



# Medical Alumni and Faculty

Newsletter No. 14

Spring 2016

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## Diary in Pictures



*Dr Sheila O'Neill, Dr Paula O'Leary,  
Dr Eva McCarthy*



*Dr David Flynn, Dr Jim McCarron.*



*Dr Mary Hegarty, Dr Oonagh  
Gilligan, Dr Rory O'Brien.*



*Dr Pat Cogan, Dr Marion Smith,  
Dr Deirdre Horan, Dr Donagh Hickey.*



*Dr Maeve O'Sullivan, Dr Christopher Constant,  
Dr Nell Crushell-Fennell, Dr Donagh Hickey,  
Dr Nuala Moore, Dr Eimer Dudley.*



*Dr Diarmuid Quinlan, Dr Sean Nugent.*



*Dr Coleman Fiore, Dr Brian Jordan, Dr  
Michael O'Halloran, Prof Cillian Twomey*



*Dr Cliodhna Foley-Nolan, Dr John Coulter,  
Dr Eva Mc Carthy, Dr Teresa Mc Sweeney.*



## Introduction

*Welcome to the 14<sup>th</sup> newsletter of the UCC Medical Alumni and Faculty Association.*

It's wonderful to hear from Medical Alumni at home and abroad and extraordinary how dearly people hold the memories of classmates, teachers and fellow students, even if the time spent in UCC has been decades ago. However more and more, the profile of UCC Medical Alumni has changed and expanded so that now there is a huge cohort of recently graduated alumni especially from North America and South East Asia. We would like to hear from you! Please visit the website <http://www.ucc.ie/en/medical/aboutus/medalumni/> or email [medalumni@ucc.ie](mailto:medalumni@ucc.ie).

UCC continues to lead in a variety of health research areas, and the College of Medicine & Health has expanded to include the wonderful extension to Brookfield housing ASSERT, Application of Science to Simulation-based Education and Research in Training, and Dept of Speech and Hearing Science. Alumni overseas maintain the links with the

Medical School and a fruitful liaison has been established with Johns Hopkins University School of Medicine to the benefit of current students doing electives in US.

The newsletter includes a number of articles from Alumni on a variety of light and not so light topics, as well as a synopsis of the conference held in September 2015. A new student prize in memory of the late Dr Pamela Gilligan, Dept. of Anatomy, was set up by her family, and an account of this interesting family is given in the article "Hannah's Legacy" by her granddaughter Dr Oonagh Gilligan.

The next Scientific Meeting is to be held on Thursday 8th September in Brookfield Health Science Complex and we would love to see you there. As always, class reunions are often held around this time to include attendance at the Scientific Conference and represent a very strong way of keeping in touch. UCC can assist you with organising these events.

It has been my pleasure to Chair the UCC Medical Alumni for the past 4 years. Many thanks to the Committee, to the newsletter contributors, and to those who acted as referees and assessors for the various scholarships and prizes run by the Medical Alumni. Sincere thanks also to Rachel Hyland for editorial (and other!!!) assistance. ■

*Katy Keohane, Chair UCC Medical Alumni Committee.*

Prof Mary Horgan, Dean



## Welcome

Welcome to the 14th edition of the Medical Alumni and Faculty newsletter.

The scope and reach of the School of Medicine continues to develop. During the last twelve months we have seen sustained advances in what we offer prospective students with the creation of new academic programmes in Pre-hospital Care, medical education and masters programmes in Anatomy & Neuroscience.

As a medical education faculty we must take all practical steps to oversee doctors' education and training across the continuum from undergraduate all the way to retirement. Developments in CPD branding and programmes, on-line programme

development and faculty development days display that we are making significant progress in that regard.

The strength of how our school is perceived owes a great deal to our national and international connections. In December, I had the pleasure of opening the RCPI's first office outside of Dublin which is based in Brookfield. Connections such as this are invaluable in assuring the continued progress of our faculty.

Finally, August last saw the release of "A Doctors Sword", a film documenting the astonishing life of Alumnus Dr Aidan MacCarthy. It is undeniable that since the foundation of our school, our alumni have

produced an indelible mark across the world in numerous ways.

The spirit of Dr MacCarthy exists in every one of us as we continue to push boundaries, and utilise the training that we received as medics. As the class of 2016 prepare for their final exams, I have absolute confidence that they will maintain the legacy and reputation of UCC's School of Medicine; a legacy and reputation that you all uphold as alumni of our school. ■

*Professor Mary Horgan, Dean  
School of Medicine UCC*



## Doctor Up In The Air

**Recent discussions in the media about the lack of training of doctors/medical students to handle in-flight medical emergencies prompted a few reminiscences.**

Having gone to Canada in the late '60's perforce leaving relatives and friends behind as all emigrants do, we inevitably went back and forth across the Atlantic many times, both as a family and separately as happy and sad occasions arose. My first experience of an in-flight emergency occurred on a Boston-Shannon-Dublin Aer Lingus flight in the early 1970's. A call went out 'If there's a doctor on board would you please identify yourself'?....It was a Boeing 707, then the most modern of aircraft but not very big by today's standards. A quick look around and I could see no dramatic events unfolding so I tucked my head down, hoping some other medic would show. As a pathologist, I felt that my services were unlikely to be required at that juncture. The kids said loudly 'Daddy, daddy you're a doctor', so up I got, no other volunteer having appeared. The passenger was an old gentleman who was returning to Ireland on holiday after many years in America. He had a few pints in the airport bar to steady his nerves for the trip and now, six miles above the Atlantic, acute retention struck. His travelling companions, two elderly blue-rinse sisters, were completely embarrassed and didn't want to know about this brother who suddenly couldn't pee. My God, the shame of it! There wasn't any medical kit aboard: I had the chief stewardess ask over the speakers if anybody had a catheter, with no success. The Captain said 'Shall I go back Doc?' I asked him our position and he said about halfway there so I told him speed up if possible and put me in touch with the MO at Shannon. I told him the situation and we were met at the ramp when we pulled up. The old gent had travelled the rest of the way sitting hopefully on the toilet. I subsequently got a very nice letter of thanks from the Chief Medical Officer of Aer Lingus, accompanied by a splendid company tie, light blue alternating with dark blue stripes and Kelly green shamrocks cascading down. I've worn it on St. Patrick's Day in Toronto for the past many years, boring anybody foolish enough to ask about it with the yarn... after that event I packed catheter in my hand luggage but never had occasion to use it.

As a Pathologist practicing near Toronto International Airport I got to see sequelae of quite a few of in-flight- occurring acute events, ranging from fatal asphyxia due to impacted posterior oropharyngeal food bolus mistaken for an in-flight cardiac arrest, to mass hysteria in a group of students manifested by nausea and vomiting at first thought to be of infectious origin. Acute intestinal obstruction in a 'mule' due to multiple impacted drug-filled condoms was another doozy. We had a case of cerebral malaria admitted from the airport, and on one dramatic occasion Lassa fever was suspected, luckily a false alarm, though it did shut admissions down for a week. Apparent acute infectious illnesses in travelers from countries harbouring deadly exotic viruses always caused a frisson of concern, and public health and infectious/tropical disease specialists were always on the qui vive.

Once I answered to a choking emergency in mid-air, but the patient had coughed it up before I had to do anything. I learned from twice responding to choking episodes in restaurants that a quick flip with an inverted long- handled spoon beat the Heimlich manoeuvre hands down. Weirdly enough once I responded to a call for a doctor in a restaurant and found myself preceded by a Ph.D. in consumer economics whom I had previously seen addressing a meeting I was attending on bed utilization.

Socially I knew some pilots and in those relaxed times would occasionally get invited to travel in the jump seat behind the captain whenever one I knew was piloting the plane and I was a passenger. On one occasion I was sitting up on the flight deck of a Lockheed L1011; we were about 400 miles heading west of Shannon when a flight attendant came in and said 'we need a doctor, captain'. 'Get back there Paul' he ordered. 'Gerry, you know I'm a pathologist, not that kind of doctor'. 'Get back!'. ....OK, OK- back I went to find a passenger slumped in his seat with a little guy fussing around... 'Are you a doctor?'...yes, he was. Great. Just then a flight attendant arrived with a large case of medical supplies. Things had sure changed since the days of the 707. He seized a pre-loaded syringe of adrenaline. 'What're you going to do with that?' I asked. 'He's had a cardiac arrest and I've got to give him an intracardiac injection'. 'Hold on' I said: recognizing a stethoscope among the paraphernalia in the case from

my long- past student days I listened in... 'Lup dup, lup dup' as per normal. 'He's only fainted', said I, and he reluctantly backed off. To impress the stewardesses I then threw a glass of water in the sufferer's face just like in those old movies and he came around rapidly. A combination of jetlag, booze and Valium had laid him low. When I went back to the flight deck I told the captain that I had just saved his bacon. I never got a note of thanks or other acknowledgment from the airline despite the Captain reporting my act of daring do in his flight log. Surprisingly, I was never asked for identity when I responded to a call on any airline.

In-flight events handled by my psychiatrist wife Elizabeth were hyperventilation tetany in a hypernervous passenger, and hypoglycaemia in an elderly mild diabetic whose meal schedule had gone out of kilter due to complying with airline timetables. She also once answered a call where the passenger threw a seizure, apparently from acute alcohol withdrawal after a happy summer spent boozing steadily with his mates in the Old Country. There were lots of elderly people travelling across the Atlantic to visit children who had emigrated. I even got to play a game with myself scrutinizing passengers in the departure lounge at Heathrow to see if I could spot likely imminent patients-to-be. I was never able to predict with any accuracy, the few calls to action I did respond to came as bolts from the blue. Thankfully most flights were the usual humdrum boring affairs.

After a while I got to consider myself mildly skilled at handling in- flight events; once I was at a medical meeting where one of the speakers was the Chief Medical Officer of a large international airline. His subject? 'How to handle in-flight medical emergencies' which he went into in great detail. Right up my street. After his talk I went up and was speaking to him about my experiences. Was he impressed? No way. He said 'Never respond to a call, old chap, the b.....s will sue you in California'. ■

Have a very nice flight doctor.

*Dr Paul O'Brien is a retired pathologist UCC Graduate 1960.*

## The Walking Afterlife

**Class reunions are such a dose of reality! Old acquaintances are renewed, memories refreshed, and differences, tempered somewhat by 40 years of the concerns of others, are set aside for the evening as the foolishness of unguarded youth.**

We took our places at table like war veterans without the ribbons and medals, graduates of a medical system forged on the open wards of Cork's infirmaries and intended for the domestic arena but ultimately played out upon an international stage. We had travelled back in time and space, feeling a loyalty to that little medical corps we fancied ourselves to be when so long ago we elected like many before us, stethoscope in hand, to make our stand at the bedside. A small but significant minority had stayed away for obscure reasons but this seemed only to heighten our interest in them. Some had obviously died and others had less obviously so.

The after-dinner speeches confirmed that those who had retired, had moved on to a better place, while the odd recalcitrant, cement-like, seemed trapped in an increasingly narrow place from which forward was clearly not an option. (This was consistent with what I subsequently learned about retired physicians. Few regret the decision while nearly all found their lives and family dynamics greatly enriched. Those who had embraced retirement had new interests, in some cases new partners, and looked genuinely happy. As the evening broke up we were reminded that the next reunion was in ten years and that we should make good our good-byes.

For me, the inevitable seemed to be beckoning; time to put my affairs in order and prepare to step into the walking afterlife of the retired, not as one bereft of identity but hopefully as a bird released from a cage. As some wit once observed: "The problem with being retired and having nothing to do is that you never know when you are done."

Upon my return to the United States and resumption of office practice I found myself possessed of a Monday morning lassitude that I recognized would neither lift nor tolerate being ignored. In social situations I was increasingly being asked if I was still working. My response was to quote two quite disparate personalities (the late Joe O'Donnell, UCC '67) who presciently observed: "you can't operate on them all" and Charles de Gaulle,

("the cemeteries are full of indispensable people.") Three years of that and I concluded that the time had arrived when I would have to stop being clever and get down to the serious business of actually listening to myself. I informed my staff, my patients, my colleagues and my friends of my plans to close my practice. I was advised not to stop completely since I might find myself regretting my decision, retired with nothing but time on my hands. There were alternatives available to me which I investigated and rejected (save for an on-call position at the nearby hospital) concluding that retirement meant just that. So I retired and discovered that after 45 years of seeing patients, though some may have missed me, I was not indispensable.

But there were some immediate unexpected consequences. First, I had to stop playing doctor. Though still a pediatrician in good standing, I found myself at family dinners listening to my children talking about issues of child rearing, to wit my grandchildren, and discovering the awkward truth that no-one was particularly interested in "hearing it from the horse's mouth." Yes, I tried but I soon realized that I was more an impediment to free speech than the oracle I fancied myself. It was cocktail hour and it was "cocktail conversation." My presence as pater familias was necessary only to make the gathering possible and to pick up the bill. In case I had not noticed, my children were now parents. In addition, they had me where they wanted me, helplessly dependent for their technical expertise in downloading, rerouting and rebooting.

I had read somewhere that the secret to weathering the ageing process was to remain useful. Yes, I was still on the on-call schedule at the hospital. The question that remained was whether I could turn off the past like the ignition key in a car, sit in the silence and occupy the present? The past I viewed philosophically; the past was prologue. I had survived my ration of success and failure intact. I was surprisingly active even if it required a morning fistful of pills. The future was my worry. How was I to handle that? The answer came from a surprising source, the present.

A few months into my retirement I found myself standing at the finish-line at the Boston Marathon. After about a half an hour I decided to move up a block to get a better view. Shortly thereafter the bombs went off. I had been saved by the trivial need to get an unobstructed view. Within the year, while returning from the airport, I stopped at an intersection before getting on the highway

and my front wheel fell off. Ten minutes later and I would have been speeding along the highway at 70 miles per hour. A half hour here, ten minutes there, it occurred to me that there might not be a future. It was the present that was trying to kill me. The future might well be only a mirage.

How often have we heard it said that "the worst thing you can do is retire"? Look at those we have known who died shortly after retirement. Actuarial data shows that 20% of one's 50 year high school reunion will be dead. When it happens it gives one cause to reflect. For example, two of my colleagues who retired when I did were dead within the year. Seemingly, their untimely departure from this world had been accelerated by noncompliance with medical advice. And where does that appear on the death certificate? What is it about the physician psyche that prevents them from being a good patient? Yes, we are reputedly bad patients. But why? The answer might be quite simple as a golf partner of mine observed: "You can't teach a doctor anything." Yes, as patients we have the same irrational fears as our patients. Bipolar Disorder occurs in doctors and that I have seen in full flight all too often. There are addicts among us with an equally committed addiction to denial. But other than the obvious why do we make such uncooperative patients? There is little data available to either confirm or refute the presumption. But, a presumption so widely held is at the very least worth examining.

Physicians, nurses, social workers, ministers, teachers have personality profiles that have much in common. They are devoted to the needs of others. Sadly, they are notoriously neglectful of their own. A psychological study of first year student nurses where 60% of the entering class were deemed to be co-dependent. The explanation posited for this was that many student nurses were the adult children of alcoholics. Since alcoholic parents are emotionally unavailable the child tries to be seen by striving for excellence at home and at school, hoping in the process of earning parental attention and appreciation. The parent's inability to carry the parental load of responsibility is compensated by the child assuming more and more a parental role, ideal future helpmates for those who cannot take care of themselves whether they are patients or alcoholic spouses. This is how the child and later the adult child of the alcoholic feels safe, believing, if they can control their environment they will be safe. This leads to an inflexibility that we all recognize when we hear someone



say: "If you want something done properly you have to do it yourself!" They are "take charge" people and they are only comfortable when they are in charge. When things do not go as planned, there is an outpouring of bitterness and resentment that no-one is willing to help. However, could it be a situation of their own making? Might they not want the help?

The seductive power of power goes unnoticed by those who wield it. A physician friend had a seminal moment with this when she broke her wrist. When commiserating with her on the telephone, she interrupted me. "No, it's wonderful! I have to let people help me. You can't imagine how liberating it feels to let people help you." From then on whenever I received offers of help I did not reject them out of hand, while in the office I did not offer services to my patients until I discerned whether either the patient or the parent was willing or able to accept the offer of help. To accept help is to acknowledge a need, an admission of vulnerability that does not come easily to the powerful. Oscar Wilde once observed: "Loving oneself is the beginning of a lifelong relationship." If you do not love yourself it is unlikely you will accept it from others. And that is probably also true for medical advice. For the ageing physician "into thy hands I commend my spirit" becomes uncomfortably personal. Physicians, as caretakers, in control of "another man's wound," have a secure status. After all, the norms of society are suspended for them. They see their fellow human beings emotionally and physically naked; they are permitted to put their fingers in places where even consenting intimates dare not go; they are called "doctor."

But what if they were to be called "patient"? What if they were to be called "grandpa" or "granny"? Switching roles requires flexibility and a secure sense of self, a confidence your world will not collapse should you place yourself in the care of another. Role switching must seem more challenging for female physicians who relinquish in quick succession their titles of "doctor" and "mom," to end up as "granny." Mothers also have to face the consequences of the passage of time, as children grow up, move away, become independent and become parents themselves. How well do they manage the transition from parent to grandparent? I have known competent, successful mothers in their 50s complaining bitterly about their own mothers who find that they constantly need correcting. (These are the biological mother/daughter dyads not the infamous mother-in-law/daughter-in-

law relationships). A generation of stay-at-home mothers calling to task a generation who had not only successfully raised their children but were also successful professionals. Society's expectations of the mother's role lies at the core of this cross-generational antipathy. She is expected to uphold society's standards of behaviour, be society's moral compass and enforce those expectations. When the child fails in any way to conform the blame is placed squarely at her doorstep. (When have you ever heard it said: "I wonder what that child learned at its father's knee"?)

In the case of elderly parents how often do they transition from the assertive parent to the child-like dependency of old age? With lengthening life expectancy and the march to senility, come reports of the struggles of adult-children to straighten the affairs of their incompetent parents. Often it is not until they have left the soup on the stove and nearly burned the house down does reality prevail. In the final analysis it all has to do with change. Those who adapt to change withstand the vicissitudes of life more successfully. But change is not just an alteration of the status quo, it is a loss of the status quo. There can be a feeling of loss, bereavement, grief, associated with change. We can resist change but it necessitates increasing energy from a dwindling pool of energy. And resisting it denies us a future. As the old Chinese saying goes: "living each day the same means living only one day of your life."

Inherent to the passage of time is change. There may be an element of perceived control when we state that the acceptance of change is pivotal to adapting to it. But what if our perception of time changes as we age? Studies confirm this. The passage of three hours is fairly accurately identified in the absence of a clock by those in their twenties as three hours and five minutes, three hours and forty minutes by those in their seventies. The perception of time has sped up for the elderly. How often have we heard an elderly person exclaim: "Where have the past 15 years gone?" For those of us still in the early stages of the walking afterlife it is not an uncommon occurrence to have to ask: "What day is it?"

The quality of time changes with ageing. A day in the life of a ten year old is 1/36,500 of its life span but 1/2,555,000 of the seventy year old's. It is more likely to be unique since much of a ten year olds experience is new and as such much more memorable. And as the saying goes: "An rud is anamh is iontach!" (That which is seldom is wonderful!) For the retired,

savouring the fresh fruits of liberation from the work schedule, it must be a rude awakening to discover that time, like a rock rolling down hill, is gaining momentum.

Time can be prolonged by increasing the intensity of the experience. All very well but that may be a tall order and it may seem impossible. Must we become child-like and begin to investigate the world through the eyes of the ten year old? Or make a "bucket list" of the things postponed because of more pressing responsibilities. Should "live in the moment" become the *carpe diem* of each day? Yes, living in the moment is a good concept but is it realistic? What if living in the moment consists of watching The Barclay Premier League on television for hours or playing "solitaire" on the computer.

A friend of mine had her veterinarian sit her down and discuss her dog's increasing debilitation. Dogs have no sense of time, only that they are either in pain or not. When the time came should the dog be euthanized? Why should it be any different for humans? It occurred to me that though this view may have been received with equanimity by the dog it had bestowed a knife-keen sense of the passage of time on its owner. Pain can slow our perception of the passage of time but none of us wish that life should be excruciating. The walking afterlife, ageing in place, waiting for Godot, is a progression whose end we all know. Time is finite and must be accepted. When I observed to the surgeon who had performed my cardiac by-pass 19 years ago that I was unlikely to live as long as I had expected he replied: "It's not quantity, it's quality." So, I resumed playing squash until I grew tired of that and moved on to other things.

In college there was an unconfirmed story that when Gertrude Stein was dying, her life-long companion, Alice B. Toklas, kept asking her: "What is the answer?" Gertrude, struggling to sit up, replied with her dying breath: "What is the question?" I'm sure that Alice B. would have settled for: "Love is the answer" and it would have been a good answer. There may be a more fundamental answer to the meaning of life as I discovered one day as I was swimming laps. The adjoining lanes were a group of young mothers availing of the time their children were at school to exercise. I heard one exclaim to another: "You can't control life! You've just got to embrace it and ride it for what its worth." ■

That works for me.

*Dr Fergus Moylan is a Pediatrician and UCC Graduate 1968.*

## UCC Medical School Medal & Windle Prize



Prof Mary Horgan, Prof Mary Sheppard  
(Medical School Medal), Prof Colin Bradley



Prof Mary Horgan, Dr Liam Plant (Windle  
Prize), Prof Colin Bradley

The annual Medical School Graduation Dinner took place on Wednesday 27th May 2015. The recipient of the prestigious Medical School Medal was Professor Mary Sheppard, which was presented to her by Professor Mary Horgan, Head of School of Medicine, UCC. Dr Paula O'Leary introduced the Windle Prize, gave the citation and presented the award to Dr Liam Plant. ■

## The Dr Raymond Shanahan Prize

This prize is awarded biennially on the basis of a submission of original observations or published research paper in a topic related to cardiovascular disease.

The applicant must be the first author of the work.

Eligible candidates are post registration non-consultant hospital doctors and their equivalent in G.P. Trainee Schemes. Eligibility is confined to graduates of University College Cork Medical School and graduates from other medical schools training in the University's teaching hospitals or training schemes.

Applicants should submit 3 copies of the work to be considered, together with a letter from the Head of their Department where the work was carried out, indicating the applicant is the primary author. The work may consist of a case report published (or in press) within 2 calendar years of the advertised award, or a case study/presentation / observation written up as for publication, or a research work/observation where the work done is within 2 calendar years of the advertised award. ■



*Pictured: The winner of the Dr Raymond Shanahan Prize 2015 is Dr John (Bill) McEvoy for his published research "Using Modern Phenotyping to Explore the link between Smoking and Cardiovascular Disease".*

## UCC Medical Class Of 1965

Having enjoyed a special day in UCC for all golden jubilee graduates, and also the Alumni Scientific meeting, the medical class of 1965 adjourned to Hotel Europe in Killarney for a weekend of conviviality and fun.

Of a class of 28, sixteen attended, together with partners, family and friends. In all, 37 sat down to dinner on the Saturday night. Greetings and good wishes were sent by others who could not travel, while our four deceased class members were recalled with sadness and affection.

Chat was instantaneous and constant. All were pleased to be there and to be together. There were perhaps a few hints of wear and tear; fewer played golf than at earlier outings, and not quite as many stayed up into the early hours.

Nonetheless, the medical class of 1965 is ready to defy passing time for a while more. Before saying farewell, talk was of another get-together next year, with a major event expected in five years time! ■



*Back Row; John Kilgallen, Rory O'Brien, Pat O'Carroll, Barry Ferriss, Peter Genovese, Bill Shannon, Fergus Purcell. Front Row; Bill O'Dwyer, Kay Stott, Mary Leamy, Cyril Kenefick, Noel O'Mahony, Helen O'Mahony, John O'Mahony, Peter Gaffney, Vincent Prendeville.*



## Hannah's Legacy

My great-grandmother Hannah O'Connor was a woman ahead of her time. In the early 1900s, an era when third level education was not commonly pursued, especially by women, she encouraged all her 7 children to go to university. To this end she moved her family from Douglas to live on the Western road to facilitate student life and ensure appropriate chaperoning. Four of her daughters studied medicine in University College Cork, qualifying between 1914 and 1926. Her son and youngest daughter studied law. This was an extraordinary achievement for one family given that a total of 452 women had qualified in medicine in the Ireland between the 1880s and 1920s.

My Grandmother May O'Connor was one of 2 women who qualified in Medicine in UCC in 1919. (see picture) Her only female classmate, Anna Dengel, went on to found the Medical Mission Sisters, an order which continues to this day to provide better access to healthcare for the poor. May herself had the remarkable achievement of studying both medicine and dentistry simultaneously, being the first woman to graduate as a dentist from UCC in 1918, before completing her medical degree the following year.

The final med papers (see picture) from 1918, which we recently discovered amongst family papers, speak volumes about what has and has not changed in medicine in the past century. In 2015 doctors no longer have to worry about smallpox, but still need to know how to manage a pneumothorax, pleural effusion and a hernia. It is a pity we don't have the exam scripts as it's likely that the answers to the questions posed would provide a more interesting historical perspective than the questions themselves. For example, what were the "2 detailed prescriptions" asked for on the question on how to manage uraemia and what would the surgeons of today make of the question on myeloma which appears on the surgery paper?

Career opportunities for women in medicine in the early 1900s were limited. Many went into public health or to work on the missions. My grandmother moved to UK, where she worked in Kent as a senior medical officer for schools. She married my grandfather William Moore (medical class of 1922) and subsequently assisted him as a dispensary doctor in Freshford Co. Kilkenny. Their 3 children Eva (class of 1950), Michael (class of 1954) and my mother Pamela (class of 1956) (see picture) all followed in the family medical



*Class of 1919. May O'Connor middle right*



*Class of 1956 Pamela Gilligan nee Moore – 2nd from right, middle row*



*Dr. Pamela Gilligan*



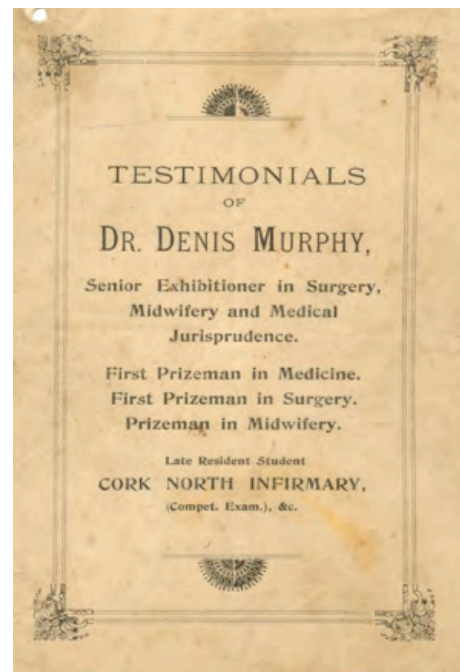


tradition. By the time my mother qualified opportunities for women to study medicine had improved considerably, with 6 out of a class of 15 being female. She did not pursue a full time clinical career, putting family first. She was, however, like her grandmother a firm believer in education. She joined the Anatomy department in UCC in 1971 and worked there for 27 years. She loved UCC and her students. When she died in 2014 it was evident that she was held in very high regard by many of her past pupils. We were regaled with stories of small acts of kindness, extra tuition, handholding through pass-fail orals etc. Above all she encouraged everyone to be the best they could – those at the bottom to have the self belief that they could pass and those at the top to fulfil their potential. With this in mind the inaugural “Dr Pamela Gilligan Prize” was presented this year at the medical alumni meeting for the best final med project.

By the time I qualified, as a 3rd generation female medic, in 1991, university education for women was taken for granted and there were equal opportunities in medicine for all. My current post as a haematologist in Cork University Hospital allows ongoing links with the medical school in UCC.

While the brief I was given was to write about the 3 generations of female medics, our UCC medical alumni family tree stretches in fact to five generations. Hannah's legacy includes 23 doctors, 17 of whom qualified in UCC and extends from her brothers Denis and Daniel who qualified in the 1800s (see picture) to her great-great-grandson Rory Gilligan who hopes to start medicine next year. I am proud to be part of this tradition and grateful to the woman who had the foresight to believe in education for women. ■

*Testimonials for Dr Denis Murphy from 1898*



## Dr Pamela Gilligan Prize

Dr. Pamela Gilligan qualified from UCC in 1956. She came from a medical family, her mother having qualified in medicine in 1919, her father in 1922. She inherited a firm belief in the importance of education. With this in mind the inaugural “Dr Pamela Gilligan Prize” was presented this year at the medical alumni meeting for the best final med projects.

Dr Stephanie English completed a Final Year Project “Incidence of acute kidney injury in adult patients with cystic fibrosis”. Dr Conor Haugh completed a Final Year Project “Identifying the learning outcomes for a pre-departure training course for medical students on electives in low-resource settings in Africa”. ■



Dr Stephanie English and Dr Conor Haugh, winners of the Dr Pamela Gilligan Prize pictured with Prof Katy Keohane, Dr Oonagh Gilligan and Dr Eve McCarthy.





**MEDICAL ALUMNI & FACULTY SCIENTIFIC CONFERENCE  
SEPTEMBER 3, 2015  
UNIVERSITY COLLEGE CORK**

**Brookfield Health Sciences Complex G.05**

Registration

<http://www.uccconferencing.ie/product/medical-alumni-faculty-scientific-conference-2015/>

The Annual Scientific Conference is a multidisciplinary graduate meeting for all medical graduates, staff and friends of University College Cork which is organised by the Medical Alumni Committee.

**APPROVED FOR 6 CONTINUING PROFESSIONAL DEVELOPMENT POINTS**

08.30	Registration	
08.55	<b>Prof Mary Horgan</b>	Welcome from Dean, School of Medicine
Chair:	<b>Mr Peter Gaffney 1965</b>	<b>Session 1</b>
09.00	Dr Clíodhna Foley-Nolan 1980	Food, Health, Partial Knowledge and Probabilities
09.25	Dr Sean Manning 2004	Understanding Susceptibility to the Obesity Epidemic - a Boolean Logic?
09.50	Prof Gene Dempsey 1995	Recent Advances in Newborn Care
10.15	Mr Emmet Andrews	Through the Keyhole .. Colon Cancer Surgery : A Benefit of the Computer Age
10.40	Coffee Break	
Chair:	<b>Dr Paula O'Leary 1987</b>	<b>Session 2</b>
11.15	Dr Suzanne Timmons 1995	The Confused Older Patient
11.40	Dr Eugene Egan 1970	Straws in the African Wind - Anaesthesia on the margins
12.05	Mr Christopher Constant 1975	The Shoulder; has Cinderella finally come of age?
12.30	Dr Jim Mc Carron 1970	Non, je ne regrette rien
12.55	Lunch	
Chair:	Prof Katy Keohane, 1974	<b>Session 3</b>
14.00	Dr Eoin Hunt	<i>Prof Denis O'Sullivan Fellow</i>
		Association of asthma severity with chronic pulmonary aspiration, altered pulmonary microbiota and airway remodelling
14.15	Dr Conor Haugh 2015	<i>Dr Pamela Gilligan Prize</i>
		Identifying the learning outcomes for a pre-departure training course for medical students on electives in low-resource settings in Africa
14.25	Dr Stephanie English 2015	<i>Dr Pamela Gilligan Prize</i>
		Incidence of acute kidney injury in adult patients with cystic fibrosis
14.35		<i>Award of Dr Pamela Gilligan Prize</i>
14.40	Dr John McEvoy 2004	<i>Dr Raymond Shanahan Prize</i>
		Using Modern Phenotyping to Explore the link between Smoking and Cardiovascular Disease
15.00	Coffee Break	
Chair:	<b>Dr Tom English 1980</b>	<b>Session 4</b>
15.30	Dr Alan Fleishman 1975	Family Medicine in the USA and in Abu Dhabi
15.55	Mr Criostóir Ó Súilleabháin 1990	Advances in treatment of Hepato - Biliary Cancer
16.20	Dr Diarmuid Quinlan 1991	Update on Diabetes Control in General Practice
16.45	<b>Prof Katy Keohane 1974</b>	<b>Closing Remarks</b>
19.30	<b>Reception followed by Dinner</b>	<b>Staff Dining Room</b>

Refreshments €25 / Gala Dinner €60 / Refreshments & Gala Dinner €80

## Food, Health, Partial Knowledge and Probability

Cliodhna is currently Medical Director of the Food Safety Promotion Board (safefood). She spoke about the obesity epidemic while weaving in the legacy of world famous Mathematician and Philosopher George Boole of UCC renown. Boole explained that “probability is expectation founded upon partial knowledge” and the current health problems associated with overweight and obesity present us with a situation of impartial but evolving knowledge, but there is enough knowledge to take more action than is currently the case. There are logical probabilities that should prompt and substantiate this action.

The European WHO predicts that Ireland, based on the size and demographic makeup of our current obesity epidemic, will be the “most obese” country in Europe by 2030. This probability is made all the more stark by the present situation where childhood overweight is the “new norm”, where significant levels of clinical hypertension prevail in childhood and where childhood bullying is statistically linked to weight status.

### **Childhood overweight has a lifelong health impact with the following probabilities of adult obesity:-**

- 15% for a healthy weight child
- 65% for an overweight child and
- 82% for an obese child

A number of aspects of evolving knowledge were outlined. We now know that the gut flora (microbiota) of obese patients differs from that of lean subjects. The phenomenon of epigenetic changes whereby our genetic makeup is influenced by factors in our environment was discovered. Moving from a genetic predisposition to obesity requires an obesogenic lifestyle (readily available highly processed foods, sedentary work & leisure pursuits) to “switch on” these genes. Ultimately genes do not fully dictate our destiny.

Brain computer imaging, based on Boolean logic technology, highlights the changes in the brain’s reward centres associated with obesity. The similarities with alcohol and cocaine dependency are striking and illustrate the phenomenon of diminished satiation associated with food experienced by obese patients. This phenomenon is also shown by the existence of hormones such as leptin and ghrelin which are associated with poor appetite control and satiation.

The role of immunology in the understanding of obesity is another evolving field. Research was mentioned, including some from Irish colleagues, on the impaired function of killer T cells in obese patients. These cells play a very important role in the body’s defences against infection, cancers and autoimmune diseases. This provides a pathophysiological link between overweight and obesity and a myriad of associated diseases.

Economic analysis of the cost of overweight and obesity has been undertaken, showing that while the cost of overweight is highest at a population level, costs to the health and

### **Impartial Knowledge**

Gut flora  
Appetite hormones  
Epigenetic changes  
Brain imaging

### **Probabilities**

Obesity in 2030  
Lifelong obesity  
Lifelong costs  
Less impact individual action  
Inflammation  
More impact environmental change

social services are greatest for individuals with the highest BMI. In 2012 the cost of adult obesity on the island of Ireland was estimated at over €1.6 billion annually. Health services and sickness absence are the major cost drivers.

Solutions were considered in terms of abatement, halting the epidemic and moving towards a reduction in levels. An important development on this front is the recognition of obesity as a critical global issue on a par with smoking and armed conflict as the top three global social burdens generated by human beings. This challenge is being taken on by the forthcoming Irish Obesity Policy (due by end 2015).

The important, but limited, role of personal responsibility was highlighted. Our children are being reared in an obesogenic environment where their names feature on

cola bottles, where “unhealthy” food products are marketed using games and 20% of their daily calorie intake comes from “treat foods”. It is very difficult for adults and children alike to resist.

Economic analysis based on mathematical probabilities clearly show that the highest impact on the obesity epidemic cannot rely on individual willpower. It must involve a restructuring of choices in our environment so that the healthy choice is the default.

The evidence base for interventions to reduce obesity is far from complete. It is, however, clear that a sustained portfolio of initiatives, delivered at scale, is urgently needed to address the health burden. In terms of responsibility, it was emphasised that no one sector can make a significant impact. We need to experiment with solutions based on our partial knowledge, especially in the many areas where interventions are low risk. Boole reminds us “a perfect acquaintance with all the circumstances affecting the occurrence of an event would change expectation into certainty, and leave neither room nor demand for a theory of probabilities”. A co-ordinated long struggle based on probabilities of a worsening obesity scenario if we do not act lies ahead! ■



Dr Cliodhna Foley Nolan



## Understanding Susceptibility to the Obesity Epidemic - a Boolean Logic?



George Boole

The obesity epidemic is a twentieth century phenomenon, which perhaps would have sparked the interest of George Boole. In the bicentenary of his birth, the prevalence of obesity in most developed countries is 25% or greater. George Boole lived through the Great Famine, which deeply concerned him upon his arrival in Cork. In his masterwork "An Investigation of the Laws of Thought", Boole dedicated the final chapter to a discussion of the potential application of the laws of mathematics to the functioning of the human mind. This subject clearly interested him. He surmised that:

***"the laws of thought, in all its processes of conception and of reasoning...are of the same kind as are the laws of the acknowledged processes of Mathematics"***

and that:

***"...if the mind is truly determined to be a subject of law, and if its laws also are truly assigned, the question of their probable or necessary influence upon the course of human thought in different ages is one invested with great importance, and well deserving a patient investigation."***

There are a number of strands that connect Boole's work with the obesity epidemic. Obesity is now widely acknowledged to be a disease of the brain among the scientific community and beyond. Furthermore, body mass index (BMI), a measure of obesity, is

heavily dependent on genetic susceptibility; the genetic contribution to obesity represents up to 70% of all contributing factors. Drawing parallels with Boole's hypotheses, the obesity epidemic can be viewed as a logical consequence of the human mind's response to environmental changes in a genetically susceptible population. The progressive increase in food availability in developed countries since the mid 20th century is the crucial environmental factor. The 'drifty gene' hypothesis as proposed by John Speakman offers perhaps the most comprehensive explanation of our genetic susceptibility to obesity. Obesity might not have been actively selected for, but was passively allowed to float ('drift') into the human genome over the past 2 million years of our evolution, following the advent of both fire and weapons, which minimised the pre-historic risk posed by predators. Absence of strong selection on genes responsible for imposing an upper limit on our weight gain ensued, resulting in an increased prevalence of random mutations in these genes. The advent of an obesogenic environment in the latter half of the 20th century then rapidly unveiled this hidden genetic drift.

Even though environmental factors are the key drivers of the obesity epidemic, understanding the genetic basis and underlying mechanisms for obesity remains a biomedical research priority. Insights into the biological pathways implicated in human obesity can be gleaned by investigating common genetic risks variants. Of the common variants associated with increased BMI, those in the first intron of the fat mass and obesity associated (FTO) gene bear the strongest association with obesity and are strongly associated with extremes of obesity. A study incorporating neuroimaging with gut hormone measurement in FTO-locus genotyped subjects found that the FTO-linked obesity risk genotype affected neural responses to food cues. In addition, subjects with the FTO-linked obesity-risk variant exhibited higher levels of the 'hunger' hormone ghrelin as well as altered neural responses indicative of a blunted discrimination of the reward value after eating. Thus, the study elucidated a link between a common genetic risk factor, responses in reward centres in the brain and high-caloric density food.

Apart from understanding the biology, obesity genetics research aspires to provide other valuable applications. Destigmatisation

of obesity is an important issue that can be enhanced by effective mass communication of scientific discoveries in the field. Translation of these discoveries into preventive and therapeutic measures of direct clinical benefit for patients is the holy grail of obesity research, however 'personalised' obesity therapy currently remains beyond tangible reach for all but a few with exceedingly rare mutations. Feedback of genetic risk to individuals is a developing intervention the impact of which merits further research. Finally, Boole would no doubt strongly support research into this disease of the brain:

***"If it be asked to what practical end such inquiries..., it may be replied, that there exist various objects, in relation to which the courses of men's actions are mainly determined by their speculative views of human nature."*** ■

## Straws In An African Wind - Anaesthesia on The Margins!



It is useful to view anaesthesia through a surgical prism. The gaps in delivering surgical services and anaesthesia are usually similar.

Surgery the Neglected Stepchild of Global Health were headlines in a recent Irish Times article by Prof. Magee of RCSI. He quoted from the Lancet Global Commission in Surgery (April 2015) stating unmet surgical needs will shortly surpass infectious diseases as the greatest killer and cause of morbidity in underdeveloped countries. It highlighted unimaginable shortfalls in service delivery. So why is it neglected? A quick historical review may explain.

The colonial health service was mostly curative and based mainly in urban areas - public health programs were few. At independence in the 60s, ministries of health (MOH) emphasized meeting population needs by public health programs. Curative medicine took a back seat for several years.

Research however increasingly demonstrated minimal surgical coverage. In Kenya (Nordberg 1982) only 10% of necessary C-sections, 13% of inguinal hernias and 14 % of incarcerated hernias were operated upon. Others found (and still find) alarming gaps in personnel, essential surgical and anesthetic equipment, drugs and infrastructure. Surgery and anaesthesia was (and still is) mostly performed (> 90%) by non physician cadres.

The British Commonwealth Secretariat- a key institution advising ministries in its former African colonies convened a meeting in Lusaka in 1982 to address anesthetic gaps and recommended participating members from 9 regional countries to:

1. Establish Non Physician Anaesthetist (NPA) training programs
2. Design a common curriculum
3. Use appropriate technology

Explore community dimensions of anaesthesia – pain control trauma and resuscitation

### Tanzania (pop. 14 Million in 1980)

Tanzania responded by creating a cadre of NPAs - Anaesthetic Officers (AOs) in 1984. Training duration was 2 years and the location was Kilimanjaro Christian Medical Centre (KCMC). This is a 450 bed referral hospital, known for training paramedical cadres.

Training (3 months) for nurses was already established when I joined KCMC (1981). Anaesthesia was delivered by a "drawover technique", independent of gases, oxygen and electricity and appropriate for Tanzania. Oxygen was added when available. Ether was the main agent available and spinal/epidural anaesthesia rarely performed. The AO cadre became the official focus, but nurse training was expanded, increased to 1 year and attracted students from Congo, Cameroon, Uganda, Kenya, Madagascar and the liberation movements - SWAPO and the ANC.

### The Course

Good practical skills based on a solid, relevant theoretical base were course objectives. Rotations to district hospitals informed students of what to expect on graduation and provided feedback to modify the course. Equipment maintenance, servicing of vaporizers and minor repairs was mandatory, students wrote research theses based on action research principles and department management modules developed skills later needed in under-resourced settings.

Enthusiasm for NPA training gathered pace across the region. Distinguished anesthetists assisted the various programs in Kenya, Zambia, Malawi, Uganda, Mozambique and Ethiopia. HEDCO (my organization) successfully proposed a 10 year project costing over a million pounds to "Irish Aid". This resulted in construction of a school, student hostel and staff houses. Educational support included textbooks, computers and subsidies for conference, workshops and refresher courses. Monitoring and evaluation by Irish specialists was financed. A workshop for servicing and minor repairs was fully equipped. Training of technicians in England and updating of staff in Irish hospitals was subsidized and a Landrover provided for school transport needs. Graduating students received an extensive equipment and core library package costing over 1000 pounds. Four University of Dar Es Salaam anaesthesia residents received fellowships for 1 year in Beaumont Hospital and a group of Dublin professionals funded 6 Intensive Care nurses for updating in Beaumont that generously accommodated them.

The American Society of Anaesthetists (ASA) through Prof. Nick Greene established an overseas teaching program (OTP) at KCMC in 1991. An uninterrupted sequence of Anaesthetists came from the US and remained for periods of 2-4 months. They mentored and taught staff and students, participated in departmental conferences, guided research, but did not administer anaesthesia. Before arrival all underwent an orientation. Individual Doctors from different countries on a voluntary basis were self-supporting but accommodated on campus. Advocates for the course included Dr Zorab former President of the World Federation Societies of Anaesthesia, Prof Dundee of Belfast and Professor Cunningham of Beaumont. Their reports ensured that Irish Aid continued.

The project financed frequent curriculum reviews and contributed to the development of National Standards of Anaesthesia and to a Post Lusaka progress review that included more than 10 regional Commonwealth countries. Manuals of policy, practice and quality control were developed. Our staff conducted outreach activities with flying doctor organizations and for a time provided Anaesthesia after the Rwanda genocide in Goma refugee camp.

When I left Tanzania, the course had produced 120 graduates and over 100 nurses. AOs were all posted to public hospitals and nurses to mission hospital. The course still continues in Tanzania, the project has finished and students are fewer because of MOH cutbacks.

### Ethiopia (pop. 90 million)

This paper concludes with a brief account of recent training initiatives in northern Ethiopia (Tigray). This region has 4 ½ million inhabitants and a horrific history of famine and war. It has extreme gaps in surgical and anaesthetic services. All anaesthesia is delivered by NPAs- there is no physician anesthetist in the region!

In 2012 the Voluntary Service Overseas (VSO Ireland) sent me to the fairly new, well-equipped Mekelle University Hospital (over 400 beds), which is the only tertiary referral hospital in Tigray. I was tasked to assist the NPA training program. Surgeons are all physicians, consultants or residents and all surgical subspecialties (except open heart) are represented. Anaesthetic staffs are nurses and most have completed degree courses in anaesthesia sciences (BSc. or MSc)

A situation analysis of all the public hospitals and we conducted, demonstrated results,



which were unfortunately similar to findings described for Tanzania 25 years earlier. Our objective was to inform a "Training the Trainers Program" for those in peripheral hospitals. Two preparatory and 1 actual training workshops have already been held. Group work, with problem analysis and context specific solutions agreed between participants (often in the Amharic language) characterizes our model. Surgeons, obstetricians and physicians participate to improve interspecialty understanding

and cooperation and culturally sensitive ethical practice is emphasized in a region with different ethnic and religious groups. Shortly we hope to develop indicators for an anaesthetic management information system and thus develop a quality control instrument of information for the training centre and the health bureau which implements health policy for the region.

### Conclusion

This paper indicates some past and present initiatives to close anaesthetic gaps in

Tanzania and Ethiopia caused by a complex that includes poverty, under-resourced health services, demoralized staff, mismanagement and postcolonial hangovers. Poverty and the economic difficulties will not disappear in the foreseeable future and demands for safe anaesthesia will continue to rise inexorably with "development" and soaring populations. The ingenuity of those working at the anaesthetic "coal face" should be recognized and further developed through training. ■

Mr Christopher Constant

## Has Cinderella Finally Come Of Age?

Historically, despite the fact that shoulder surgery dates back to the 1800s and before, in the 1970s the shoulder joint was referred to as the Cinderella of Trauma & Orthopaedics. The shoulder had a low profile within orthopaedic Surgery, was not considered important, was not regularly discussed and the research that had been undertaken had not reliably advanced our understanding or treatment of shoulder problems. Only the basics of shoulder anatomy were taught, biomechanics were poorly understood and the clinical relevance of these was unclear. Investigations included plain and contrast x-rays. Common rather generic treatments included sling support, injections, manipulation and physiotherapy. Treatment for instability concentrated on reducing movement rather than dealing with the primary pathology. The result was that when I graduated in 1975, I knew little about shoulder problems, there were few centres for treatment of such disorders, outcomes of treatment were not known and there was no justification for the treatments on offer. In the US, Dr Charles Neer II was working on fracture classification and degenerative shoulder problems and their treatment with the outcomes being based on subjective patient assessments and other non-functional parameters. Outcomes based on subjective patient satisfaction, the diagnosis, and specific patient-related activities were not reliably reproducible. This made worthwhile communication when considering treatment, difficult.

As a result, it was commonly accepted that in shoulder injuries, age, rather than injury

management, was the predictor of outcome, with patients under 50 years of age doing well and those over 50 years of age doing poorly, irrespective of clinical management, and with no clinical evidence to suggest otherwise.

As an orthopaedic registrar at Cambridge, I chose to disagree with the accepted view on the importance of age, hypothesizing that other factors played a part, in response to which I was challenged to prove or disprove it.

Faced with the problem of establishing whether functional outcome after shoulder injury was age-related, I had to establish an effective clinical method of assessing shoulder function and furthermore identify whether there was a physiological change in shoulder function with advancing age in males and females. Without these, it would not be possible to assess, or make any conclusions on 'age-related' functional recovery after shoulder injury.

Functional assessment and diagnostic assessment are not the same and diagnosis is not a reliable indicator of function. Functional assessment therefore had to be performed separately from making a diagnosis. Furthermore the outcome, as assessed by patient satisfaction and/or on diagnostic clinical criteria, is not a reliable indicator of function.

It was therefore determined that the essential criteria for a useful outcome functional score included its simplicity to perform in a clinical setting, its reliability and low cost, its independence of the diagnosis or specific activities and the inclusion of functional

parameters. We identified subjective parameters as pain (absence of), and activities of daily living that were occupational, recreational and sleep related as well as arm positioning. Objective parameters were active painless ranges of motion in flexion and abduction, along with functional external and internal rotation, each motion scoring an equal maximum number of points and finally shoulder strength. Using these parameters, the normal shoulder in a healthy 25-year old adult scored 100 points. No previous outcome shoulder scores were truly functional, as they did not fulfill the necessary criteria.

The parameters inter-related so that loss in one parameter had a secondary effect on other parameters. This resulted in a sensitive score that responded well to small changes in function brought about by loss of individual parameter function, with good inter and intra observer reliability.

Having applied to submit the work to UCC in 1981 for a Masters, I was pleased to be awarded Master of Surgery (MCh) in 1986 on presentation of the volume titled "Age-related recovery of shoulder function after injury".

The Score was named the Constant Score and achieved recognition by the European Shoulder Society who validated it in 1991 with further international recognition to follow.

Using the Constant Score it allowed us and others to observe natural history of shoulder disorders, physiological age and gender related deterioration in shoulder function, functional recovery with and without treatment and disability quantification. It also permitted us

to predict outcomes after injury when appropriate management was provided. Between 1982 and 2015, it is estimated that more than half a million assessments have been performed and used in research, clinical work and disability assessments.

In 2011, the original research paper on the Constant Score was the 9th of the top 100 orthopaedic papers cited in the mainstream orthopaedic journals, which interestingly did not include the Journal of Shoulder and Elbow Surgery.

In 2012, the original research paper on the Constant Score was the top cited work in the literature on shoulder surgery with both the highest number of citations and the highest citation density (number of citations per year).

In 2013, the Constant Score and its uses were considered essential core knowledge for trainee orthopaedic residents in the US.

Aside from its clinical and research uses in the field of shoulder disorders and surgery, the Constant Score has resulted in the ability to justify expensive treatments and operations in a climate of limited resources where there is an increasing emphasis on, and preference for, cheaper forms of treatment.

The use of the Constant score has raised the profile of shoulder surgery in demonstrating its worthy use in the management of shoulder disorders. As a result, there has been a considerable increase in interest in the field of shoulder surgery with more trainees than ever before expressing an interest in specializing in this field. The scope of shoulder surgery has widened with tangible proof of benefit using the Constant Score, and hospital managers are now more inclined to fund expensive treatments.

Clearly, with the aid of the Constant Score, The Cinderella of Orthopaedic Surgery has indeed finally come of age.

I owe thanks to family and colleagues who supported me throughout my work and especially to Mr Alan Murley (RIP), without whose guidance I would never have succeeded. I am also grateful to University College Cork in initially recognizing the potential of the work and subsequently awarding me MCh in 1987. ■

## Non, je ne regrette rien

The making of a Surgeon is a hazardous process for the candidate and also for those he interacts with. After four years of Surgical Residency in the US one is considered Board Eligible and can launch a Surgical Career. I was attracted by that shorter route and by the superior technology available in the US in the early 70's.

I believe my education at UCC gave me an excellent preparation for my Surgical Career.

I especially gained from the many hours spent in the Dissecting Room where I learned dissection techniques and the visual and tactile experience helped compensate for my poor memory. At the clinical level Dr Victor Dillon's first demonstration of taking a history and examining an abdomen is still a vivid memory.

The Philosophy rounded out my education and was a most therapeutic way to vent steam and gain communication skills.

Two Internship jobs in New York but no visa led me to accepting six months Surgical Internship at The North Infirmary. I gained a tremendous Surgical experience there and of course met the feisty redhead that later became my wife and Anesthetist. Special thanks to Mr Kahn who was an excellent surgeon and mentor. I knocked heads with Theater Sister who did not want me borrowing a little plastic connector vital to connecting an endotracheal tube to an Ambu bag. Mr Crosbie at the Cork Examiner was another nemesis.

For my six months Medical Internship I was rejected by the Bons but The Victoria Hospital welcomed me with open arms and open minds. Mr McKillop and I hit it off from day one and I spent most days in the OR. I also worked closely with Mr Ritchie OB/GYN and developed an interest in GYN surgery. At the Vic I got tremendous surgical experience, very little Medicine but credit for six months Medical Internship.

My first year of Surgical Residency was at NYU Hospital, Bellevue Hospital and Manhattan VA Hospital. I did not enjoy New York at all and got way less surgical experience than in Cork. My only good rotation was in Bellevue ER where the trauma experience was second only to a battlefield.

I completed my Residency at Virginia Mason Hospital in Seattle. I got a wide Surgical experience including a lot of GYN Surgery. I also had the privilege of working with Dr Richard Soderstrom who was one of the

pioneers of GYN laparoscopy. I spent extra time getting C-section experience when I was recruited to Port Townsend.

My wife-to-be, Noreen, was accepted in the Nurse Anesthesia Program at Group Health Hospital in Seattle. It did not hurt that the Program Director Dr Patrick Bennett was a Limerick man and UCD graduate.

I was hired by a Clinic group of four General Practitioners in Port Townsend. Salary was

\$30,000 per year and fringe benefits included fishing and bird hunting. They made me an offer I could not refuse.

Port Townsend's economy at that time depended on the local Paper Mill, and a vigorous logging, boat repair and fishing industry. It also had a large population of Hippies and Trust Funders. With about 16" of annual rainfall the climate is quite tolerable.

Just prior to my arrival St John's Hospital had transitioned from being run by an order of nuns to being a Public hospital with an Administrator, elected Hospital Board and tax funding. The Hospital was named Jefferson General and the statue of the Virgin was banished to the garden and declared a "piece of art".

Before starting in Port Townsend I reviewed the available equipment and instruments and submitted a list that was not negotiable. It included a basic operating laparoscope, a complete set of vascular instruments and some vascular grafts.

The Hospital had about 25 Med/Surg beds and a similar number of nursing home beds. I was allocated a share of the nursing home beds and also took my share of general ER call.

Getting up for an 8 am surgery was often difficult after arguing with a drunk at 3 am. The Hospital had two OR's but no recovery room.

Sandy Sandquist and older and very well trained and experienced Nurse anaesthetist was hired and quickly changed all that. Sandy was a WW2 veteran who went from being a plaster tech to dripping ether in Europe. On his return to the US he went to Nursing School and then did his Anaesthesia training at The Mayo Clinic. Sandy lived 100 yards from the hospital, was always available and was unflappable. When Noreen graduated as an anesthetist she joined Sandy in practice. They managed their end of the table and I managed mine. Conflicts were very rare.



Population of Jefferson County in 1975 was approx 15,000 and was served by several fire districts staffed mostly by volunteers. They had ambulances but were not licensed or insured to transfer patients out of the County. Road transfer was a major hassle in those early days.

In dire emergencies we could sometimes call the Coast Guard for helicopter transfer.

Coast Guard personnel all wore wet suits and required that a Dr or Nurse accompany a patient on a trip. Clad only in scrubs I made several trips to Seattle kneeling on the floor of a helicopter with no light on inside and the doors wide open. The ultimate hassle was when one was stranded in Seattle due to weather or another emergency call for Coast Guards.

Four years after my arrival in Port Townsend the Western half of the floating bridge flooded and sank. For two years we were then essentially on an island.

Excellent Pathology Service was provided by a large Seattle lab. Specimens were sent by courier, processed overnight and usually a report was called or faxed by next afternoon.

I learned fine needle aspiration and slide prep from a Pathologist friend and that enabled rapid diagnosis of any palpable masses.

Jefferson General initially lacked even an automatic xRay processor so one had to get used to reading wet films. Only plain film mammography was available and needle localization was another hassle.

Prior to my arrival the GPs did Classic C-Sections but I brought the improvement of Lower Segment C-Sections through Pfannenstiel incisions.

Continuing Education was a challenge. When I decided Endoscopy was the future I lined up half a dozen suitable patients for Colonoscopy and another half dozen for Upper GI endoscopy. A Gastroenterologist friend brought his equipment and Olympus loaned us a teaching arm and thus began my Endoscopy practice. I later added Hysteroscopy. My neck and spine will never recover from those pre Video Endoscopy days.

Despite years of GYN endoscopy and laparoscopy I was slow to adopt laparoscopic cholecystectomy. Eventually I did a two day course in Seattle did one pig and watched videos and actual procedures in other hospitals. A friend came from Whidbey Island and helped me with my first couple and I then forged ahead.

My practice evolved to essentially equal parts General Surgery, Endoscopy and GYN. Finding a partner with similar skills or interest was then the ongoing challenge. As a result I was for most of 19 years on call essentially 24/7 at least for the OB/GYN. When in town I was rarely more than 30 minutes from the Hospital.

I found those atraumatic vascular instruments very useful in bowel cases but they also saved several lives. Of the five ruptured or leaking aneurysms I took to surgery all survived. One of those I had cross clamped, heparinized and controlled distally. I asked for a 22mm X 11mm bifurcation graft. After some frantic searching I got the bad news: "We don't have any, the ones we had expired and we sent them back and they have not been replaced." Expletives are deleted.

After some frantic phone calls I got through to the vascular surgeon in Seattle who planned to move to Port Townsend. He cancelled his office collected his vascular pack, grafts and scrub nurse (wife) and got a float plane from Lake Union. We sent a car to get him at the local boat haven.

That waiting was probably the longest and most helpless two hours of my life. Dr Stavney completed the surgery, post op recovery was complicated but the patient survived. With the arrival of improved ultrasound we diagnosed aneurysms more readily and using a private helicopter service that became available we were able to evacuate most but many still did not survive. A few years later absent Dr Stavney who had rejoined the army and gone to Landstuhl in Germany where he worked on wounded from the First Gulf War, I found myself once more given no real alternative but to operate on a huge guy exsanguinating from a ruptured aneurysm. I had my friend John Rowe call my vascular surgeon friend Al Dixon on Whidbey Island and ask for his help. While I opened the abdomen and got control of the bleeding John took his fishing boat across to Whidbey and eventually delivered Al to my OR.

Both of my girls were delivered at Jefferson General attended by my GP friend John Rowe. Watching the slow progress of my wife's vaginal births was a different challenge and I concluded that just observing in a delivery room is no place for an ADHD Surgeon. Noreen had imported a Nurse anaesthetist friend for her epidural and afterwards learned the technique and it became routinely available thereafter.

I retired from Surgery March 17th 1999. I had practiced essentially on my own for 19 years and an additional five years with a perfect associate. I was at burnout however and PAF was also wearing me down.

Today Jefferson Health Care still has only 25 licensed beds but enjoys "critical access status." It has state of the art digital X-ray machines, CT scanner, MRI, Cardiac Ultrasound etc. It has an excellent Oncology service which has served me well this past three years. Most doctors are now employees of the Hospital including four General Surgeons. Helicopters are almost as frequent as taxis (one way trips about \$23,000).

***No I have no regrets. I worked hard and played hard and have conquered many challenges.***

*Go raibh maith agaibh. ■*

## Family Medicine in USA and UAE

The health of a nation is primarily determined by the presence of the public health system. Second in importance is the presence of a primary care network across the nation or state. The three tenets of primary care are: continuity of care with one's own doctor, comprehensive care and coordination of care.

Starfield, Shi, & Macinko (Shi 1992, 1994) showed that those U.S. states with higher ratios of primary care physicians to population had better health outcomes, including lower rates of all causes of mortality including heart disease, cancer or stroke; infant mortality; low birth weight and poor self-reported health. Vogel and Ackerman (1998) subsequently showed the association with an increase in life span. (Shi et al. 2003). Interestingly a greater supply of specialty physicians was associated with higher mortality. English studies (Gulliford 2002) and those from the Netherlands (Atun 2004) show the same findings.

**UK primary care in the 1980s** was the global gold standard for family medicine. The British National Health Service (NHS) has a systematic nationwide network of family physicians providing the three tenets through this network of small group practices. More recently, while the structure remains the same, they have adopted clinical guidelines and have clinical metrics which are standardized across the country and linked to pay. Continuity of care decreased as a result of the introduction "out-of-hour" services to improve the quality of life of the doctors. Another limitation is that each individual clinic has its own electronic medical record (EMR) that is not linked with others and therefore accessing the data for practice improvement is more challenging.

**USA** - There is an unequal distribution of primary care physicians (PCPs) in America, most are in solo or small-group practices. The disadvantages of this is that they have unsophisticated IT systems, a lack of practice data with an inability to compare for improvement. Lord Kelvin (1824-1907) the mathematical physicist and engineer who was born in Belfast said: "You cannot improve what you cannot measure."

Compared to other countries America spends the most and yet gets poor quality healthcare. The Forbes report scored USA as last in the top 10 health care systems. Bloomberg's Ranking places USA # 33 (Ireland #19. UK #21 UAE #30). The two main reasons are inequity of care (at risk for too much for the rich and too little for the poor) and uncoordinated care. In

a number of states, especially in the Midwest where there are large group practices with primary care networks, health metrics rival the best healthcare systems in the world. There is a marked correlation between % of physicians in integrated group practices and the quality of care in the US.

The Mayo Clinic Health System (MCHS) is such a multi-specialty group practice that is two thirds primary care with a large group of family doctors (600) distributed in three states in 90 locations with all three tenets of primary care in place. Data is transparent and down to the individual physician level. Standardized clinical measures and disease protocols are utilized with the resultant high quality of care.

**Patient Centered Medical Home** is an American approach to primary care that stipulates all the necessary features of optimal primary care in a way that is implementable across America and beyond. These features are:

**Comprehensive care** — a team of providers work to meet patient's physical and mental health care needs, including prevention and wellness, acute and chronic care.

**Coordinated care** — care is coordinated across the broader health care system, including specialty care, hospitals, home care and community services.

**Superb access to care** — patients have access to services with shorter waiting times for urgent needs, enhanced in-person hours, 24 hour telephone or electronic access to members of the care team.

**Systems-based approach to quality and safety** — the organization uses evidence-based medicine and clinical decision support tools, engages in performance measurement and improvement, measures and responds to patient experiences and satisfaction, practices population health management, and publicly shares robust quality and safety data and improvement activities

**Health based and proactive**

**Supported by a different financial model**

This approach is highly successful. The Patient-Centered Primary Care Collaborative (PCPCC) 2012 Results Summary of the results: "The data are clear, consistent and compelling: The PCMH improves health outcomes, enhances the patient experience of care and reduces expensive, unnecessary hospital and ED care."

**The Emirate of Abu Dhabi** recognizes the importance of primary care. Its network is called Ambulatory Healthcare Services (AHS) which is a primary care network that also has other outpatient subspecialty practices to support primary care. It has two ACGME accredited family medicine residencies. It runs a school health service for all government schools and a visa screening program for infectious diseases.

There are 303 family medicine doctors, 40% of whom are residency trained and 60% general medical practitioners. Of the care provided 70% of care is walk-in and there is a sophisticated appointment based Chronic Disease Program. The clinics are open 16 hours a day and there is a single EMR for the whole government health system - SEHA.

AHS introduced the concept of PCMH. All patients were asked to choose their primary care physician (PCP). Patients were then encouraged by doctors and staff to see their PCP which has not been the custom. One of the approaches to improve continuity has been making it worth the patients' while to wait to see PCP such as automatic electronic communication follow up to PCP of admissions to hospital or ED allowing their physician to contact them. Another has been enhanced referral communication processes with semi-automated letters to facilitate the coordination of care. The barriers have been the culture of immediacy and the long hours of operation with two 8 hour shifts diminishing the chances of continuity of care.

The development of physician staff structure for the dissemination of information, clinical protocols and standards together with transparent real time quality data down to the individual physician level has resulted in Key Performance Indicators (KPI's) improving dramatically – an increase from 4.55% of patients meeting international standards to 76.5% in two years. Ninety percent of patients now have a PCP. Medication reconciliation occurs in >80% patients with chronic disease. There has been a significant decrease in documentation deficiencies and insurance denials and a significant improvement of productivity as measured by work resource value units.

### Conclusion

- Internationally the evidence supports having disseminated family medicine networks for reasons of both quality and cost.
- The three tenets of Family Medicine are essential



- Continuity of care with one's own doctor
- Comprehensive care of the whole person
- Coordination of care across the health care system
- Further benefit is derived from the transformation to PCMH with these extra essential features in addition to the three tenets:
- Tracking and coordinating performance measures for quality improvement
- Care management
- Use of data for population management
- Use of evidence-based guidelines ■

## Update on Diabetes Control in General Practice

Dr. Diarmuid Quinlan

Diabetes and the complications consume 10% of the HSE budget. Ignore it at your peril. Diabetes (Type 2) is common, often silent ("Silent assassin") and eminently suited to management in general practice. Diabetic eye disease is a leading cause of blindness in adults, while diabetic foot disease is a leading cause of foot amputations. Diabetes in Pregnancy is very common, affecting 1 in 8 of all pregnancies, with a catalogue of adverse outcomes for mother, baby and the health service. Cork has a very substantial deficit of consultant endocrinologists. We have made great progress in diabetes across HSE South, due to a close collaboration with HSE, primary & secondary care, academia and Diabetes Ireland. Gestational diabetes and insufficient consultant endocrinologists are two key outstanding issues.

"Diabetes in General Practice" (<http://www.digp.ie>) was established by a group of GPs in 2001, and is now a medical charity. We now comprise 60 practices, including almost 200 GPs and over 100 practice nurses. Our twin aims are Education and Research.

**Education;** we have a "Diabetes in Primary Care" module, with 20 GP participants. This is a joint collaboration between UCC & NUI Galway. The 7th intake commenced in Sept 2015. Nurses participate in a diabetes module, hosted by UCC/Mercy University Hospital, with 35 nurses, now in the 6th intake. The nurse module on diabetic foot care has been attended by over 240 nurses to date. DiGP hosts 3 educational meetings each year, with a huge attendance at the annual DiGP conference (250 places). DiGP fund and support a GP based diabetes nurse specialist, in collaboration with South Infirmary Victoria University Hospitals, to initiate injectable therapies on patients inadequately controlled on maximum oral diabetic medication.

**Research:** DiGP has collaborated with UCC to facilitate extensive research. A landmark publication in 2010 showed that (unfunded) Diabetes care in DiGP met the same clinical

care goals as an NHS (funded) model of care in Scotland. The sustainability of unfunded care has been addressed in recent months by the HSE.

The HSE had great foresight in establishing a Diabetes Service Implementation Group (DSIG) in 2010. This group had 2 initial objectives, and we later expanded our remit.

**1. Retinopathy screening:** Diabetic eye disease is a leading cause of blindness in adults. Chaired by a very determined HSE manager Ms Gabrielle O'Keeffe, this group successfully invited over 2,500 patients with diabetes for retinopathy screening. We identified that 25% had some retinopathy, and 11 patients had sight-threatening proliferative retinopathy. The resulting paper "Quality-assured screening for diabetic retinopathy delivered in primary care in Ireland: an observational study" was published in the British Journal of General Practice. This group repeated the initiative the following year, inviting over 5,500 patients. Thankfully the National Diabetic Retinopathy Screening programme became fully operational in 2014.

**2. Podiatry and diabetes:** In 2008 Ireland had 330 amputations, and some 1300 patients admitted to hospital with foot ulcers. The average "bed occupancy" was 21 days, a very costly outcome both for the patient and HSE. Chaired by a resourceful HSE manager, Ms Yvonne Finn-Orde, this group secured funding for 6 podiatrists for Cork and Kerry, during austere times. Working closely with Diabetes Ireland, these podiatrists dramatically improved patient care. When the national programme was established, HSE South secured a further 5 podiatrists (of a total of 16 appointed) to help address the podiatry deficit.

**3. Children and Diabetes:** DSIG established a paediatric group chaired by Prof of Paediatrics, Jonathan Hourihane. The subsequent appointment of two paediatric endocrinologists, and an insulin "pump

programme and school", with additional nursing support, has greatly improved both the experience and quality of care for children with diabetes.

**4. Integrated care and Diabetes:** The HSE have committed to funding diabetes care in General Practice. This is the first programme to resource chronic disease management in General Practice. Such structured resource allocations are a key determinant of high quality health outcomes in other countries.

**5. Gestational diabetes:** Gestational diabetes affects 12% of all pregnancies. It is common and clinically silent with implications for mother and baby, during and after pregnancy. Our gestational subgroup have highlighted the enormous financial and healthcare burden of suboptimal diagnosis and management at national level. We have obtained additional diabetes trained midwifery support. The women get much support from our consultant endocrinologists. However there is a huge deficit, which can only be addressed with the appointment of a whole time endocrinologist dedicated to gestational diabetes.

**6. Diabetes and endocrine care in Cork:** There were 3 endocrinologists in Cork when I was a student, and that number hasn't changed. Despite the explosion in consultant numbers over the decades, we still have just 3 endocrinologists. Cork has a full range of all specialities, so the endocrinologists manage diabetes and many other endocrine conditions including post radiotherapy/neurosurgery, endocrine cancers/tumours and patients with CF. Some parts of Ireland have six times more endocrinologists per head of population. The longstanding deficit in endocrinology resource in Cork is highlighted at every opportunity, locally, regionally and nationally.

Diabetes consumes 10% of the health budget. Ignore it at your peril ! ■

## Dr Tom A Barrett 1971, Cork and Vancouver, British Columbia



**Born 2 August 1944, RIP 31 January 2015**

Tom was a much respected doctor in both Ireland and Vancouver where he spent practically all of his working life, post his internship in the Mercy Hospital, Cork in 1972. He worked in Vancouver General Hospital in paediatrics and subsequently commenced practice as a family doctor. He was a very successful family physician and was ably assisted by his wife, Marian, who was the nurse/manager of his practice.

Tom had a wide ranging interest in sport from rugby to road bowling and golf and excelled at all of these. Having captained a winning Presentation College school rugby team, he played and won a Munster Senior Cup medal with Cork Constitution as a callow youth in 1964. On arrival in UCC Med School in 1965 he played rugby with UCC thereafter and was captain of the senior team in 1970. His exuberance and enthusiastic approach to rucking and loose mauling earned him the opprobrium of the occasional referee. As captain in 1970 in the Munster Senior Cup first round versus Young Munster, after two minutes we looked for Tom and he was walking towards the line after an indiscretion. Tom claimed it was a mistaken identity!

His road bowling ability was well known in Cork and he had some notable triumphs and accompanying gambling coups under the guidance of his lifelong friend, Kerry Creedon and road manager Barry Cremin, and the backing of Derry "Starry" Crowley of the erstwhile Western Star pub. Tom was a big-hitting golfer who played to single figures and was one of the first people to adopt the "broom handle" putter. He was one of the leading lights of Point Grey Golf Club, Vancouver for over thirty years.

Tom passed away peacefully aged 70 in the presence of his family and loved ones at his home in Vancouver. He had endured a typically courageous battle with multiple system atrophy. Tom was the beloved husband of Marian and adored father of Gillian and Niall and father-in-law of Gillian's husband, Rob. He is survived by his brothers Denis and John and their wives Siobhan and Sheila, his brother-in-law Billy and numerous nephews and nieces.

Requiem mass was held in Togher Parish Church, Cork on 19 February 2015 for the Barrett family. His remains were subsequently interred with his parents in St Josephs Cemetery, Ballyphehane. There was a very large attendance at the Mass and the farming community from all over Cork county were well represented to honour the extended Barrett family, who farmed extensively in the Cork area.

Following the funeral, there was a very warm family reception hosted appropriately in Fota Island Golf Resort. Barry Cremin, Tom O'Leary and Peter Morehan spoke glowingly of Tom's life in Cork, Canada and in UCC. It was a fitting finale for the big man. Ar dheis De go raibh a h-anam dhilis. ■

*Paddy Crowley*

## Dr Eoin Casey



Dr Eoin B Casey was a consultant rheumatologist with a vast experience in the field of musculoskeletal disorders. He received his medical degree from UCC in 1962

and after spending his Intern year at St Finbarr's Hospital, Cork, he went to the UK to undertake his general and specialist education in Derby and Sheffield. He pursued higher training in Neurology in London and was subsequently awarded his MD for research in Clinical Electrophysiology. He then spent several years in Rheumatology / Rehabilitation in London, moving to Dublin as a Consultant in these dual specialties in 1974.

Dr Casey was a single-handed Rheumatologist in the Trinity-associated hospitals for nearly 30 years, cycling his bicycle between St James's Hospital, Dr Steevens' Hospital and the Adelaide and Meath hospitals, the latter two subsequently merging into Tallaght hospital in the 1990s. He retained close links with Trinity College, holding the honorary title of Senior Lecturer and pursuing collaborative research with his colleagues, particularly in the fields of Immunology, Dermatology and Gastroenterology.

Dr Casey had a life-long interest in teaching and inspired several generations of young physicians. He continued to provide guidance at the weekly Medical Update meetings in St James's and was famous for the pre-MRCPI tutorials for Senior House Officers which took place in his own home several times a year.

Dr Casey was President of the Irish Society for Rheumatology from 1990 – 1992. The ISR honoured him with the 2013 Lifetime Achievement Award for services to teaching, research and clinical work in the field of Rheumatology.

Dr Casey died on the 23rd May 2014 and is survived by his widow Jill and his six children, Liam, Lizzie, Isobel, Alice, Mary-Ann and Edwina. ■



## Prof Benvon Cramer (Parfrey)



**Born Sept 22nd 1950, Died Jan 2nd 2015**

Benvon was the youngest of 3 children born to Brendan and Catherine (Kitty) Cramer. Both her parents were teachers, and the importance of education was evident in the home. She was a fun-loving and lively youngster, competitive from an early age, always succeeding in keeping up with the boys. From the age of four she expressed the wish to be a doctor, and never deviated from that intention. She attended school in Cork at Scoil Mhuire where her academic excellence was obvious, but there she also made lifelong loyal friends. In school, hockey was a great interest, which she played with fierce commitment, mostly as a formidable defender (in the position of left back). When she entered UCC Medical School in 1968, she maintained a continuous high standard in all her yearly examinations, usually in the top 3 in all subjects, including an honours degree in Final Med (rare in those days). She graduated in 1974. Very popular amongst her classmates, no one could be jealous of Benvon's high achievements as she shared her knowledge with everyone, and joined in all social class activities and clearly enjoyed herself. She also continued her hockey career throughout the undergraduate years in UCC, being a crucial player in teams which won the White Cup (all-Ireland), Munster Championship, and the Intervarsities.

Internship followed in St Finbarr's Hospital in the Medical and Surgical Professorial Units. Her "handover" ward round policy to intern colleagues on call for her patients at night was exemplary, long before such practices were official policy. In 1975 she married her former classmate Pat Parfrey in Cork, and together they moved to London UK, where

Benvon opted to specialise in Radiology. Subsequently they worked in Canada, first in Montreal, where she completed clinical and research fellowships in Radiology at the Montreal Children's Hospital and the Montreal Neurologic Institute, and later in Memorial University in St John's Newfoundland in 1984. Her initial clinical work was predominantly in the field of Pediatric and Maternal Fetal Diagnostic Imaging at the Janeway Hospital and subsequently expanded to encompass a wide range of adult radiology. In 2001, she was appointed Professor and Chair of Radiology, a position she served in until September 2014. A brilliant clinician and teacher, she also had an outstanding research career with numerous publications and was awarded the prestigious Caffey Award for best clinical research paper by the Society of Pediatric Radiology in 2000. She gave multiple presentations to learned societies at provincial, national and international conferences, including at several UCC Medical Alumni Scientific Conferences. She served on many committees and boards, which included Chair of the Canadian Heads of Academic Radiology. She was instrumental in the design of the radiology department at the new Janeway site, the development of a provincial PACS program and a strong proponent of the development of a PET scanning facility at the Health Sciences Centre. Benvon was a visionary leader of the discipline of radiology whose personal philosophy was to view perceived problems as opportunities to find solutions.

On a personal level, Benvon was a loyal friend, mentor, and colleague. Her family meant everything to her and she balanced an outstanding professional career with devotion to her family to perfection. That devotion extended to grandchildren and she had a particularly close relationship with her daughters-in-law. She was renowned for her hospitality which was enjoyed by all those visiting the busy, warm, welcoming home she shared with Pat and their four sons. For her support of rugby spanning 30 years, she was presented with the Chairman's Award by Rugby Canada. With Pat, she hosted the 35th anniversary reunion of her UCC Medical Class in St John's, in spite of having been diagnosed and treated for breast cancer shortly beforehand. The warm hospitality enjoyed by all at that event is a wonderful memory of that trip.

Benvon continued to work professionally although receiving difficult therapy for recurrence of cancer, a testament to her courage and commitment. She passed away peacefully at home in St John's and is survived by her husband Prof. Patrick Parfrey; sons Brendan, Kevin, Owen and Patrick; grandchildren Ben and Fiona; sister Geraldine and brother Barry and a large circle of friends worldwide. A special remembrance Mass was held in October in the Honan Chapel, at which a large number of family and friends gathered, and her love of rugby was marked by a beautiful rendering of "The Fields of Athenry".

Benvon was a superb physician, teacher and researcher, a cherished colleague, devoted wife, mother, grandmother, sister, aunt and a very dear friend. She leaves us all with a rich legacy of beautiful memories and love. ■

*Eilish Walsh, Katy Keohane*



## News from Alumni

London: Dr Aine Merwick

A public event celebrating the contribution of Irish healthcare and academic professionals in the UK is planned for November 29th 2016. The event is being organised in association with the Irish Embassy in London, and will be by invitation only. Interested UCC Medical and non-medical Alumni in the London / nearby area as well as other health-orientated groups, or other individuals with an interest who are not UCC graduates should contact:

[ainemerwick@yahoo.co.uk](mailto:ainemerwick@yahoo.co.uk) or [alumniondon@umail.ucc.ie](mailto:alumniondon@umail.ucc.ie).

Alumni who would like to keep updated about UCC events in the London area can register via <https://community.ucc.ie>



**UCC Medical Alumni  
Annual Scientific Conference  
September 8th 2016**

## AINSWORTH SCHOLARSHIPS SESSION 2015/16



Applications for the above postgraduate Scholarships are invited, from doctors who intend to practise their profession in Ireland, primarily those who are medical graduates of University College Cork.

Full particulars of the Scholarships and of their award may be viewed at:

<http://www.ucc.ie/calendar/scholarship/sch004.html>  
(Postgraduate Scholarship section of the College Calendar). Further details may be obtained from Professor Catherine Keohane, School of Medicine, Brookfield Health Sciences Complex, College Road, [catherine.keohane@ucc.ie](mailto:catherine.keohane@ucc.ie) who may be contacted for informal discussion.

**The latest date for the receipt of applications is Friday, 20th February 2016.**

## Contact Details

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**Tel:** +353 (0)21 4901 587 **Email:** [medalumni@ucc.ie](mailto:medalumni@ucc.ie)  
[www.ucc.ie/medschool](http://www.ucc.ie/medschool)

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