathyroid carcinoma was described by John Harnett with a relatively successful outcome in the patient. Benvon Parfrey then discussed the provision of teleradiology services to a vast area of outlying centres in Newfoundland and Labrador, with examples of cases from her own specialty of Paediatric Radiology. This latter talk included impressive information on the commitment and enormous economic investment of the Canadian Health Service to a single electronic patient record.

As usual with UCC Alumni Scientific Meetings, it was the exposure to topics and specialties outside one's own which was so interesting as well as the talks themselves, and they generated vigorous discussion. The contrasts between the Canadian Health System and the HSE were striking.
After the science there followed a

wonderful lunch downtown and the first of a series of trips around the Avalon peninsula of Newfoundland, taking in Signal Hill with its breathtaking views over the bay and the adjoining hills. One was reminded of the Kerry coastline, but with the distinctive wooden brightly coloured painted houses of St John's and perhaps a more "savage" landscape. The steep cliffs resembled the Norwegian fjords. We were blessed with good weather although strong winds persisted, the tail end of Hurricane Bill which had blown through the previous Sunday, when the airport was closed. No ice floes in the harbour, they had gone, along with the humpback whales before we arrived.

Over the next few days we took trips around the region visiting the most easterly point in N. America, Cape Spear (see photos), "The Rooms" museum located where the cod and seal fishermen stayed, and learned about the medical services to the "outposts" distant stations where life was very hard and a living from the sea was eked out under the dictat of climatic conditions, contending with ice and storms.

We were royally entertained chez Parfrey, where the combined interests of medicine and rugby were evident. The most recent early pensioner Gary Lee delighted us with an after dinner talk which recalled the wilder and funnier episodes of our UCC days with just the right mixture of fondness and irreverence for our teachers. Modesty forbids me retelling some of the accompanying jokes, besides I can't compete with Gary's talents as a mimic.

On Thursday evening we took a bus to the Bay of Conception and watched the sunset as we had a tasting menu with accompanying wines in restaurant "Atlantica", worthy of at least 2 Michelin stars and most unexpected in such a location.

On Friday there was golf in the inland course of Clovelly for the hardy surviviors of the night before, hosted by John Harnett. The strong winds against us provided the perfect excuse for any stray shots. Friday evening saw us dining again in great style at a Japanese inspired "Mashu", a triumph of presentation and taste with wines to match.

The icing on the cake was Saturday when the sun came out strongly and we toured around Bull's Bay in O'Briens boat. We not only experienced the coastline from the sea, but followed a rare Minke whale which dived and surfaced close to the boat, to our great delight. We also circled around Gull island, where colonies of puffin, gulls, kittiwake, and other seabirds nested. Unlike the Skelligs, gannet were not in evidence.

Most of the group went on to other locations or returned to Ireland on Saturday. The general consensus was that the trip was a wonderful success. My own view is that none of us would have gone to St John's if it had not been for the generous offer by the UCC Alumni there to host a meeting combined with our class reunion. Thanks to the exceptional hospitality of the Parfreys and their colleagues, we not only had an excellent Scientific meeting and caught up with other Alumni activities, both professional, family and social, but we got to visit a beautiful part of the world with a history of hard survival of its people, many of whom trace their origins to Ireland. For those who travelled, it was a fantastic and enjoyable trip, for those who did not, you really missed out!

Judy Burke, Adrian Honan, Harry Comber, Marie Rabette, Gary Lee, Dan Burke, Donna Oliver, Mary Lee, Katy Keohane, Pat Parfrey, Barry Oliver, Charlie McCarthy, Benvon Parfrey at Cape Spear.

Adrian Honan, Pat Parfrey, Benvon Parfrey.

Brendan Barrett, Pat Parfrey.

Katy Keohane

Judy Burke, Barry Oliver, Katy Keohane.

Marie Rabette, Kathy Honan.

Joe Curtis, Gary Lee.

A medical delegate on assignment with the International Committee of the Red Cross

***'Until he extends his compassion to include all living things, man will not himself find peace'. Albert Schweitzer,* Nobel Laureate. Expect the unexpected. This may well have been the mantra with which all delegates set forth to distant conflict areas, when accepting a mission with the Swiss humanitarian organisation, founded by the Geneva based business man Henri Dunant in the mid nineteenth century.**

Doctors who volunteer their services to the International Community of the Red Cross (ICRC) do so as part of a specific remit to work within a multi-disciplinary team, either as surgeons or anaesthetists at a field hospital near to a battle zone, or as medical delegates coordinating urgent health action into the field where civilians need health protection, shelter and basic primary care. In other actions, under the auspices of the Geneva Conventions and their Protocols, medical delegates accompany Protection Teams to visit political prisoners across the Globe.

The Geneva Conventions, of which the ICRC are the guardians, permit (under international humanitarian law) the right of access to persons detained by a State on grounds of national security. ICRC delegates are privileged to visit these persons without any witness or guard being present, and to take details of their circumstances and conditions of incarceration, endeavouring wherever possible to ameliorate suffering. The same privileges are extended to the ICRC to visit prisoners of war and ensure their safety and health under the terms of the Geneva Conventions.

Dr John Good

It all began with a book, lying on the hall table at my parents' home. The biography of Albert Schweitzer, philosopher, theologian, musician and doctor who founded a leprosarium in Lamberene, Gabon, on the West coast of Africa, had riveted my attention. I was happily doing my GMS thing in Co Kildare, married to a wonderful lady and rearing a family of five sons. Suddenly I was beginning to think long and hard, what would it be like to undertake such work? It remains a mystery to this day how such a seemingly bizarre idea led to a frightening detachment from the reality of the 'here and now' to pursue tropical medicine studies in Dublin and ultimately be assigned as a medical coordinator with the Red Cross to South Sudan, where civil war and internecine strife had raged for almost twenty years.

I flew to Geneva and had what may be described as an intensive, if short briefing over a few days on the 'situation on the ground', the logistics, the health care and self care and the scope of my responsibilities. This would entail arranging the evacuation of wounded combatants, almost always by air in small aircraft capable of short landing and takeoff, from the battle zones to a safe location across border where a field hospital had a team of surgeons on standby. Initially I flew to Khartoum for more intense briefing, passing through Cairo airport en route and parting company with a cherished Waterman fountain pen, 'borrowed' by an immigration control officer. First lesson. Travel light and carry nothing of value! Then on to the Turkana desert base with its airstrip and a field hospital with a capacity of some 350 beds during emergencies. A team of six primary care nurses with public health and midwifery training, principally from Europe and Australasia, provided an incredible service with the minimum of equipment to isolated villages dotted over South Sudan, when fighting had receded and the area was deemed temporarily free of hostilities. For the next two years home was a stone floored, whitewashed mud and thatched tukul in the Turkana Desert, in a sheltered compound surrounded by local native Turkana people. Some were employed as local staff for domestic work but otherwise there was no direct contact with the local people, since the team was mandated

to work in the conflict area across the border or in the diplomatically protected zone of the hospital.

But we were afforded the luxury of running water and cold showers, with an excellent canteen and the wonderful company (for the most part) of a multinational work force of doctors, engineers, nurses, logisticians and an agronomy and fisheries expert. Days went quickly, busy on medevac runs when security clearance was given, ferrying severely injured to the hospital, many with tetanus and early gangrene and wound infection. At other times there was planning with water and sanitation engineers to restore damaged wells or rig up India pumps for a supply of safe water, since many of the nomadic tribes people of the Dinka and Nuer clans depended on herds of cattle and goats for their survival. Every six or eight weeks time off was given for rest and recuperation, flying to Nairobi across the Equator and perhaps on to Kenya's Masai Mara, Zanzibar or Mombasa for a few days. Because of the stress of field work, in the presence of much visible injury and death and sometimes bombing threats or rocket fire in the field itself, considerable attention was given to expatriate healthcare and psychological monitoring. Malaria was a constant health hazard in the rainy season but accidents were fortunately rare.

The missions spent with the Protection teams in the ensuing seven or eight years, visiting political prisoners in Asia, the Caucasus and the Middle East were of a totally different nature, demanding some knowledge of public health and skin diseases, especially with recognition of conditions such as beri-beri, scabies, tuberculosis and nutritional deficiencies. Sadly too was the evidence of ill treatment and torture, matters which needed to be handled with extreme diplomacy and discretion. The efforts to engage in meaningful dialogue with prison doctors, without appearing judgmental and being aware of their own difficult position, presented more challenge. Later on other members of the delegation were assigned to raise issues at both State and diplomatic level based on reported findings of the Protection teams. While there was certainly personal satisfaction in being able to conduct an amount of compassionate healthcare, much of the work was fraught with elements of frustration and helplessness in the face of real war situations (bombing and rocket fire, bicycle bombs in crowded markets, checkpoints with armed militia etc) and the attendant natural fear reactions such situations evoked. One had always to realise that whether it was to rescue casualties of war or bring some outside contact to prisoners, there was no realistic likelihood that these actions would change the minds of those having the authority to proscribe war or indeed take it upon themselves to extract information, from those in their custody, by whatever means and in contravention of international humanitarian law.

The concept of privilege in being able to work with the International Red Cross, the experience of living and working among many different cultures and the safe return to my family and family medicine in Ireland, almost physically and psychologically in one piece, has provoked the persistent search and yet to be attained goal, recognised by Schweitzer as 'peace'.

There is currently a search for any Surgeon Noonan archive material (newspaper features/clippings, photographs, written accounts of placement experiences, whatever is out there, etc) with a view to the following:

(1) Documentary Film - Covering the history of the society, annual fund raising activities & events, the actual placement experience, the different sites/locations to which the students travel to, the stories behind the locations & beneficiaries, etc.

(2) Exhibition (in association with The Jennings Gallery in Brookfield/UCC) and Book - Compromising photographs & reflective pieces written by previous Surgeon Noonan participants.

They would be grateful to receive any materials/information that former UCC graduates/Surgeon Noonan participants may have.

The projects outlined above would hopefully serve to (a) raise Surgeon Noonan's profile, and (b) generate some welcome funds for the placement sites/locations.

Any help/input would be gratefully appreciated. Please contact Alex Kelleher on Mob: (087)9619382 / Email: kelleher_alex@yahoo.ie with any relevant details or queries.

Dr. Fergus Moylan

What's New State Side?

Back in the 1980s when I was working at Tufts Medical Center in Boston it was part of my duties to attend the Pharmacy Committee meetings. The chairperson was a very prominent physician, department chief and editor of the New England Journal of Medicine. One particular meeting was singularly discomfiting since the chair's son had committed suicide three weeks previously. After we had muddled through the meeting I had a second meeting with my own department chief. When I related to him what had just transpired he commented:

"I once had lunch at the Harvard Club with the other three chiefs of Pediatrics in Boston and I was the only one who had not lost a child to suicide."

One would have thought that being the Chief of Pediatrics in a major medical center such as Boston would inure one from the ravages of such personal loss. But they were, despite their medical advantages, just as incapable as everyone else to protect their families from the fatal consequence of mental illness.

Suicides are not what the practicing physician deals with since by their very nature they are fait accompli and as such are relegated to the responsibility of total strangers, ambulance personnel, police, pathologists and undertakers; lost to all in the medical profession except for the medical statistician. Rarely, however, do the unfortunate victims lack medical care. In fact, when one considers the above, they may have shared their short lives with the medical profession's finest.

In the 25 years I have been in general pediatric practice suicide has been by far the most common cause of death in my patients. All but one had been at one time under psychiatric care for Bipolar Disorder. Some had died by their own hand e.g. drank "anti-freeze"; others had died as a consequence of suicidal behaviour e.g. doing motorbike "wheelies" in the middle of the highway. Yes, some had been drunk or on drugs. One hanged himself in jail. All had left behind shocked, confused and deeply wounded families. They also left behind a shocked and confused medical profession, deeply at a loss as to what part it had or had not played in a family's greatest tragedy. The general practitioner says "Well, I sent the patient to the psychiatrist" while the psychiatrist says: "He had not been keeping his appointments." The families search for answers and they are told there are no answers. The newspapers report that the victim had been despondent recently over the loss of a job, a relationship, or some such vicissitude of everyday life.

How can such loss of life occur within plain view of the medical profession? A perusal of the medical literature would suggest that these final fatal acts are a function of unpredictable, impulsive behaviour and as such not preventable. Why then do children commit suicide and can they be prevented? I don't profess to know the answer but I do know that Bipolar Disorder, which was the explanation in most of my patients, is a diagnosable and treatable condition.

Sixteen years ago I gave a talk to Neurology Grand Rounds at UCC on ADD or as it is now known ADHD (Attention Deficit Hyperactive Disorder). I still remember the look of recognition on the faces of some of the audience. I also remember some of my slides which contributed to that look of recognition ("When they are good they are very, very good and when they are bad they are horrid"). Little did I realise at the time that an article was in preparation for publication by the Pediatric Psychiatric Department at the Massachusetts General Hospital which would refute that particular statement. What the authors of that article discovered from a review of nearly nine hundred patients referred to them was that many children who present with ADHD also have bipolar disorder (BPD) and that nearly all children with BPD have ADHD.

Further reports suggest that two thirds of those with BPD can date the onset of their symptoms to when they were children and in one in six as early as preschool. In addition, in contrast to adults who go through weeks or months in a manic, hypo manic or depressed mood, children can have rapid cycling between these moods within the same day.

What constitutes mood swings? These are inappropriate responses to something that might be funny or irritating. They result in disproportional responses, either fits of laughing or crying. Or as a patient of mine described it when I asked him if he was moody: "I go from being really happy to really angry with no in between". Another complained that she "was really happy and then the least little thing pisses me off". In general, bipolar children are extremely irritable, difficult, unhappy children who are impossible to please. Unpredictable emotional "meltdowns" are common. They rarely exhibit mania and when they do it usually goes unrecognized, often being dismissed as just an extreme version of their hyperactivity. They tend to be excessively talkative, argumentative and beyond the reach of reasoning. There are times when they are silly, goofy, over the top, happy go lucky. Since most of them have ADHD this is usually the explanation given for their behaviour. When they are put on stimulants (which is the standard treatment for ADHD) their initial response, if you are lucky, is short lived or as is sometimes the case they become unbelievably irritable, since the stimulants may activate their BPD. How common is BPD? It used to be thought to be 1% of the overall population. However, since nearly half of depression in children, which is 10%, is in retrospect found to be BPD, the incidence is probably closer to 4%. That means that in any classroom of 25 kids there is probably one potential case of BPD. You may say: "This is just a figment of an overheated American imagination? None of this was there in my day". Well, it was there in my day. In elementary school I had a classmate who ended up in residential care. And in boarding school I had a classmate who committed suicide. Both were bipolar.

Earlier this year I had a fourteen year old transfer to my practice because his mother liked my office staff (my secretary is from Connemara). I had a quick look at his chart, enough to realize that I had my work cut out for me. He sat across from me angry, hostile and unfriendly. According to his mother and the record he had been seen repeatedly for the previous seven years in Boston for encopresis (fecal soiling). He had been hospitalised twice to clean him out,

once for an intestinal biopsy and manometric measurements. In fact, he had never been continent. He had already missed fifteen days of school that year as a consequence of his fecal accidents and having to keep appointments with the gastroenterologist in Boston. Eventually, since many of these visits became heated exchanges either with the doctor or his mother it was concluded that there was a psychological underpinning to this intractable problem. He was referred to a very good child psychologist who diagnosed him as ADHD and recommended that he be started on stimulants. This he adamantly refused in another heated exchange and the psychologist asked him not to return. Well it was clear to me at first blush that this was a very angry kid with a lot of family pathology (one brother was in jail). When I asked if he was ever a "happy camper" and learned that yes he could at times be happy go lucky I pushed a little harder. Could he be goofy, silly, over the top happy? Oh yes! This line of questioning, I could see, seemed to them not only puzzling but irrelevant. They had come to have his encopresis and his ADHD treated. They were definitely not prepared for what followed. I explained that I believed he was having mood swings; in fact he could be bipolar and as such not a good candidate for stimulant treatment. At this he got up and left in disgust. His mother looked totally deflated. It was as if he had sucked all the oxygen out of the room. When she had recovered a bit I explained to her again why I thought he was bipolar and why it was inadvisable to treat him for his ADHD without addressing this first. I then suggested that she return when he had calmed down, since I was familiar with bipolar patients storming out of my office.

However, having said that I had to admit to being surprised, considering how angry he was, when he showed up a few days later with his mother. I explained to him why I wanted to stabilize his moods before I addressed his ADHD and that I was not even sure that his ADHD needed to be treated. He agreed to a trial of a small dose of one of the new second generation atypical antipsychotics. Of course, I did not put it exactly like that. No parent, not to mention an extremely angry adolescent, is going to embrace the concept of taking an atypical antipsychotic no matter how small the dose. So I told them that it was a mood stabilizer (which, of course, it is). Sure! That sounds harmless enough, especially since these medications are currently being heavily advertised in the United States for the treatment of adults.
Two weeks later he returned and looked like the cat that had swallowed the canary. Did he like the effect? Yes. Did he want to continue to take the medication? Yes. But, as his mother explained, he was still struggling with his ADHD and wanted to be treated for it. I put him on a two week trial of increasing doses of a standard stimulant used in the treatment of ADHD. Again, to my surprise, he returned. It worked. And he wanted to continue to take it. But, as his mother explained, he now wanted to be treated for his encopresis so he could attend school.

Eighty percent of children with encopresis still have the problem six months after the initiation of medical intervention. For a sizeable proportion of children the toilets in American public schools are a refuge of last resort. Bearing this in mind, I put him on a daily laxative which was tasteless, effective and could be added to orange juice etc. He was to take this when he got home from school, thus avoiding the need to use the school toilets.

Four months later he was attending High School, getting average grades and though he was still having fecal accidents they were infrequent and not at school. All the tension in his face which had up to this defined him was gone. He was a different person, a happy person. I asked him: "Have I been able to correct all that was bothering you?" His conceded: "Pretty much."

On a daily basis I see patients whose parents struggle to make their children happy. No matter what they do it is never enough. And yet there are times when everything seems to be as it should. But it never seems to last. They work on the basic premise of all accepted good parenting: the more I do for my child the happier my child will be. And the more difficult the child the harder they try, for it is a commonly held belief in United States that failure is a function of inadequate effort. So they try harder. Mothers blame themselves and the entire world is willing to let them. The sad fact in my experience is that no matter how outrageous the child's behavior the medical or the mental health professional consulted is unlikely to diagnose their condition as a mood disorder. They will blame the behaviour on ADHD or ODD (Oppositional Defiant Disorder, a common feature of BPD) but they resist labeling it bipolar. And so it goes undiagnosed and untreated.

My son once pointed out to me that this was the first time in human history when the younger generation was teaching the older generation. He was referring, of course, to the age of computers. But it is not just in computers that they are running rings around us but in the area of common behaviour problems. Their everyday language reflects a comfortable familiarity with OCD (Obsessive Compulsive Defiant Disorder), ADD and Bipolar Disorder. Time and again when I ask a patient what they think their diagnosis is or what their friends think of them or when I suggest to them that they may be bipolar their response is often confirmation of what they and their friends have suspected for some time. "He's so bipolar!" is a comment in common usage in the schools and in my estimation it is frequently used correctly.

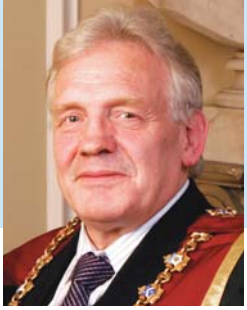
Fifteen years ago I began to prescribe a lot of inhaled steroids for respiratory problems. Frequently the parent would ask whether this meant their child was asthmatic. I would and still do hide behind such diagnoses as "Reactive Airway Disease," "Respiratory Allergies" or "Exercise Induced Bronchospasm." And when these fail to satisfy the parent I say: "Let's not worry about what it is called," preferring to focus more on the relief of symptoms and less on the semantics of diagnosis. This approach must have some validity since I cannot remember when I last hospitalised a patient for asthma.

It is debatable whether all the patients I treat are bipolar. Certainly most psychiatrists are reluctant to relax their criteria, feeling that the patient must be by definition manic, a state less likely to occur in children. The psychiatrists are only seeing the tip of the iceberg, the 1% versus the estimated 4% thought to be the real incidence. Could it be that, as in the case of asthma, a willingness to recognize that mood swings may be more frequent than previously believed and a readiness to prescribe the newer, safer and more effective second generation antipsychotics, might result in fewer hospitalisations, less suicides?

Recently I asked a noncompliant patient of mine what would happen if he stopped taking his medication. His answer was clear: "I wouldn't last long."

And so it goes, another profound observation by a child seeking medical intervention in his every day struggle to be seen, recognised, treated and healed.

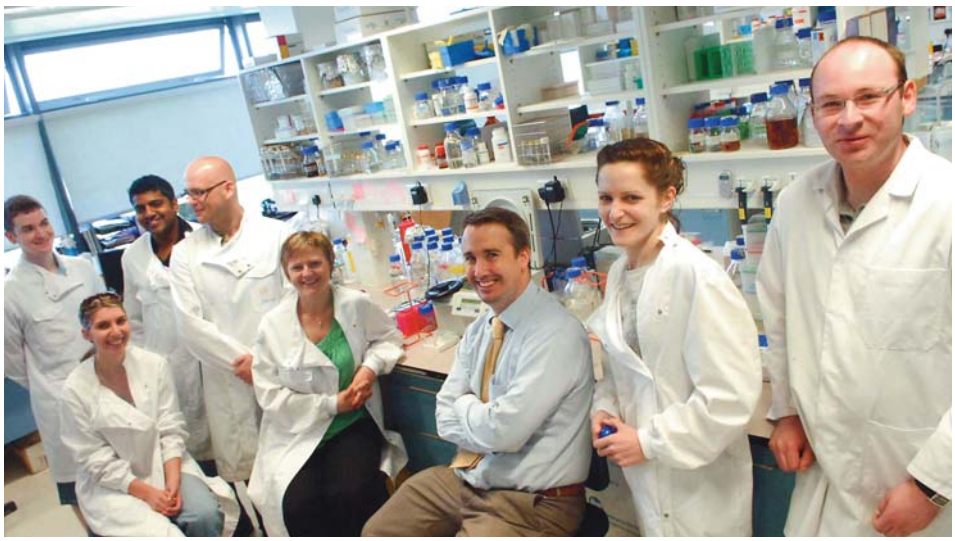
Prof. Gerry O'Sullivan



"The best way to predict the future is to invent it"

Predicting the future in cancer research is difficult but there is cause for optimism. We have come along way in the last ten years and the pace of discovery is accelerating so we should anticipate significant progress over the next decade. While the disease burden will remain significant in the community several of the cancer types that are today incurable will be controllable within the next ten years. But the demands are also going to be greater. The life expectancy of the population will increase. With increasing age there is an increased incidence of cancer and here current therapies are either less successful or less tolerated because of their invasiveness, toxicities or because of a lack of patient fitness from co-existing diseases. Thus a continued goal is the development of treatments which are more effective, safer and applicable to patients compromised by infirmity or advanced disease. Progress is more likely to come in small increments in many separate areas rather than in a single major breakthrough.

Cork Cancer RESEARCH CENTRE

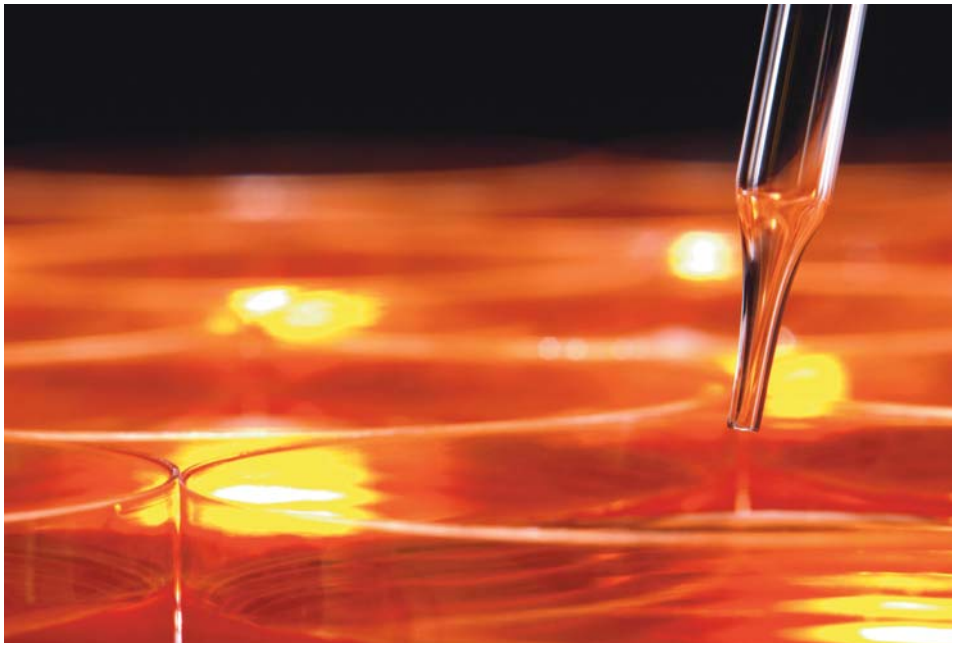


Staff of Cork Cancer Research Centre

Developments arising from the human genome project and from the widespread application of high throughput gene based analytical technologies are already having a significant impact in the clinic. For some patients the risk of developing specific cancers can be predicted making the selective application of surveillance tests or preventive therapies both efficient and effective strategies. There will be a greater emphasis on personalised treatment. Many patients will be treated based on a predicted responsiveness of the cancer derived from its molecular profile. Thus while there will be a more rational usage of toxic or invasive therapies there will also be the immediate recognition that many cancers are resistant to current treatments. Recent developments in Cork Cancer Research Centre (CCRC) give hope that new approaches will shortly be available for some of these recalcitrant cancers. From the cancer cell death studies, mechanisms of drug resistance have been defined and already there is the promise that within the next few months a clinical trial will commence on a new treatment approach.

Rational drug design for cancer treatment is a field of great promise. The concept that molecules may be designed to specifically interrupt cancer dependant pathways or mechanisms, with advantage, and without collateral injury to normal tissues has been proven for some cancers. However most tumours do not depend on a single mechanism or metabolic pathway and much work remains to be done to bring designer type drugs into multi - agent treatment protocols.

Pursuant to the understanding of the biological processes involved in tumour growth, spread and host responses thereto, several new types of biological treatments are under development and some are already at the stage of clinical application. Immune, gene, cell and viral therapies have now been developed for specific biological targeting. There is compelling evidence that many tumour types can be forestalled by the immune system and vaccines are reaching trial particularly for melanoma and prostate cancer. In the CCRC we have developed a vaccine for prostate cancer that could achieve clinical application. Successful gene therapy of cancer is now a realistic goal. Already we have established that gene therapy may be used to induce production of immune molecules by the growing cancer cells and thus establish immune control over the cancers. This is particularly effective in the control of secondary spread and should eventually have a central role as an adjunct to surgery or other treatments. Viral based therapies of cancer have now achieved clinical trial status. The viruses are modified to become non pathogenic, to enable gene therapy and to selectively replicate in the cancer cell thus killing the tumour cell after modifying its immune function. It is likely that these will be clinically applicable within the next few years. The stroma is the non cancer component of the growing tumour and is derived from



cells that migrate there from the bone marrow. These cells differentiate to become blood vessels, collagen producing cells etc thus providing a scaffold and blood supply that enables three dimensional growth and spread of the cancer. The growth of these stromal components may be targeted for treatment – particularly the new blood vessels and is the basis of the anti angiogenic therapies which are now used in treatment. There is a continued exchange of cells between the bone marrow and the tumour and these cells are amenable to modification to transport toxic molecules and viruses into the tumour. In our laboratory non pathogenic microbes have also been modified to selectively propagate in the tumour suggesting the possibility that an off the shelf cell therapy.

In the treatment of solid tumour cancers surgery remains the most successful modality of therapy whether used alone or combined with radiation and chemotherapy. Major surgery however can be debilitating and is not applicable to many patients because of fitness or disease stage. The power of procedure based treatments can be expanded by development of minimally invasive methods to ablate tumours and to regionally deliver appropriate therapeutics. Electrical drug (Electrochemotherapy) and gene delivery has been introduced to Ireland by the CCRC and brought through preclinical evaluation and clinical trial. We have now developed new technologies and systems that will allow endoscopic delivery of drugs and genes to internal cancers. This form of treatment is highly effective, has a low toxicity and invasiveness and should include patients that heretofore were not treatable.

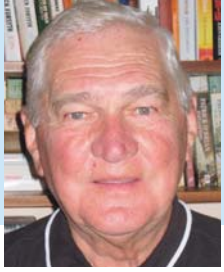
Prof Albert Deisseroth in a recent interview said "There is a revolution happening in cancer research and Cork is at the centre of that revolution" a generous appraisal by the eminent internationally acclaimed American scientist. Indeed we can be at the centre – we now have a solid platform on which we can build. We have the conviction, the scientific capability, the high standard of clinical cancer care in the region and the public support to realise our objectives. Over the next few years we will expand our laboratory to more than twice its present capacity, we will increase our academic staff complement, we will engage further with the cancer prevention clinic to enable development of rational preventive approaches for at risk people, we will expand further with the clinical research centre the conduct of clinical cancer trials which will not only evaluate new therapeutics but will inform our research. The cancer question will only be resolved by the scientific method and in Cork we have the capability. We can make a difference through conviction, collaboration and inventiveness.

Profile:
The Cork Cancer Research Centre (CCRC) is a multidisciplinary organisation that provides a research partnership between the University and the Cork Hospitals. Its mission is to investigate major issues that concern the genesis, progression or treatment of cancer. Its purpose is to provide discovery and innovations that may be applied to the prevention of the cancer in the first place or to the development of more effective treatment strategies. Its foundation is based on the unshakeable belief that the cancer questions can be resolved and that in Cork we can create the capability to make significant contributions.

Cancer research is a continuum from basic investigation through to clinical application. In our Centre we foster such an environment: Where there is an interactive atmosphere conducive to collaboration between investigators of differing skills and profession; where we have the human and technological resources to provide high standard penetrating research; where inquiry and innovation are relevant to knowledge creation and clinical application. In addition our Centre and programmes benefit from collaborations and shared studies with investigators in Cancer centres in Europe, United Kingdom and USA.

Since its inception in 1999 the Centre has been a leading force in developing new treatments. Current research at the Centre is mainly directed towards the critical challenge of secondary cancer and is directed at three research themes: Cell Death and Survival Mechanisms, Novel Therapeutics including gene therapy, clinical delivery, in addition there is a significant and expanding programme on cancer prevention and education.

Dr. Frank Golden



Memories of an Applied Physiologist

'My God it's cold. How the bloody hell did I get myself involved in this torture?' All the scientific thoughts that my poor brain may have contained before I jumped into the water were quickly replaced by questions like: 'Why would any sane person, voluntarily throw themselves into 10°C water just to find out more about the effects of cold water on the body?' 'How much longer must I endure this agony?' Once the initial shock had declined - as the skin thermal receptors habituated to this horrible environment, leaving just the more tolerable deep cold pain and the discomfort of uncontrollable shivering - I began thinking of those unfortunates who have had to endure these conditions without the comfort of knowing that they could get out and have a warm bath anytime they wished. I also developed a better understanding of those frightened individuals we rescued from the sea and how ignorant I had been about the stress they had undergone and were still enduring when we got to them. Even after rescue some of these poor individuals died despite my best interventions. My associated guilt was the catalyst that started me thinking of the physiological changes that were occurring during cold-water immersion and after rescue.

In my case, as a first year medical student in 1955, and even later on graduation in 1960, if anyone suggested to me that I would wind up practicing Applied Human Physiology, I'd have laughed at their poor judgement and even offered them odds of a thousand to one that they couldn't be further from the truth. How wrong could I have been? Of course I never envisaged a 'Road to Damascus' life changing experience would come into the reckoning along the way.

As a young impecunious doctor working in London, on the advice of my Bank Manager, I took a short-term commission with the Royal Navy Crew with the promise of a financially rewarding tax-free gratuity after 3 years. In one of my early postings, while working as a G.P. in the Naval Air Station in Cornwall, I was involved intermittently in Air-Sea rescues - including the 'Torrey Canyon' super tanker in 1967. Apart from some 'nail-biting', 'sphincter-testing' moments, some of these rescues proved both interesting and challenging from a medical viewpoint. But it was the helplessness of not knowing what to do with some of those who died, either while being winched up to the helicopter, or shortly after arriving in the back of the aircraft, that proved to be the cathartic experience that led to my interest in physiology. Neither medical textbooks nor calls to various local medical consultants proved enlightening as regard possible mechanisms other than 'hypothermia'. That conundrum led to my interest in physiology.

In a subsequent posting to the RN Air Medical School in Hampshire, I discovered a refrigerated pool under the floorboards of an out-building, that had been used in the immediate post WWII years for the development and testing of protective immersion suits for aircrew. At last, rather naively, I saw a chance to put some ideas to the test!

It was while undergoing one of those auto experiments, enduring the suffering described above, that one day the 'laboratory' door opened and an elderly, diminutive, shaven headed character, wearing rather dilapidated clothing and looking as if he had just been released from 'Belsen', appeared with my then Boss at the pool side. He wouldn't tell me his name at first but said he just wanted to see what was going on and ask me some questions. I tried as best I could to explain what I was doing, and why, but unfortunately my replies were rather unintelligible due to the intense shivering of my jaw.

After a warm bath, and still unaware who he was, we resumed the conversation over a cup of tea. He clearly had an enormous depth of knowledge on the subject of cold-water survival, most of which, embarrassingly, was new to me but his main interest concerned the background to my interest. After about an hour we were formally introduced; it transpired he was the famous Professor RA McCance, Professor of Experimental Medicine in Cambridge. Although world renowned in the area of nutrition; during the war years, in conjunction with his equally famous colleague Elsie Widdowson, they did the underpinning research to provide advice to the British Government on the dietary requirements for the besieged population of Britain in WWII. (A diet that most specialists in preventative medicine would like to see reintroduced). His interest in thermal physiology dated from the war years when as Chairman of a subcommittee of the MRC, the RN Medical Survival Committee, advised the Admiralty on matters relating to the physiology of survival at sea. This topic was a matter of some concern at the time given the enormous loss of life in the North Atlantic convoys. It was through his encouragement that I began a long journey as a part-time student, under the supervision of Professor GR Hervey at Leeds University, towards attaining a PhD in Applied Physiology.

Initially I spent three invaluable months in Professor Ron Linden's well-known cardiovascular physiology department, learning 'experimental method'. Thereafter, my seven-year study time was interspersed between some infrequent laboratory work and Naval duties. These included: some general practice; teaching & training; working on a variety of practical questions relating to everyday military 'medical' problems and assisting with air and marine accident investigations, etc. At that time I was also providing advise to the UK Government on Merchant Marine safety matters – co writing the syllabus for the Merchant Navy sea survival training, that is now also in use in Ireland and several other countries - as well as advising the North Sea Oil industry, which was in its early days of deep sea oil exploration, on thermal related issues

In many situations, knowledge gained from literature surveys, or straightforward data gathering – including interviewing many survivors of 'helicopter ditchings', sailing, fishing, or shipping incidents – was sufficient to answer the questions. Many others, however, required some applied research in order to devise a practical solution, e.g. the cause of some injuries in aircrew; working in flooded compartments of ships; cooling in divers; crew fatigue in long duration helicopter flights; etc. However, of more direct interest to me

were matters related to sea survival, especially in cold environments. This was not only limited to simply gaining a better understanding of the physiological changes occurring but also to applying that knowledge in devising potential lifesaving strategies and protective equipment. Such problems varied between: hypothermia and drowning (both through research and treatment of patients in the local Naval Hospital); cold water swim failure; liferaft, lifejacket and survival suit development & testing; 'non freezing cold injuries'; dehydration during arduous exercise in extreme cold environments; etc. All of this work combined a mixture of laboratory experiments and field studies, sometimes in fairly arduous conditions - including a week at sea in a drifting liferaft living only on survival rations, and living in the field in Northern Norway in winter for a short time. Regrettably, the military nature of much of this work impeded the freedom to publish in the open literature – the 'Cold War' was still in full swing – nevertheless, at the end of the day, there was great satisfaction from finding the right answers and seeing the lifesaving advice and measures working.

My PhD work on the physiological changes in immersion hypothermia involved: both laboratory and field human experimentation; the creating a mechanical model and subsequently – with considerable help from a Cambridge mathematician – a computer model, leading finally to an animal model to convince some of the 'grandees' of the Physiological Society who were somewhat sceptical about the modelling results. This work proved to be most rewarding as the variability between "subjects" was much more controllable than with humans!

The animal research involved a reasonable number of experiments on anaesthetised pigs (40kg) at the 'University Farm', situated between Leeds and York, where I set up a laboratory containing cold and hot water tanks. This proved to be a major logistical exercise that would never have been achieved without the assistance of a very able Lab technician. How I wished at times to be based in a convivial academic department with a fully equipped laboratory at hand, rather than a 'shed' in a distant rural pig farm. Despite this inconvenience the results proved rewarding. The modelling hypothesis was supported while the long accepted explanation for post rescue collapse and death provided by Nazi experimenters at Dachau was rejected. In addition, some data taken to ensure that the animals remained in good physiological state throughout their immersion, serendipitously, provided a major clue to discovering the answer to post rescue problems, viz. hypotension following hydrostatic decompression. A very welcome secondary benefit was the discovery that all traces of anaesthetic evaporate from an anaesthetised pig during roasting and did not in the least detract from the succulent taste of young, meal-fed, animals. This finding won me an enormous number of friends in the physiology department, many of whom I was only briefly acquainted with, nor have seen since! Regrettably, human experimentation has no such secondary benefits although in a scientific sense can be equally rewarding.

The results from the pig experiments subsequently led us to the development of a practical rescue method of lifting the victim horizontally from the water. This device is currently used by many Air Sea rescue organisations, worldwide.

Not long after finally completing my PhD, my time was almost totally devoted to the subject of 'Non Freezing Cold Injury' (NFCI). I had previously encountered a few cases of NFCI after one liferaft trial, and a few in some Royal Marines returning from winter training in Norway, but nothing compared the hundreds that occurred in the Falklands War. My immediate task was to devise a practical diagnostic screening technique to classify the degree of residual clinical injury in returning troops and to formulate a management policy. Regrettably the literature relating to 'Cold Injury' was not a great deal of help as it centred predominately on 'Freezing Cold Injury' ("Frostbite"). Sadly, while the physiological testing of a large number of Falkland veterans provided a better understanding of the mechanisms of the clinical complications of NFCI, we were unable to identify the precise underlying pathophysiology and thus provide a definitive treatment. The hunt is still on.

In a hierarchical organisation such as the Navy, with progressing seniority and the associated slow, but inevitable, decline in cerebral capability, I became more involved in administrative matters, including the management of the Navy's Haslar Hospital. However, following my retirement from the Navy in the mid '90's, I was fortunate to be invited by Professor Tipton, to work with him at Portsmouth University. At one time he was my PhD student – who did some brilliant work on helicopter underwater escape in our laboratory. Subsequently he became a very close colleague in much of the later work on immersion matters. Obtaining funding for experimental work in physiology has always been difficult but with the growing interest in genetics in recent years, even the microbiologists are complaining. Currently, support for whole body physiology is well nigh impossible other than from the military or industry. We were lucky to get some funding to support work on cold injury. Sadly the hunt for an appropriate animal model has been fraught with problems from the outset, but at least it has led to it some promising collaborative work with the pharmacologists.

As the dusk of life approaches with incremental speed and with it a tendency to reflect from time to time - particularly with a glass of fine wine in hand - on how one's career has evolved over the years. I often regret that I didn't pursue a career more directly involved with hands-on healing, but then if I did I would never had such an exciting, interesting, and generally enjoyable life as it has turned out to be. In the course of my lifetime I've had the great privilege of attending many international scientific meetings, assemblies and dinners, conferring with many historical notables in my field along with explorers and humble brave fishermen. The more I reflect the more I wonder at my luck in becoming involved in a career in applied physiology.

Mr. Michael Hanna

Change is on the way for the Health Service in Cork and Kerry

During the past year, a major change project has been underway to reconfigure the way health services are managed, organised and delivered in Cork and Kerry. It falls within the wider transformation programme of the HSE that includes similar reconfiguration projects in the North East, the Mid West and the South East.

These projects are essentially following through on reviews of acute hospital services undertaken by consultancy firms Horwath and Teamwork in 2006 and 2007. The principles are simple:
• put the patient at the centre of the health service;
• concentrate complex care;
• deliver as much non complex care as close to the patient as possible;
• bring consultants together into regional specialty teams;
• build an alliance with higher education and research.

The difficulty lies in changing hearts and minds to make this happen with no extra resources. In Cork and Kerry we have a fragmented service in which hospital loyalties take precedence over patient needs. This means the larger hospitals grow at the expense of the smaller ones and the bigger centres of population suck in disproportionate resources from rural communities. We are used to complaining about Dublin taking a disproportionate share of the cake but Tralee can say the same about Cork.

Nobody would quibble with the principles listed above: they are evidence based, they are international best practice and above all, they are person centred. The problems start when you try to balance them. Start by putting the patient at the centre of the health service. That means the patient who lives in Glasheen and the patient who lives in Allihies or Rockchapel; that means the elderly patient with mysterious aches and pains and the patient with a rare form of cancer; that means getting consultants to develop their subspecialties and operate a general medical rota; if you are a consultant it means working in the tertiary centre and providing regional outreach. Or take our present buildings: we have a modern hospital at Wilton, modern in parts and maybe not quite so modern in other parts, like the curate's egg. We have the Mercy University Hospital in a cluster of buildings a stone's throw from the River Lee which catastrophically broke its banks last November just outside the entrance to the A&E department. We have the South Infirmary and Victoria University Hospital sharing different histories of an older Cork. Then there are Mallow and Bantry, small but dearly loved, providing vital service to their communities and excellent care for many patients. In Tralee we have Kerry General, a smaller version of CUH, the only general hospital in Kerry, an icon for the Kingdom but a long way from the cities of Cork or Limerick. So we have problems of geography, problems with facilities, problems with custom and practice.

Within Cork city, there was a major attempt to integrate hospital services in 2002. The Acute Hospital Planning Forum carried out a major planning exercise that made detailed recommendations on how the three hospitals might work together more effectively in relation to development of staff and services. Hospital management and clinicians agreed to work more closely together. Some resources flowed – Cork University Maternity Hospital was built, CUH and MUH got new A&E departments, and a new Cardiac Renal tower is due to open at CUH later this year - but nothing fundamentally changed in how services were organised or delivered. Formalised structures for cooperation promised in the report were stillborn.

How do we make it different this time? First, our population is getting older and our health status is under continuous threat from unhealthy lifestyle behaviour, so the pressure on our health services is increasing inexorably. We had a presentation of age demographics at a meeting recently. The presenter pointed to the left hand side of a steadily increasing stack of histograms and commented memorably "This is where we are now, working" and then to the right hand side "and this is where we're going, sick". Each year the screw turns tighter and each year the distance it turns is a little more. The HSE is keenly aware of this as it presses ahead with an ambitious transformation programme and its new Directorate of Quality and Clinical Care seeks to make real the role of clinical director as envisaged in the new Consultant Contract 2008. Secondly, HIQA is developing its credentials as a quality watchdog with some teeth. (Nobody who has been the subject of a HIQA inquiry will want to repeat the experience.) Thirdly, there are no more resources – and everyone knows it. In fact, there are less resources so we simply have to use them better. So the context has changed and the imperative for reform is stronger.

UCC's Professor of Obstetrics and Gynaecology, John Higgins, was appointed Director of Reconfiguration in March 2009 and charged with turning the Horwath and Teamwork Review into an implementation plan for Cork and Kerry. He was given some funding to put together a small team of health professionals and administrators and told to publish the Horwath and Teamwork review and take it from there.

What has happened in the intervening months? John began by setting up a broadly based Reconfiguration Forum consisting of all the key decision makers in the region. The Forum meets every second Monday from 7.15am to 9.00am and debates and discusses regional issues that bear on reconfiguration. Along the way it has

found itself drawn into problem solving some major current issues because it is the only forum that brings together senior clinicians and managers from Cork and Kerry in the same room consistently and regularly. From the workings of the Forum, one can see what a regional health service could be like. There has been wit and wisdom, persistence and passion and through it all a growing awareness that apparently intractable problems can be solved by thinking and acting together. In addition to the Forum, John has put together a non executive advisory board that brings together expertise and experience from a mix of senior figures in the public and private sectors. The advisory board meets every six weeks and gives of its time free gratis. It has been fascinating to see business men becoming hooked on health service reform and to realise how business approaches can help solve complex health service problems.

On the clinical side, over 40 subgroups were set up to address each medical and surgical specialty and a number of functional subgroups were established to look at such things as education and training, GP referral, a single patient chart and number, communications and theatre utilisation. These groups had consultants, nurses, therapists, patient advocates, GPs and university representatives. Their deliberations will feed into the final reconfiguration plan. Resources were also put into (Toyota) Lean training to support bottom up change in processes and into project management training to provide a cadre of managers who will have the necessary skills and training to carry through implementation of the plan - without extra pay, please note.

Another novel aspect of the exercise has been engagement with public representatives and members of the public. Last autumn, we introduced a pod of six Advanced Paramedics into West Cork as an outcome of the Emergency Services Review carried out last summer. This team is providing a 24/7 emergency service out of Bantry with their own vehicle and an impressive range of equipment. Before the team "went live" they conducted a roadshow throughout West Cork, attending schools, marts, agricultural shows, ICA events, explaining what they would bring to emergency care. People told us this was the first time the HSE had ever explained what it was doing before it did it. It was helpful to us too in a number of ways: it bonded the APs to the people of West Cork; it gave us time to think through issues raised before the service began; it gave us time to liaise with the GPs in the area and with the staff of Bantry Hospital. Now the APs work in the hospital as they await calls. Currently we are working in the same way to introduce Acute Medical Units (AMU's) into each hospital in the region. This project is being led by Dr Jennifer Carroll, a UCC alumni who has transformed the emergency medical service in St. Lucks Hospital, Kilkenny. "We teach them so well"!

The reconfiguration plan is currently in preparation and we expect it to be published in July. Prior to that we have been discussing its main recommendations with key partners so there won't be too many shocks. We are already commencing implementation planning for a number of strands so that planning will move seamlessly into implementation. We hope the plan will become a once off reorganisation of what we do, where we do it and how we do it. If we succeed, resources will be better concentrated, services will relate together in a more rational way, facilities will be used more efficiently, and we will build a mood for change in the years ahead. One of our outcome measures is to deliver 2008 levels of service with 2011's budget. That is an achievable target.

What will this mean for the training of our doctors, nurses and therapists? We want to change not just the organisation of our health services but also the culture. We want to create a culture that is forward looking, innovative and solution focused rather than problem focused, a culture where we learn from our mistakes and move on to internalise those lessons in our practice and our teaching. A colleague told me a good story yesterday about teaching students patient safety in UK medical schools. One school introduced a module for final year medical students covering clinical governance, risk management and patient safety. At a meeting of medical schools last year it was suggested that other medical schools might want to do something similar, to which certain Deans asked why they would need to teach patient safety to their students as they won't make mistakes.

Call for Submissions

For the next Newsletter and "one liners" recalling expressions or sayings of patients, staff, colleagues and land ladies from old times at UCC. I expect they will bring back happy memories and a smile to many.

Interview with Dr Con Murphy, Family Doctor,

Chief Medical Officer to the Cork County Board and Cork Senior Hurling doctor since 1976 and football team doctor since 1977.

P.C. Con, you were born on 7 June 1949 to Anna and PA Murphy (known as Weesh) and you are the first born of the family. I presume the story is apocryphal that your father – then the Cork Senior football full back and winner of an All Ireland football medal four years previously in 1945 – picked you up by the ankles – noted the distinct lack of musculature – and said to Anna no more of these and four daughters were born subsequently.

C.M. Yes Paddy, you have always said that was true.

P.C. When was your first All Ireland?

C.M. First All Ireland was in 1956 and my father was a selector. We lost that day against Galway and it was the first day I saw grown men cry. My second was the following year in 1957 when my father was also a selector and that year, famously, Paddy Harrington was wing back (he would be Padraig Harrington's father). Another loss – to Louth this time.

P.C. You went to Farranferris in 1962 where your family either wanted to make a priest or a hurler out of you to maintain the GAA playing dynasty. Neither of the above happened. You were present for the golden era of the commencement of Farranferris winning Harty Cup and All Ireland Colleges teams and you subsequently went to UCC in 1967.

C.M. Yes, while in UCC, UCC won three Sigersons plus two Cork County Senior Football championships in 1969 and 1973. Those teams included Brendan Lynch, Paudie Lynch, Moss Keane, Dan Kavanagh, Seamus Looney, Ray Cummins, Denis Coffey, Denis Cotter. I was normally confused with Ray Cummins until it came to kicking a ball!

P.C. Was it a sign of things to come that you spent most if not all of your time that time in the dug-out?

C.M. Yes, and at that time I was a selector with both the hurling and football club. We won a number of Fitzgibbons and one year I was a selector.

P.C. Exactly how and when did you become the Cork team doctor?

C.M. It happened in 1976. I was doing a years medicine down in Tralee before general practice. I came up from Tralee to Cork to Pairc Ui Chaoimh one Saturday night before Cork played Tipperary in the first round of the Munster Hurling Championship. Jimmy Barry Murphy was there and I went along with him as he was a sub the following day and Denis Conroy, Cork County Board, asked me if I was going to the match as they had no doctor. So I went and did the doctor work. The following week when Cork were playing football, Billy Morgan said you did the hurlers, why don't you do the footballers. The rest is history.

I was with Cork for nine All Ireland Football Finals. We won two of these – in 1989 and 1990. I was with Cork for thirteen hurling finals and we won nine of these. I was also the team doctor for three series of Aussie rules games both here and in Australia.

P.C. Remind us of the drama before the middle of the three in a row All Ireland Championship winning teams before the All Ireland Final in 1977.

C.M. Before the 1977 All Ireland Final in the puck around in Croke Park, Seanie O'Leary was pucking around before the match and one of the players hit him on the nose with a sliotar and made bits of his nose. I went in to the dressing room with Seanie and Christy Ring (who was a selector). Christy had one look at Seanie and said "you won't be needing your nose for playing hurling Seanie! Go back out on the field!". He went back out and Seanie then played on. Tomas O'Leary, the current Irish scrum half is Seanie O'Leary's son.

Also concerning that game, Cork would not have won except for the fact that your brother Tim had an outstanding game at midfield for Cork. During that period I was fortunate as I sat beside Christy Ring for three years. I think others might not have wanted to sit beside him but he liked to sit beside me as he considered me a good luck omen. It was fascinating to hear him. It was like sitting beside Pele for a World Cup Final.

P.C. Con, in 1983 you married Joan Nagle.

C.M. In 1983, I married my long term girlfriend and love of my life from my UCC days, Joan Nagle. We have three boys. Colm is a Doctor in Australia, Brian is an Engineer in Vancouver and Cian is in UCC.

P.C. The old saying that athletic ability can skip a generation rang true with your boys!

C.M. Yes Patrick. Thank you again for reminding me that I was so uncoordinated! I was lucky to be able to walk not to mind walk and chew gum simultaneously!

P.C. In the modern era, what were the highlights in your sporting career?

C.M. Probably Jimmy Barry Murphy's team that won the All Ireland Hurling Final in 1999. We were rank outsiders against Brian Cody's Kilkenny and we were very lucky to win on a score of 13 points to 12.

During those years, I roomed all of the time with Jimmy Barry Murphy as we were great friends.

P.C. And in football Con?

C.M. The best football win was in 1990 versus Meath under our great friend Billy Morgan of UCC days. This gave us the double All Ireland in hurling and football. Winning a Cork County Championship in senior football in 1999 also stands out.

P.C. And the biggest disappointment?

C.M. The big disappointment was drawing against Meath in 1988. There was a Kerryman as referee – we won't mention his name – but it was barefaced robbery.

P.C. Who would you rate as the best player you have seen?

C.M. Jimmy Barry Murphy without doubt in hurling and the best player in medicine was Professor Denis O'Sullivan.

P.C. You were chairman of the GAA Medical Advisory Committee in Croke Park in the past ten years. What did you achieve?

C.M. I was chairman during Sean Kelly's presidency (2002 – 2005). We introduced the gradual implementation of compulsory helmets which is now mandatory for all hurlers. I know yes that I famously stated "Urbi et Orbi" in the early 1980s when helmets were being researched and designed by a much more competent and research orientated colleague that "they would never take off"!

Secondly, during my time, we introduced the blood sub rule allowing a player to be treated while a temporary substitution was being made rather than a full substitution. This came about interestingly at a Cork match when Fergal McCormack accidentally got split by Alan Browne in 2000. He was bleeding profusely during the first half. He did not leave the field at that particular time. A reporter quite rightly pointed out that this was very poor for the image of the GAA so the blood rule was researched and designed and introduced into both hurling and football in 2004.

P.C. Your hopes for the future Con.

C.M. It would be that Cork would win the double again and Cork hurling to resume it's rightful place at the top of the hurling world and reclaim the title of the home of hurling.

Professor Fergus Shanahan awarded "David Sun" Lecture

UCC's Professor Fergus Shanahan, MD, FACG, was awarded the prestigious "David Sun" Lecture at the American College of Gastroenterology annual Postgraduate course in San Diego in October 2009.

Some 2,500-3,000 people attended his lecture titled "Gut Microbes: From Bugs to Drugs". The David Sun Lectureship in Postgraduate Education was established by Mrs Sun in memory of her husband, Dr David Sun, an outstanding gastroenterologist and investigator. The Lecturer, with a distinguished background in gastroenterology or an allied field, is chosen in recognition of his/her contribution to science and clinical medicine.

Fergus Shanahan is Professor and Chair of the Department of Medicine at UCC and Director of the Alimentary Pharmabiotic Centre (APC), a UCC/Teagasc Research Centre funded by Science Foundation Ireland and industry, focusing on gastrointestinal health and development of therapies for debilitating disorders such as Crohn's disease, colitis, irritable bowel syndrome (IBS) and food poisoning (http://apc.ucc.ie).

Picture shows: American College of Gastroenterology President, Professor Eamonn Quigley, presenting a plaque to Professor Fergus Shanahan on the occasion of his delivering the "David Sun" lecture.

Dr. Carol Dundon

North Infirmary Revisited

Last July I revisited the North Infirmary. I had been a medical student and an intern there many moons ago, but this revistitation was very different!

In 1917, the North Infirmary was asked by the Military Authorities to designate a surgical ward for soldiers returning from the Frontline of World War I to Cork. The Infirmary did this to such good effect, that Rev Mother Josephine was awarded the Royal Red Cross Decoration for the outstanding care the soldiers received. These patients were struggling to adjust from life in the Trenches, to life in the North Infirmary. No easy task!

I went to the Cork City Archives and set off on the trail of this particular period. It was totally and utterly fascinating. The only problem was the enormity of the eye catching and thought provoking material. It was hard to know where to begin. Anyhow, after many enjoyable days in the Archives, I emerged with two One Act plays. They are based on real life characters who once inhabited the Old Infirmary nearly a hundred years ago. I wanted the plays to be site specific, in other words to put them on in the Infirmary, now the Maldron Hotel.

This was not a problem. The Hotel liked the idea and said we could use the "Jack Lynch Room". This has a seating capacity for fifty people. Together with some friends we founded the "Goldfish Players", and booked the venue for four nights in July. Things were going well.

Casting had not been a problem either. The actors and actresses seemed to intrigued by the whole concept, which was, by any standards, a rather unusual one. Rehearsals began in March. They took place in three different venues all of which I liked. Firstly we met in the Pavilion of the Cork Cricket Club on a beautiful evening. This was the first reading of the plays. It was a tremendously exciting time for me to hear my plays being read by the group for the first time. I was taken aback by how well they were reading the lines. Already they seemed to be inhabiting their parts in a highly promising way. Other rehearsals took place in the old Sunbeam Wolsley Factory and the Cork Arts Theatre. But the thrill of that first reading in the Cricket Club will never leave me!

A sudden phone call from a ten year old girl caught me by surprise. Her elder brother was in the play and she wanted me to write her in as well. I was pleased by her keen initiative and promptly inserted a little girl called "Veronica" into the play. This was not as difficult to do as it sounds. Writing to order, complying with a directive from a ten year old is, in fact, infinitely easier that toying with a blank sheet of paper on which no characters have yet appeared! "Veronica" loved being part of it all.

There were two plays, "Paper Lanterns" and "Back from the Trenches". They were separate entities but were linked by a common underlying theme – the guild to survivorship. One of the plays featured the ghost of a fallen comrade. This was a disembodied voice off stage. It worked well. We also made a recording of the omnipresent Shandon Bells. These were essential to both plays. The patients made constant reference to the bells, some loving them, others grumbling about being kept awake at night by them, we also used the Bells to punctuate the Scenes and Acts. I loved the recordings and found they bought a strong atmosphere into the room. I felt we are starting to get very close in our bid to recreate the Infirmary of 1917.

One spot of bother was the "Coronet". This is the larger swanlike headgear worn by the Daughters of Charity in those days. I could not locate a coronet in Cork or Dublin. We ended up having to send to London for one as they appear in "Phantom of the Opera". It duly arrived in a big cardboard box to our wild excitement. Now the show could go on! We bought endless cans of spray on starch and sprayed the Coronet at least twice a day during the production. The actress playing Mother Josephine looked very elegant in it. She used to get a spontaneous clap when she appeared on stage. She was also clapped when she was coming down the main staircase. Her evanescence every evening lent an air of mystery to the proceedings. Props of that vintage mounted at an alarming rate, thanks to our hardworking stage manager. Packets of Woodbine cigarettes were bought in – one of the packs got smoked by an outsider during one of the rehearsals. Old fashioned sweets, bottles of lavender water, handmade Christmas decorations were all in abundance. I had written in a bowl of apples and oranges in the script, which were at least contemporary – so that was easy!

Photo of actress playing role of Mother Josephine wearing the traditional Daughters of Charity headgear. (Actress Aileen O'Leary)

On the Opening Night, we all gathered in an upstairs room in the Infirmary. Everyone was in high spirits. I did not think anyone was unduly nervous. There was great last minute reading of scripts, and we gave the Nun's headgear one last good spray of starch for luck. Excitement was mounting as the time drew nearer. I went downstairs, curious to see who had turned up. I knew it was an unusual venue and in some ways experimental in nature. To my delight I recognised most of the audience gathering. It was great to see familiar faces. There seemed to be a very good buzz around the place as they all greeted each other. The seats filled up quickly and before I could take it all in, the show began! It was a very thrilling moment for me.

I felt I had done exactly what I set out to do. Thanks to our excellent Director and marvellous cast we managed, I feel, to bring back the spirit, mood and atmosphere of the North Infirmary in 1917. Many of the audience told me afterwards that they found it a very emotional evening, especially those people who had a direct link with the old place. Afterwards the cast were heady with delight – it had gone very well for them all. Their excited chatter bore this out.

We did the plays for four nights in all. We were feeling decidedly sad on the last night. The boy who played the Ghost was going to America, which made it even sadder. When the audience were gone we stayed on in the Jack Lynch Room until the early hours of the morning. Eventually we said goodbye to each other, as the real Bells of Shandon chimed. It was a moment of sadness, but we all felt we had pulled off our site-specific plays to our deep satisfaction. It would be nice to do it again!

Dr. Patrick Gaffney

Book Review:

Text-book of Surgery. By Patrick Kiely BSc., MD, MCh, FRCS (Eng.) Second edition (Pp 1158, illustrated, 63s.) London HK Lewis & Co Ltd 1958

Last year was the fiftieth anniversary of the publication of this book and although it is not used now it is perhaps useful to look back at the book and its author.

Patrick Kiely, or P. Kay as he was widely known, was Professor of Surgery in UCC 1942-67. The first edition of his book was published in January 1958 the second in 1959. At the time of writing as well as his teaching and administrative work he had a clinical commitment in both the public and private sectors.

It is a long book, all the work of P. Kay except the chapters on the Eye and Ear, Nose and Throat by Professor V. O'Hea Cussen. Two chapters, on Anaesthetics and Gynaecology, were omitted from the second edition. It is detailed, too detailed. For instance it takes sixteen pages to cover injuries of the ankle and foot making it difficult to discern the more important ones. Its style is simple and unadorned, as were his lectures. In description of conditions it is fluent and in summaries concise. When he uses long sentences, for instance in the examination of the patient with low back pain his exposition of what to look for is memorable and clear.

His students did not have to show familiarity with his textbook and he would have expected them to use whatever book they preferred. He did not often refer aloud to his own book. The experience of the writer who did not use it himself was not that it was widely used by fellow students but we were a small class and perhaps not typical. My copy was purchased in Hudson's Bookshop in Birmingham in 1964 so it was still on the shelves of medical bookshops at that time. One problem with it is the lack of clarity of headings. These are bold typed but in a fairly undifferentiated way so that headings for subsections are in the same type as main ones. If he was writing the book today P. Kay would probably be advised by his students how to configure it; (how much easier it is to do that today than then). More problematic is the profusion of causes for every condition, for it is not readily apparent what is important and what is not. He acknowledges his debt to other authors particularly to Walter Mercer in orthopaedic surgery, he sometimes uses WM's classifications, but he does not plagiarise him.

In a review of the book in Journal of Irish Medical Association at the time, Harold Browne notes some of the changes in the second edition; annotations about antibiotics, blood chemistry, etc, the chapters on the blood vessels and surgical conditions of the lungs and oesophagus have been revised, a summary of cardiac and other intrathoracic congenital abnormalities added. An unsigned review in the British Journal of Surgery is critical of the quality of the illustrations some of which were said not to represent the clinical condition of the legend. Sir Zachary Cope in a review in the British Medical Journal notes that "All (this book) …is from the pen of Professor Kiely... (he) has succeeded in presenting the main facts of surgery within a reasonable compass." He notes "a tendency to cling to the older outlook ... A generation ago tuberculous arthritis and the gummatous lesions of syphilis were common but today the one is rapidly diminishing, the other seldom seen. Perhaps textbooks cannot change so rapidly because some examiners are conservative in outlook".

In his preface P. Kay quotes Professor Geoffrey Jefferson of Manchester "the branches must not become separated from the tree in general surgery". P. Kay goes on to say "In other words it is essential for the student and junior postgraduate that the pieces into which general surgery is being split up should be suitably integrated. For this the general surgeon is still the most suitable teacher and there are a number of excellent textbooks of surgery available to students written mainly by general surgeons".

His book has its place on the shelf beside them.

Mr Michael Hanna

Fire & Ice - A Photographic Journey of Antarctica

"This exhibition is compiled from my collection of photographs taken throughout the 1980's and 1990's while on fieldwork in Antarctica. It includes images of volcanoes, life in the field, shots of wildlife and a visit to the historic huts of Scott and Shackleton on Ross Island, that were the staging posts for historic exploration of the continent at the beginning of the 20th century".

The Jennings Gallery recently held this exhibition of photographs taken by Professor John Gamble over many years of field work in Antarctica where he studies deep earth Olivine-bearing ultramafic xenoliths. These objects are thrown up by Antarctica's volcanoes that tap into deep veins of magma 60 km below the surface of the earth. Thus he uses natures own boreholes to retrieve fragments of the upper layers of the earth's mantle. The show however is more concerned with surface features, - the huts of Shackleton and Scott, the lonely profiles of his colleagues against the vast backdrop of Antarctica's frozen landscape where there are no markers of distance, no indicators of scale, where the eye is deceived and the spirit awed by enormous formations of ice and rock. And then there are the penguins, comic birds to look at, but as John told us, if you try to lift one up, it is like picking up a brick!

The exhibition was opened by Dr. Clare O'Leary who had to drive over from South Tipperary General Hospital where she had an afternoon endoscopy list. Clare has climbed Everest and the other six highest continental peaks; she has also treked to the South Pole and back. In doing so she followed in the footsteps of Scott himself and travelled over the routes travelled by Crean and Shackelton. UCC's Medical School is deeply privileged to have Clare not only as one of its Alumni but also as a clinical teacher and a role model for its medical students.

We had over 120 people at the launch. John's wife and daughter and many of his friends and colleagues shared his pleasure with the occasion. A number of people from the Tom Crean Society attended. Before the launch, he gave us an entertaining illustrated talk of some of his experiences and insights about this strange laboratory in which he has chosen to build his academic career. That career is widely respected and highly distinguished. He carries his erudition lightly, but it is not all of us that can claim to have a volcano and a glacier named after us.

There are about 30 images in the exhibition and we put some maps and some items of his kit into the exhibition "bunkers" in the gallery. These include an old ice axe that he found in Antarctica. Whose? We will never know.

THE Jennings GALLERY
BROOKFIELD COMPLEX, UCC

Appreciations

Dr Pat Beausang

Consultant in Geriatric Medicine, Stirling Royal Infirmary (b 1966; q University College Cork, 1991, BSc , MB BCh, BAO, MRCP (I)), died from Acute Leukaemia on 16th August 2009.

Pat, a twin to James and one of six children, was born on the 9th of July 1966 and brought up in Ballincollig, Co. Cork, Ireland. He was from a medical family, his father (Dr John Beausang) having been a general practioner. He won an academic scholarship to the Christian Brothers College in Cork City prior attending University College Cork. Pat excelled at University and won a Health Research Board scholarship for his intercalated BSc in Physiology which was subsequently awarded with 1st class honours.

Pat qualified as a doctor from UCC in 1991 and commenced his postgraduate training at Cork University Hospital. He was a notoriously hard working SHO and worked as a registrar within the Department of Geriatric Medicine at the Cork University Hospital. He had a particular gift for teaching basic, bite size principles of Medicine to students and his teaching sessions were hugely popular.

He decided to pursue a career in Geriatric Medicine and was noted by his contemporaries at the time to be meticulous, yet immensely practical. They described his common sense approach to complex medical issues as "The Beausang Method".
Pat moved to the West of Scotland in 1995 to take up a Specialist Registrar Training in Geriatric Medicine. He rotated through various hospitals including Stonehouse Hospital, the Southern General Hospital, the Western Infirmary and Gartnavel General Hospital.

He completed his training in 2000 and commenced in post as a Consultant Physician in Geriatric Medicine at Stirling Royal Infirmary. His main areas of interest were in movement disorder and orthogeriatrics but the Day Hospital at Stirling, with its multiplicity of challenges and rewards was an area of particular focus. He was modest and unassuming but had a dry and at times wicked sense of humour. However at all times he was dedicated to the care of his patients.

Outside of Medicine, Pat was a keen athlete and had previously participated in 10 km races. He was also a keen follower of football and Liverpool Football Club was the focus of this interest. In addition to football he had a very broad and detailed knowledge of sporting facts in general.

His family however was his abiding love. He met and married Cat in 1999 and had renewed his wedding vows in July 2009 just prior to his sudden illness. He is survived by Cat and his two children, Orla and Louie, whom he adored. He had taken up swimming lessons very recently to keep up with Orla and Louie.

The ceremony to celebrate his life in Stirling was attended by all the differing and varied occupations from within a hospital due to his inclusive nature and excellent wit as well as many friends and family.

As one of his friends from University stated, "I've always thought that you are lucky to meet a handful of real friends throughout your life. To those of us who knew him, Pat will be remembered as a true friend, regardless of time or distance, and we are better for having known him."

Dr Diarmuid Quinlan and
Dr Mike O'Connor

Mr KC Condon

Cal Condon who died on the 1st June 2009 was born on the 21st September 1927, the youngest in a family of seven, to Justin C. and Annie Condon. His father ("The Boss") was an auctioneer and rent collector for the town of Youghal, Co. Cork. He was educated at Christian Brothers School, Youghal, Castleknock College and University College Cork, graduating in 1950. It was at UCC he met Dr Margaret (Peg) O'Donoghue whom he married in November 1956. His Post Graduate training continued at St Mary's Hospital Portsmouth, Bury General Hospital and St Catherine's Hospital Tralee. Plastic Surgery was his chosen speciality and he spent two years as SHO at Rookstown House, Basingstoke, Hampshire, under tuition by Sir Harold Gillies and Charles McCash. While there he gained extra credit as he tied fishing flies for Gillies who was a keen angler and had success with the "Condon Specials". Subsequently he worked as Registrar with Emlyn Lewis at St Lawrence's Hospital, Chepstow and as Registrar at Rookstown House.

He completed his training in Plastic Surgery spending two years (1958-1960) working as Senior Registrar at Queen Elizabeth Hospital, Bermingham.

Following the death of his brother-in-law, Michael Kelleher, Cal took up the post of General Surgeon at the Bon Secours Hospital, Tralee, where he spent the next ten years. There were no vacant posts in Plastic Surgery in Ireland at the time.

During the latter years in Tralee the late St John O'Connell, Consultant Orthopaedic Surgeon, arranged for Cal to travel to St Finbarr's Hospital and St Mary's Orthopaedic Hospital one day a week to attend and Out Patient Clinic to do inpatient consultations

and to operate on a long list of seriously injured or burned patients. Many of these lists continued late into the night.

In 1970 Cal was appointed Consultant Plastic Surgeon and Director of the Accident and Emergency Department at St Finbarr's Hospital. He moved to the Cork Regional Hospital, now Cork University Hospital when it opened in November 1978. He established what is now a major Trauma Centre with five A&E Consultants and introduced Plastic Surgery to Cork. There are now four Consultants in the specialty.

Cal enjoyed teaching and was held in high esteem by all who were trained by him and with affection by his colleagues and staff. He was in great demand as a medico legal witness. His opinion was much appreciated during his time on the Irish Postgraduate Training Committee, the Specialist Advisory Committee in Plastic Surgery, and the Irish Association of Plastic Surgeons of which he became Chairman.

Outside of work Cal was a keen sportsman; fishing, shooting, golf and sailing were his passions. He was Captain of Tralee Golf Club in 1968 and involved with John Kelleher in putting together the land package that ultimately became Barrow Golf Club. He was a competent sailor being a member of Tralee Sailing Club and subsequently Royal Cork Yacht Club where he competed successfully. He had a memorable and "hair raising" experience sailing across the Atlantic.

Cal was a great family man and particularly enjoyed the annual family holiday in his beloved Dooks. He is sadly missed by his wife Peg, sister Peg Finn, three sons Justin, Michael and Cal and his seven grandchildren Justin, Derry, Richard, Luke, Karl, Sebastian and Hope.
May he rest in peace.

Dr TPF O'Connor.

Dr Derek McCoy

The appointment of Dr Derek McCoy as county physician to Bantry General Hospital in 1971 was a catalyst for the modernisation and advancement of medicine in west Cork. His contribution still impacts positively on healthcare in the region and further afield.

Born in Belfast, he was the only child of William and Veronica McCoy. After graduating from Queen's University Belfast in 1957, he interned at Musgrave Park and Antrim Hospitals. A further two years were spent as a senior house officer at Belfast City and Musgrave Park Hospitals before he heard the Franciscan missionaries were looking for a doctor in western Kenya.

On April Fools' Day in 1960, Derek, his wife Breda and their 12-week baby daughter Deirdre undertook the three-week trek to Nyabondo in the middle of the African bush. For 2 years, he was the only doctor for hundreds of square miles, providing medical care in all specialities. He used this experience to equip himself with a remarkable range of practical skills and knowledge in diverse Medical areas. He also demonstrated the first signs of his pioneering approach to Medicine by establishing the first laboratory service in Nyabondo.

He returned to Ireland in 1962 and worked for three months in the South Infirmary Hospital before assuming the post of Medical Registrar at St Finbarrs Hospital, Cork, under the tutelage of the iconic Prof Denis O'Sullivan. In this role, he continued his pioneering approach to Medicine by being central to the establishment of the first Renal Dialysis Unit for Munster, St Gerard's, named after his son who died aged 10 months.

His defining appointment, however, was as County Physician to Bantry General Hospital in 1971, succeeding Dr Tim O'Connell. Although appointed as a Consultant Physician, such was the range of his skills he actually performed as Physician, Obstetrician, Anaesthetist and Paediatrician at the hospital, a feat unthinkable in the modern medical era.

His dedication to this post knew no bounds, with an around the clock, permanent on-call commitment for 28 years. Despite this onerous responsibility and the financial straitjacket of dark recessionary times in the 1970s and 1980s, he was not satisfied with merely maintaining the status quo. He set about introducing new services and modernising practices.

He oversaw the establishment of the laboratory services at Bantry General Hospital. He attracted a technician back from Australia knowing if he could hoodwink the Health Board into paying her for the first month it would be well-nigh impossible to get rid of her. The Health Board obliged.

The closure of St Finbarr's Hospital and the transfer of services to Cork Regional (now University) Hospital in 1979 offered a unique opportunity to recycle equipment regarded as too dated for a new flagship hospital. Witnesses reported seeing cars returning from St Finbarr's at various intervals full of equipment which subsequently served the population of West Cork very well. Blood pressure and heart monitors used at Bantry General Hospital for over a decade were saved from the rubbish skip at the South Infirmary/Victoria Hospital. The problem of retrieving information from these monitors, which were prone to overheating, was solved by placing them in his refrigerator for an hour after use.

He established the Intensive Care Unit at Bantry General Hospital which today enjoys an excellent reputation and personally fundraised for the heart monitoring equipment that helped to save many lives. In addition, he put himself at considerable discomfort by sacrificing a Medical Registrar's post for a six-month period to purchase the first endoscopy equipment for the hospital in the 1990s. He described this time as probably the most difficult of his working life but it allowed him to establish an endoscopy service admired by many much larger

hospitals today.

He enjoyed the academic side of medicine and lectured in Pharmacology at University College Cork. As a teacher, however, he seemed most at home at the bedside, inspiring literally hundreds of doctors now practising in Ireland and abroad. There, he taught his bewildering array of practical skills honed in Africa and was a true exponent of the philosophy that one can reach any body cavity with a long needle and strong will.

He was probably two decades ahead of his time in appreciating the importance of adjusting drug doses in the face of declining renal and hepatic function and in recognising the negative impact of sedative medication on older people.

He was the physician on duty the night of the Betelgeuse disaster in Bantry Bay 30 years ago, an event that affected him deeply.

A man of action rather than words, he had a healthy suspicion of health service managers. This suspicion was fuelled further when the Health Board removed maternity services from the hospital in the 1980s. He recounted the dark irony that the maternity delivery room was subsequently converted into a storeroom with the notice "Deliveries between 9am and 12pm only".

He was a powerful patient advocate and viewed the current penchant for clinicians in management with suspicion. His feared that any dilution of the advocacy role of Consultants on behalf of their patients could ultimately compromise patient care.

He officially retired in 1999 but continued full-time until 2002 performing locum work. He was greatly honoured to be asked to officially unveil the new CT scanner at Bantry General Hospital in 2007.

In later life, he learned to fly light aircraft, obtaining his pilot's licence. As part of the Leeside Flying Group, he relished soaring in a four-seater Cessna 172. He was an inspiring aviator and, two days before his death, made his last flight over his beloved west Cork. He was commodore of the local sailing club and was very widely read, consuming manuals, almanacs and history books voraciously. As a result, he proved an invaluable reference point on the minutiae of anything from astronomy to battlefield tactics.

He is survived by his wife, Breda, sons Eamon, Diarmuid and Bryan, daughters Deirdre, Claire, Bríd and Katherine and 18 grandchildren.

Dr Brian Carey
reproduced with permission of the Irish Times

Dr Frederick Moore

Frederick Hugh Moore was born on January 22nd, 1922 in Bray, Co. Wicklow, and grew up in Dublin. He attended St. Columbas College and then undertook his medical education at Trinity College graduating in 1946. After various house jobs in Dublin he moved to Liverpool to train in Surgery.

While in Trinity he excelled at rugby and captained the senior team. He continued his interest while in Liverpool and played for Lancashire.

He went to work as a ship's doctor for six months and on his return from that went to work at the Bridge of Earn Hospital in Scotland. It was there that he decided to pursue a career in Orthopaedics. He was elected as a Fellow of the Royal College of Surgeons in Edinburgh. He continued to play rugby as a prop forward for Perthshire Academicals and lined out for the north of Scotland against the All Blacks in 1953.

He moved to Dundee Royal Infirmary in 1955 where he met his future wife Elma Rankine who was a resident in Anaesthetics. They married in 1960 at St. Andrews where Elma had attended University.

It was a chance meeting in Washington at an Orthopaedic Conference with the late St. John O'Connell in 1960 that led him to take up a new Consultant post in Orthopaedics in Cork later that year.

Orthopaedics was in it's infancy in Cork at the time and was extremely busy due to an outbreak of Polio in 1956. Fred took a keen interest in the musculo-skeletal problems of polio and paediatrics. He set up a highly successful screening programme for the early detection and treatment of Congenital Dislocation of the hip and clubfeet.

He was appointed as part-time lecturer in Surgery in UCC Medical School. He was also involved in the National Training programme in Orthopaedic Surgery. His real interest was in Paediatric Orthopaedics. Fred had a remarkable ability to relate to children and their parents.

He was a man of immense common sense who had an outstanding aptitude for choosing the correct management of the individual patient even if it meant advising against surgical treatment.

Prior to leaving Scotland Fred had taken up golf. He became a member of Cork Golf Club and represented his club in various competitions. His most glorious memory in golf must be a 'hole in one' at New Delhi Golf Club at the age of 80.

He was an active member of the British Orthopaedics Travelling Club and he and Elma enjoyed many trips with this club. He was also President of the Irish Orthopaedic Club, a council member of the British Orthopaedic Association, Chairman of the Cork branch of the Trinity College Association, Chairman of Blackrock Tennis Club and a member of St. Michaels Church Choir.

Above all, he was a great family man. He died in June after a brief illness and will be sadly missed by his wife Elma, son Donald, daughters Caroline and Linda.

Dr John Curtin

The UCC Graduates' Association offers members the following benefits and services:

- Access to a global network of graduates
- Invitation to graduate events and gatherings in Ireland and around the globe
- Mailing of UCC Alumni News and the annual UCC Graduate magazine
- Readership rights to the Boole Library, UCC. Members will need to register directly with the Library.
- Exclusive membership rates to the Mardyke Arena Leisure Centre, UCC
- Expert assistance on organising class reunions
- A choice of UCC affinity credit cards with AIB and Bank of Ireland
- Special graduate membership rate to the Lewis Glucksman Gallery
- Email for Life Service allowing recent graduates to activate their student email account
- Substantial discounts on goods and services with over 150 traders – e.g. 10% Nangle's Garden Centre, 10% Griffins Garden Centre, 10% Maher Sports, 10% Matthews Ltd, 15% Black Tie, 10% Blarney Irish Woollen Mills, 10% L'Occitaine and 10% Keane's Jewellers, 20% Cork University Press, 10% Oak Tree Press, and 10% Cremins Dry Cleaners etc.

Membership costs €100 for five year membership. To join, please forward payment (debit or credit card or cheques accepted) with your graduation details and current address to the UCC Graduates' Association, University College Cork

UCC Annual Scientific Conference 2010
September 16 and 17

Contributors Include:

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Dr Orla Crosbie

Mr Carl Davis

Prof Barry Keane

Prof Gerard O'Donoghue

Prof Ivan Perry

Dr Liam Plant

Dr Columba Quigley

Prof Cillian Twomey

Dr Fionnuala Quigley

Dr Eamonn Shanahan

Dr Paul Whelton

The Conference will also host the inaugural Mr Joe O'Donnell Memorial Lecture on September 16, at 4.30pm which will be followed by the launch of an exhibition Joe O'Donnell's artwork at the Jennings Gallery.

Registration for the Conference is Free of Charge.
The dinner at the Aula Maxima on the evening of September 16 at 7.30 will be €70 per person.

Please register for the Conference and/or Dinner at:
http://conferencing.ucc.ie/conference
or contact Rachel Hyland – 021 4901587 / r.hyland@ucc.ie for details.

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