Proceedings of Colloquium in honour of Dr Michael Flynn

1st October 2009

TCD/HSE Specialist Training Programme in General Practice
Acknowledgements

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Foreword

Professor Tom O’Dowd

The proceedings of the Michael Flynn Colloquium reads like a good dinner party of thoughtful colleagues and friends who had good and interesting things to say. Michael Flynn was the reason so many gathered and listened and learned.

Brendan O’Shea has provided the varied framework within which Michael lived his colourful and productive life.

Fergus O’Kelly enjoyed Michael’s company and wit, often it seems well, if not wisely. Fergus is the heart and soul of postgraduate training in general practice and elegantly marries educational and professional philosophy with pragmatism.

Medicine honours its leaders sparingly, but the colloquium gave a great sense of handing on the torch. This is evident in Afric White’s contribution — though appearing daunted initially, she is finally undaunted by the future and certain of her generations’s contribution to general practice.

Gerry Bury perhaps can do more about the future than many of us and he is clear about the challenges facing the profession and general practice in particular. Gerry has a track record of bringing about change and there is little doubt that it will happen and that the profession will be fit for its purpose.

This is a warm, thoughtful contribution to a colourful and dearly missed colleague.

Tom O’Dowd
May 2010
I warmly welcome Tess and other members of Michael’s family, along with friends, graduates and Trainers of the Scheme and members of the Irish College of General Practitioners.

This colloquium honours Dr Michael Flynn’s life – a life worth living. We meet tonight to applaud his long contribution to medicine in Ireland and in particular to celebrate his contribution to this training scheme over 35 years. The Compact Oxford English Dictionary of Current English defines colloquium as ‘an academic conference or seminar’. The Encarta dictionary expands on this to define it as ‘an academic conference or seminar in which a particular topic is discussed, often with guest speakers’. How Michael would have loved the notion of his life and times being discussed in a colloquium.

And we have indeed guest speakers with us tonight. All of them are graduates of this scheme and all at some point, were taught by Michael.

Dr Brendan O’Shea, a graduate of Trinity College, was formerly a Trainer on the scheme, which is now known as the TCD/HSE Specialist Training Programme in General Practice. Brendan is now one of the six Associate Directors of the Programme. He will present to us a brief biography of Michael, including his aforementioned contribution to the Training Programme over many years.

Professor Fergus O’Kelly is a graduate both of the Royal College of Surgeons in Ireland and of Trinity College. He graduated from the Training Programme in 1974. The current and recently graduated Registrars were probably only in their infancy then, if even born. Suffice it to say that Fergus has a long history with the Programme. He has been a Trainee, Trainer, Associate Director and, for the past 12 years, Director. He is thus well placed to take us through the development of the Programme “From there to here...” and through Michael’s central role in this development.

Our third speaker, Dr Afric White, graduated in medicine from University College Dublin and more recently, as a General Practitioner from the Programme in 2009. Brendan and Fergus will give us the historical perspective and as a new graduate Afric will take us through her hopes and excitement for her future, and that of her peers, and for general practice training in Ireland.

Professor Gerard Bury will be our final presenter this evening and to close the circle nicely, he, like our first presenter Brendan, is also a graduate of Trinity College and of this training programme of course. He is Professor of General Practice and Director of the Centre for Immediate Care Services based in the School of Medicine and Medical Science in UCD. Like Afric, he will look forward, but taking a broader view, of the future of Medical Education and Training in Ireland.
Our very good friend and Colleague Michael Flynn was born on the 4th April 1942.

We lack a reliable account of his own reaction to his birth, but one strongly suspects that it was one of immediate and exuberant delight to be here on his part.

His family roots are in Leitrim, from where his grandfather and granduncle emigrated, to farm in South Africa. Thus it was that Michael's own father was born in Kimberley. Following the untimely death of his grandfather, the younger Flynn children, including Michael's own father, were shipped back to Ireland.

Despite these very difficult circumstances, Dr Michael John Flynn, Michael's father, graduated in medicine, and, as did many Irish Medical Graduates in the early 1940's, emigrated to the UK, to practice in Preston. Thus it was that our own Michael was born in Preston, in the North of England.

His early childhood was spent in that unique social environment of the combined home and surgery, and he frequently found himself in the midst of things. We find him at an early age, complete with teddies, adding a charming touch of realistic verisimilitude to the launch of the very latest in medical technology (a new hospital bed with all the latest gadgets attached) at the local Community Hospital, where his father attended. Following this very early and striking example of a photo-op, it is understood that the very next day he found himself back in the same bed following an appendectomy.

Mindful of deep attachments, and together with his siblings, our own Michael went home from Preston to Dublin for his education, enrolling at The Dominicans at Cabra aged 7, and thence onto Castleknock College from 1953 to 1959, and thereafter graduating from UCD in 1965, at the somewhat tender age of 23 years.

Perhaps even then, the breathless rush to be ever onwards and get things done was evident.

He became active in the Irish Medical Association upon graduating, and his postgraduate career included an internship at The Mater, Senior House Officer posts at the Coombe Hospital, Temple St Children’s Hospital, St Kevin’s Hospital (subsequently St James’ Hospital), and a period as Medical Registrar in the latter. He complemented his medical degree with Membership of the Irish College of General Practitioners in 1983, and Licentiate of the Faculty of Occupational Medicine from the Royal College of Physicians in Ireland in 1985.

Whilst gaining experience in Obstetrics at The Coombe Hospital, he met, evidently fell rather seriously in love with, and subsequently married Tess Flannery. He left the hospital environment to take up a position as Assistant with a view at the Practice of Dr Bartley Sheehan in Dun Laoghaire in 1968. It was however, a view which became rather murky, as these things do sometimes. Undeterred, he put up his plate in Newtown. Very shortly thereafter, he joined Dr John Mason, with a rather better view, becoming a Partner at The Johnstown Medical Centre in 1970.

Professional activities blossomed from this partnership, the practice evolving into a recognised centre of excellence, and of innovative family
practice, especially notable for quickly grasping and implementing a series of developments consistent with progressive and best practice. Clinical responsibilities included 150 deliveries per year at St Michael's and St Gabriel's Community Hospitals. Michael and John Mason were central to all of these developments, and their growing practice was a signal inspiration to many during these years.

These developments included many practical technical innovations, including the arrival of the telephone answering machine, which was commissioned as a somewhat acute necessity, arising from the imminent arrival of another young Michael Flynn. It was felt that the onset of labour might just perhaps interfere with Tess’s availability to answer the phone at this point, hence the hurried installation of the impossibly large boxy answering machine.

Michael developed a strong interest in Occupational Medicine, building a portfolio of appointments as Occupational Health Physician in Dublin from the 1970’s onwards. These included acting as Company Medical Adviser to Warner Lamberts (later Pfizer), and more homely appointments, including acting as Medical Officer to Dun Laoghaire Harbour Board.

He integrated an academic strand to his practice of medicine at the earliest, becoming an Undergraduate Tutor at Trinity College Dublin in 1972.

Outside of practice-based activities, he took on a range of academic activities including Assistant to the Director of the then Eastern Regional GP Training Scheme in 1975, and later Lecturer at the Department of Social Medicine at Trinity College Dublin. Mindful of the need to guard and develop the standing and integrity of our Specialty, he contributed substantially to several of our Professional and Representative organisations.

In particular, he acted first as Chair of the Publishing Committee and subsequently as Secretary to The Irish Medical Association, playing a critical part in the amalgamation of this body with the Medical Union, to form the Irish Medical Organisation, regarding which he personally had significant reservations.

His duties with the IMA included ‘keeping an eye’ on the novel and in those times, the vaguely seditious idea of General Practice Training, throughout the early 1970’s. He also acted as Secretary of the Irish Institute of General Practice, which in turn, critically developed into the Irish College of General Practitioners, founded in 1985.

He contributed as Irish Representative on the European Union of General Practitioners (UEMO), and served as President of the General Assembly of the UEMO in 1980. He contributed internationally to WONCA and Europe Against Cancer, and latterly assumed the Presidency of the General Practice Section of The Royal Academy of Medicine in Ireland, to which body he was elected Fellow, and he finally assumed the Presidency of our own College, the Irish College of General Practitioners in 2005. This was to be his last high Office, which he discharged with all of his customary passion, interest and vigour.

Presidency of our own College was not his last professional honour, and to our great delight here, Michael’s memory and achievements have been...
recently honoured through the decision of our Colleagues at UCD, his own Alma Mater, in naming their end of year Lecture in his honour.

In the course of maintaining ‘a watchful eye’ on nascent General Practice Training, Michael was pulled into the active teaching of GP Trainees by Manné Berber, and thus found himself, very willingly, among the very first to be practically and actively involved in GP Training in Ireland.

Thus we find ourselves closer to home, and during these many years, Michael came here, to be with so many of us, as we progressed, at times erratically, on our own journey of professional development, and through our own professional adolescence. He brought wisdom and experience of many types, and liberally placed them at the disposal of all of us, doing so in a manner which was the epitome of modesty, creativity, concern and kindness.

He acted in the Directing Group at this Scheme, with the Trainer’s Workshop, as a Year Facilitator with our Registrars, and as friend and mentor to countless individuals, colleagues and peers, including many of us here this evening. Whatever his nominal responsibility was, on any given day, he was, most of all, himself to all of us, wearing his considerable dignity and seniority very lightly indeed.

It was observed that no one could ever sport a pink shirt and silk tie with quite the same assurance, dash and brio as ‘The Flynnstone’, and that in this web enabled era, he was most likely to be the one of us with the gem of wit or wisdom, or the shiny new tool or piece of innovation, wrested from his ubiquitous notebook, or from anywhere else, and made joyfully available to any and all within reach.

Impulsive generosity, an easy concern, and coruscating wit were his hallmarks in these days, all shot through with great experience, assurance, and a close focus on best patient care and the wellbeing of younger Colleagues, indeed all of us here without exception.

Summarising himself in his own words, he characterised himself, in a recent profile in the Irish Times as ‘enthusiastic, opinionated, gregarious, pedantic, loyal, prolix and sesquipedalian.’ On noting that the latter trait was recorded incorrectly as desquipedelian by The Paper of Record, he very kindly and easily forbore sending them a sharp admonitory.

He is missed. His chair at our own meetings remains empty. Our evidence based medicine gives us no reliable clue as to his exact whereabouts. Our thoughts are with Tess, James, Stephen, Michael and Judy, and the extended family, from whose loving embrace he quietly left us, just over a year ago. We do not have to search too deeply into our own hearts to find there cherished values that were his, and it is easy to listen and to recollect again his very many memorable humorous and penetrating insights. It is easier still to look on the breath and depth of his accomplishments, and on the values of a man who so effectively placed the highest value on collegiality and on concern for others to the fore at all times.

Countless young men and women among us have been very kindly taken in hand down the years, brought into consultations with an exceptionally fine Physician, taken home for lunch at Rochestown Avenue, warmed up over a decent glass of red, and as we progressed from the appalling uncertainties and challenges of undergraduate medicine into something more substantial, to be nodded at and cheerfully greeted across a medical meeting or Trainers’ Workshop; we can truly understand that we are collectively much the better for the pleasure and the delight of his acquaintance and his great regard.

In these days, we are very correctly focused on the needs and proper empowerment of our female
Colleagues, all of which is imperative, right and proper. The life which Michael shared with all of us can easily be viewed however as a very fine example of manliness, in the very best sense, characterised by strength, consistency, dedication, creativity, undoubted fortitude, and suffused with a keen, generous and urbane sense of unfailing good humour and fun.

On our Training Scheme, there has been a sense of sadness and loss evident throughout this last 12 months and more. We have, I suspect, comforted ourselves with the sight and sounds of young James Flynn and his own Colleagues, striding down the corridors, frequently shooting from the hip, and usually with great accuracy, as we collectively reflect on the stuff of General Practice. Despite the great sadness, it is truly difficult to be glum in such ebullient and brilliant company.

Thus it is that given the kindness, interest, compassion and fun which are so properly characteristic of our Training Scheme, it is easy to understand that Michael Flynn is not, perhaps so far away.

He is deep in the Foundations here.

In concluding, there are two references, which perhaps add some definition, the first being the poem ‘Felix Randal,’ by Gerard Manley Hopkins. As our resident latin resource, Dr Elly Harris in 4th year will doubtlessly advise you, ‘felix’ derives from the latin, meaning ‘happy.’ The second took several discussions and serial cups of coffee to finally pin down by Fergus. Even still a lingering uncertainty remains as to the absolutely correct attribution…

*Felix Randal*

Felix Randal the farrier, O he is dead then? my duty all ended,
Who have watched his mould of man, big-boned and hardy-handsome
Pining, pining, till time when reason rambled in it and some
Fatal four disorders, fleshed there, all contended?

Sickness broke him. Impatient, he cursed at first, but mended
Being anointed and all; though a heavenlier heart began some
Months earlier, since I had our sweet reprieve and ransom
Tendered to him. Ah well, God rest him all road ever he offended!

This seeing the sick endears them to us, us too it endears.
My tongue had taught thee comfort, touch had quenched thy tears,
Thy tears had touched my heart, child, Felix, poor Felix Randal;

How far from then forethought of, all thy more boisterous years,
When thou at the random grim forge, powerful amidst peers,
Didst fettle for the great grey drayhorse his bright and battering sandal!

Gerard Manley Hopkins

‘The unexamined life is not worth living’
*Socrates (O’Kelly)*
Introduction

In this talk I intend to outline the evolution of our discipline, general practice – or family medicine as it is named in the US and throughout Europe. Dr Michael Flynn had an early central and enduring role in this evolution. He contributed within Ireland and internationally – but especially to this training programme. Michael taught every one of our graduates from 1975 including those who graduated in June of this year. I will talk of the present status of the programme, its current strengths and some of the challenges it faces. I will suggest some changes we need to make to allow us to grow and contribute further to our now much more self-assured discipline.

In September 2005 WONCA – The World Organisation of National Colleges and Academies of General Practice/Family Medicine held their annual meeting on the Island of Kos – birthplace of Hippocrates. EURACT the Academic GP Teacher’s arm of WONCA launched their education agenda at this meeting, which followed on from the new definition of general practice/family medicine published in 2004. This definition and educational agenda have been adopted and adapted by many national colleges – including our own Irish College of General Practitioners. Our scheme was well represented at that meeting by both teachers and trainees.

So what better place to start our journey but in ancient Greece. Aesculapius is known as the God of Medicine – the first doctor and forefather of all physicians. His reputation, his medical skills, made him much loved and a following developed around him. He underwent apotheosis – that is he became a God. Mythology represents him as the son of Apollo and Coronis. Apollo is the god of light, leader of the muses and of healing.

Such was the following around the cult of Aesculapius that Aesculapions or places of worship and healing were erected all over Greece, the most famous one being on Kos where Hippocrates “the father of medicine” practiced his craft. Hippocrates was born in 460 BC. He is believed to be the first Physician to reject superstition, legends and beliefs that credited supernatural or divine forces as curing illness. He separated the discipline of medicine from religion, believing and arguing that disease was not a punishment inflicted by the Gods but rather the product of environmental factors and living habits.

Graduates of the Royal College of Surgeons on St. Stephen’s Green will be familiar with the three statues on its roof facing into St Stephen’s Green. They represent Aesculapius in the centre with Hygea on the left and Athena on the right. These statues represent medicine, health and wisdom respectively. So even though we are separated by millennia we still relate back to ancient Greece and the Aesculapion of Kos.

At the end of the WONCA conference we delegates were invited to travel to the Aesculapion to rededicate ourselves to the Hippocratic principles, which we duly did.

Let us now move to Ireland and again to mythology. “The early medical history of Ireland is like that of most countries, a mixture of folklore, doubtful facts and mixed pagan and Christian superstition”.

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of the Tuatha Dé Danann. They were said to have practised hypnotism and to have recognised fourteen disorders of the stomach. Legend has it that the King, Nuada, had his hand cut off in battle with the Fir Bolg and the physician attached an artificial hand made of silver. This silver hand is represented in part of the arms of the Royal College of Physicians in Ireland. It is recorded that physiotherapy and medicated herbal balls were used extensively.

The laws governing the people came to be known as the Brehon laws. They first came into being several centuries before Christ and regulated in great detail the social relationships and customs of the early centuries. The importance of caring for the sick was well recognised in these laws as was the stature of the physician.

With the advent of Christianity the Monasteries became places of refuge and of caring for the sick. One of the earliest Hospitals was in James’s Street in the Augustinian Church. However in 1163 the Council of Tours decided that monks should not be involved in surgery, since the church abhorred bloodshed. This led to the separation of physicians and surgeons. By the 14th century this division was well recognised. The physician acquired the title ‘Doctor’ while the surgeon was regarded as an inferior being and remained a plain ‘Mister’.

From about the 10th century until the foundation of a formal medical profession, medicine in Ireland was practised by hereditary physicians. They attached themselves to specific chieftains and clans. They were scholars with a university education well versed in the classical theories of medicine and were often trained in theology as well as physic. Dermot O’Meara, physician to the Butler family of Kilkenny, a medical graduate of Oxford, wrote on his return to Dublin in 1619 that very few practitioners had any qualifications and he describes the situation as follows: “Here not only cursed Mountebanks, ignorant barbers and shameless quack compounders, but persons of every craft whatsoever, loose women and those dregs of humanity who are either tired of their own proper craft or inflamed with an unbridled passion for making money, all have leave to profane the holy temple of Aesculapius”.

This of course wouldn’t happen today!

With the abolition of the monasteries under Henry 8th, there was no obvious or organised care for the sick until the founding of the secular voluntary hospitals, such as Dr Steevens’s, Jervis St. and others.

Meanwhile wars and recurrent plague also exacted their toll on the population. It is estimated that the plague (1347 – 1350) swept across Europe and halved the population. Here in Ireland it appears to have had a greater impact on the Anglo-Norman area of the East and South coasts than on the Western and Northern areas. This was for a variety of reasons to do with habitation and diet. Tallaght is known to be one of the places affected and in fact, ‘Tallaght’ is derived from the words támh leacht, meaning plague burial place.

“In 1838 in the face of a large and greatly impoverished population, the workhouse system was established, by the then government.”

In 1851 following the devastation of the Great

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3. Fleetwood JF. Op Cit
Famine a dispensary service under the governance of the local boards of guardians was established. These local boards of guardians also ran the workhouses. Some 800 doctors were employed at low salaries to look after these poor people around the country. The dispensary system became part of the poor law system with all its characteristics of discrimination, harshness and frugality. These doctors were the generalists of their day, serving the local dispensary areas and others in the community who paid them directly. This was usually in the doctor’s house separate from the dispensary.

The next major change in the medical system was the introduction of the medical card scheme in 1972, which paid general practitioners on a fee per item basis for seeing those people who qualified for free health care on a means tested basis. Doctors had to see patients, whether private or public, in the same consulting room.

And so to this training scheme…….

This scheme was established in 1975 and was the third GP training scheme in Ireland; the one in Galway was set up in 1971, followed by Cork in 1972. The initial intake was four trainees and I was one of the four. The first meetings were held in the evening, every fortnight, usually led by Manné Berber with Michael alongside. You had to get your own hospital posts at that time. The meetings were most eclectic and introduced us to many strange notions including bio-psycho-social care. We even had psychologists and sociologists talk to us, and Prof Mickey Brennan, a professor of General Practice from Canada. We had to wait a further 12 years before we had such an exotic creature here in Ireland.

These two years were followed by a practice year, when we were officially ‘Research Fellows’, as this was the only way the then Eastern Health Board could offer us a salary.

My practice year was spent in Greystones under the guidance of Dr Cyril McNulty. I thoroughly enjoyed all of it. I am pleased to see Cyril here tonight and thank him for his wisdom and guidance that year. Cyril is watching me tonight - his first trainee. Gerry Bury will speak later, - he was my first trainee and as Gerry looks into the audience he will see many graduates from UCD whom he has taught, including Afric White, another of our speakers. So the torch is passed on.

Tom O'Dowd, as Professor of General Practice, and the directorate of the scheme, have actively promoted the integration of this training scheme into the Department of Public Health and Primary Care within Trinity College. We now form a very active postgraduate arm of the department and this synergy has allowed the scheme and department to develop in so many positive ways. Our model of integration offers a different and enhanced model of training and is unique within Ireland and in the UK - although this model is the norm in other parts of Europe and further afield. All of our training practices take medical students as well as Registrars and we encourage the idea that our Registrars become actively involved in the teaching of the medical students – learning to pass on their knowledge and experience in the time honoured way.

Last year two of our practices were used as locations for the Trinity College final professional medicine exam, and another GP colleague was an examiner in the hospital setting. It is hoped to expand this further over the coming years so that more of our Trainers and their practices would become involved in the final medicine exam.

Furthermore, the Trainers of the scheme have become actively involved with the departmental research agenda. The two projects with which they were mainly involved were the Diabetes Peer Support Study and the Alcohol and Pregnancy...
Study. This is on top of supporting our Registrars’ research projects – the fruits of which you see in the End of Year Booklet, already published for 2009, and which we plan to publish annually from now on.

Teaching Philosophy
This scheme firmly believes in the concept of adult learning, of innovation in teaching and much hard work, but tempered with lots of fun. We recognise that teaching is both an enormous privilege and responsibility. It is more than a process – it is an intellectual and emotional connection between learner and teacher. It is a great responsibility on us to help shape the professional vision of our younger colleagues, to stimulate their curiosity, encourage life-long learning and help prepare them for independent professional life. It should be, and is, immensely enjoyable.

Teaching itself is a learning experience. A good teacher is one who retains his or her own curiosity, stays current and questioning and attends to his or her own learning needs. Like learning, teaching is a life-long process – it should be infectious. Many of our recent graduates are immediately inducted into helping out in teaching the first year medical students and they love it!

As a scheme we have been at the forefront of many developments, both clinically and professionally, over the years. We have always been dynamic and innovative. Graduates of the scheme were closely involved in setting up the out-of-hours co-op services which have improved services to patients throughout the country and transformed the lives of GPs and their families, especially in rural areas.

The scheme has played a central role in developing the educational agenda for GP training at local, national and international levels, through our own fora, through NAPD and through EURACT and WONCA.

Other innovations are:
- The fourth year and its programme – now ably mentored by Brendan O’Shea
- The formation of the first GP out of hours co-op ‘Dubdoc’
- The arrangement of out of hours experience for our trainees with our co-op colleagues, thus encouraging more colleagues into a teaching role.
- The development of newer and innovative training programmes – such as our involvement in the Naas satellite programme.
- Our proposal for a different programme for GP training, which would recognise prior learning experience for some colleagues who wish to change to general practice.
- Research: we have been responsible for a number of reports on the state of general practice in Ireland, which are cited in numerous papers and documents since publication. However research is one area we must continue to develop further. General practice research is generally not well developed, as is made clear in the Mant Report. It is mainly carried out by keen individuals. The Health Research Board Research Centre in Primary Care, jointly awarded to RCSI, TCD and QUB is a recent development, which will build capacity in primary care research and place us on the research map nationally and internationally. This is an example of us working with our colleagues in other disciplines within the university structures. We will all be the beneficiaries of such research endeavours.

We have grown and developed in the last 35 years to be a highly regarded, successful and most sought after training scheme. Our intake has grown to 12 per year. Forty eight trainees, plus support staff take over the facilities here every week. Further, this scheme now has four professor graduates: 3 full professors, Gerry Bury, UCD, Andrew Murphy, Galway and recently Walter Cullen in Limerick, and of course your humble Director as a Clinical Professor here in Trinity.

Humility is one of the first things we learn on this training scheme and therefore modesty prevents us from claiming to be the best training scheme – however we can and do state categorically that we take second place to no one.

So what of the future? – I turn once again to the ancient Greeks for inspiration. “It is in my opinion a most excellent thing for the Physician to practice forecasting” (Hippocrates).

So with this encouragement I will set forth some ideas.

1978 Alma Ata. The first international conference on primary care was held there and they adopted the “Declaration of Alma Ata”. It underlined the importance of primary care as the key to achieving the goal of health for all - the slogan was “Health for All by the year 2000”.

“Health .... is a fundamental human right ...The gross inequality in health status .... is politically, socially and economically unacceptable.”

While this declaration was seen as being most important it really didn’t capture our attention or imagination here in Ireland. It was seen as being worthwhile but remote – something for developing nations and nothing that would or should impinge on our practice. It was a bit like liberation theology, very laudable, but not in my parish thank you! The definition of health “health .. is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity“ was thought to be too aspirational and not achievable. At this time I was beginning to struggle in my own practice with an emerging drug problem – one the health authorities were at first reluctant to recognise and colleagues frankly didn’t want to know about – so declarations coming from afar were not immediately relevant!

Professor Barbara Starfield, from The Johns Hopkins University School of Hygiene and Public Health, started to research the area of primary care and showed that developed countries with good primary care infrastructure like Canada and the UK had better care, delivered more cheaply, than countries with weak primary care who tend to spend more of their GDP on care which is supplied by specialists.

1996 The Ljubljana Charter on reform in WHO European Region incorporated the following fundamental principles in relation to health:
- Driven by values
- Targeted on health
- Centred on people
- Focused on quality
- Based on sound financing
- Oriented towards primary health care

Ireland as a Government would have signed this charter!

These principles are value driven with the emphasis on dignity, equity, solidarity and ethics. They are rights based rather than income based.

In 2001 the Irish Government launched its own primary care strategy with all the same value-laden terminology.

It is now some eight years since the Primary Care Strategy was launched. After a very slow start with just ten pilot schemes up and running – after falling way behind its own targets, there are signs of a new push and urgency in rolling out the strategy. Michael Martin launched the Strategy but soon afterwards Mary Harney was made Minister for Health and the urgency went out of Primary Care.

A new political philosophy /orthodoxy emerged and although she denies it, the whole of medicine now looks towards private enterprise rather than a public system – Boston and not Berlin! However the HSE under Brendan Drumm has recognised that

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primary care must be the direction in which the Health System moves if we are to achieve a more equitable and affordable health care system.

Official general practice, that is both the ICGP and the IMO, have been slow to embrace the model of primary care. However, individual GPs have done so with varying degrees of enthusiasm with Garret Igoe in Cavan being one of the earliest converts, and he still has the zeal of a true believer.

In October 2002, Professor Tom O’Dowd delivered the Donal Burke Memorial Lecture in the Royal Academy of Medicine in Ireland. It was entitled ‘General Practice and Primary Care: A loveless affair’. He said “Advocates of primary care have got to get over their inherent dislike of the bio-medical model as the strategy will not work without General Practice. GPs on the other hand, will have to tussle with issues that will not go away even if the Primary Care Strategy fails. Most important among these issues are whether we are providing care for the individual or service to a community.” Michael Flynn also had worries about loss of personal care in any new arrangement of the health services – which he articulated on a number of occasions.

Here I part company with Michael’s and Tom’s view. I believe that is not ‘either or’ but that there is a third way – to use the Blairite vision – we can have both, have it all! In truth I know that Tom now shares this view. To achieve this, general practice, or more importantly general practitioners, must first embrace the notion of primary care, must become centrally involved and become the drivers of the concept. In this way we will learn to engage meaningfully with other primary care team members and with the HSE. It is only by working closely with them that we will ensure our vision is embedded in an evolving and shared vision that will be central to future health policy and service delivery. When this happens resources will follow. We cannot stay outside of the tent moaning, back sliding and nit picking but get into the tent and become fully involved in making a success of the primary care philosophy. If we configure services correctly, we can arrange it that other members of the team are primarily engaged in population based care, chronic disease management and preventive strategies, with the involvement of the GP; and that we as GPs, are still able to offer personal care, to individual patients.

I have talked with three of my colleagues, Garret Igoe (Virginia Primary Care Team), John Latham from the Liberties Primary Care Team and Brid Hollywood from the Ballymun Primary Care Team and I asked them did they feel they had lost or compromised on personal care within the primary care model? – all were emphatic that they had not – however they all said that the GPs needed to be at the centre of the team to ensure that personal care was not eroded. It has been said that primary care may succeed only in the more deprived areas of the country – well the latest Primary Care Team to open is the one in Dalkey, Co Dublin, later this month!

So where does that leave us in GP training? How do we prepare our trainees for primary care? We need this training programme to shift its focus from solely training for general practice to training for primary care. The scheme recognises and embraces the idea that in the immediate future general practitioners will be working within primary care teams. The HSE is committed to roll out its plan to establish primary care centres as the first port of call for the patient seeking health care and that GP graduates will be central to this plan. The name of the scheme could be changed to embrace this change: “The TCD/HSE Postgraduate Primary Care Training Scheme (Specialist General Practice)”
**Integrated Teaching:**

At heart it would be a traditional 4 year GP training scheme with additional integrated teaching modules with other primary care professionals, such as public health nurse trainees and practice nurse trainees. Other graduate primary care team professionals such as physiotherapists, psychologists, community pharmacists and social workers would be integrated into this teaching where feasible.

The integrated teaching would include:
- Putting the patient at the centre of the health care process.
- Chronic disease management, such as diabetes care, cardio vascular disease, stroke prevention, hypertension, asthma, other chronic lung disease and mental health problems. We are fortunate to have Prof Carmel Martin an internationally recognised expert on chronic disease management or as she more correctly refers to it “complex care”, to share her expertise in this area.
- The philosophy of the primary care team.
- The importance of team work: this could be resourced by HSE staff working in established primary care teams.
- Establishing and using agreed protocols.
- Other modules as agreed with other disciplines.

**Placements:**

4th year Registrars would do placements within existing primary care teams to learn how best to maximise the potential of the team for patient care. Other potential placements:
- GP Registrars with Public Health Nurses and PHN trainees with GPs.
- GP Registrars with Community Pharmacists and vice versa.
- GP Registrars with Public Health doctors and PH Registrars with GPs.

Also, graduates of the scheme should be equipped to take on leadership roles in a newly configured health service. To this end they would have a module on Primary Care Management to include:
- Organisational structure and behaviour
- Management principles
- Non clinical patient services, the service experience and public relations
- Strategic planning
- Information technology and communications
- Health economics
- Motivation and conflict management (Human Resource management)
- Change management

This module could be run with the assistance of the Trinity Business school and could involve management placements in industry, services and the health services.

Following implementation of the above proposals our graduates would be better placed to integrate fully and actively participate in the primary care teams, and be equipped to take on a leadership role in the future thus ensuring a more robust integrated and focused health system for the patient to experience. I have discussed these ideas with my colleagues Ger Kidney from the Midlands scheme and Philip Weihe from the UCD training scheme. Both schemes are willing to explore this new programme in the near future. At present these three schemes train 37 of the 120 trainees nationally – that is 30% of the total. This represents a major shift in the philosophy of GP training and embraces integrated teaching with other primary care team members. This proposal could act as a pilot model for other GP training programmes and will be brought to the ICGP for consideration.
In conclusion
This programme is heir to a rich medical history starting at the beginning of time. It is now in its 35th year and has contributed to the education of over 300 worthy graduates who are mainly in general practice within Ireland. They do us proud and serve at all levels through the GP and academic services and institutions. A small number have moved to other disciplines but they fondly remember the GP training and carry the marks of their training into their new world. The scheme has also contributed locally, nationally and internationally to the education and development of General Practice /Family Medicine

We are justly proud of the major contribution Michael made to this programme, where it came from, its journey to date and its robust views looking forward.

Prof Gerry Bury addressed us at our 30th anniversary celebration in 2005. His paper was entitled “Fit for Purpose” and in it he said “The much criticised Primary Care Strategy suffers from problems with implementation but contains a wealth of challenges with relevance to our roles as medical professionals”. He urged us to look constantly at ourselves to reappraise what we are doing and to ensure that we are “fit for purpose”.

I say to Gerry and to you all here this evening that this Training Programme, Michael’s Legacy, is in word and deed: FIT FOR PURPOSE.

“We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time”

(TS Eliot – Four Quartets)
For those who don’t know me, my name is Afric White. I grew up in the midst of a rural general practice. I went straight from school to study medicine in UCD, graduating in 2003. After my internship, I spent a fantastic year in Melbourne, Australia, which involved a little bit of work and a lot of play before returning to start my GP training with the TCD/HSE GP training scheme, which I completed last July.

When I was asked to speak at this evening’s Colloquium I spent a lot of time mulling over the topic at hand, somewhat fazed by its scope. The future of General Practice Training in Ireland is a veritable ‘hot topic’ much aerated, with many controversial pitfalls and I felt quite a responsibility in providing a viewpoint on behalf of my peers.

Ultimately, my musings on the subject since graduation kept bringing me back to one central idea from which I can’t escape.

I believe the most important part of medicine is the people involved and the pivotal role that individuals with their various personalities play in all that we do. Without wishing to sound twee, this is the very reason I arrived at a career in medicine and more specifically in general practice.

By the ‘person’ I do not mean just the patient, who is obviously at the centre of all our dealings but more fundamentally how we, as individuals and our collaborative effect as a group, interact to drive a process forward. In case I have lost you, I’ll go back to basics. We all have a teacher in our past, an individual we encountered along the way who has had a lasting effect on us – mine was an English teacher in secondary school, Mr Leonard Noone. He was someone who made me look at the familiar in a different way, to challenge entrenched ideas, to take a creative risk, an influence that is still with me today.

General practice, for me, stands out from other specialties in medicine, in particular for its alternative method of training. And anyone with friends currently struggling within the hospital system will know exactly how different this is. The training schemes that exist today have been hard won and established by people such as Dr Michael Flynn and others present this evening, who possess a real vision for the future.

What makes GP schemes different, is the opportunity provided within them, and their small group structure, to establish an arena in which individual directors, trainers and GP trainees can exchange ideas, argue things out, work through the reasons that we do the things we do in the course of our job every day. And apart from what happens to that end, here on this scheme every Thursday, the crucial element for me is the unique one-to-one relationship between trainer and registrar in practice, that is unparalleled in other sectors of medical training.

As a recent graduate I am lucky enough to have my ‘class of twelve’ well represented in the audience tonight and I hope they will agree that over the course of four years we have become very close and have established friendships that will endure. Although we were unaware of the significance at the time, we are also very honoured to have been the last group who had the pleasure of Dr Michael Flynn’s stewardship and guidance through our 1st
registrar year. I have spoken about the influence a teacher can have on one’s development and I can say that I have been lucky enough also to have had two trainers during my time on the scheme, who, in their different ways, certainly left their mark on me. Reflecting on all these people I am drawn back to the idea that teaching, training and indeed the study of medicine itself is not just a science, nor a master plan of techniques and skills to be learned. If it were so, we could do it all online by distance learning. Instead it is about the combination of people involved, and their various attributes and energy that drive ideas, allowing learning to evolve.

My graduating class, and our peers whom we have come to know over the years – those behind us on the scheme and on other schemes – are the GPs of the future, and possibly more importantly, we are the trainers of the future. And this is what makes me very excited about where general practice in Ireland has the potential to go. The traditional view of general practice as more of an art than a science, for me rings as true and relevant today as ever and I think we, the new generation, are in a very strong position to nurture and maintain this unique quality.

We hear a lot said about the feminisation of medicine, the impact of graduate entry schemes and the manpower crisis ahead – all good buzz words for our time. What interests me is breaking all these issues down to the individual building blocks, to the people and lives involved. Take a look at my class, and the other classes on the scheme – we are a very eclectic bunch. We are young women and men, graduating often in our thirties – some of us parents already, for whom the work life balance will be so important in the next 10 years and beyond. Some of us, like myself, followed a straight path. Others have been drawn from different medical specialties or are graduate entrants, with skills honed from prior lives perhaps as scientists, physiotherapists, lawyers, radiographers and even business people. We have hugely different interests. We are sports people. Some are artistic, musical, great writers, events managers as anyone who has attended our team building trips can testify. We are even future policy makers, critics, innovators, and dare I, say it, potential Ministers for Health. When a group like this comes together, as we do here on each Thursday, as we may do individually with our own registrars in the future, as we contribute to CME groups, steering committees, contract negotiations, there is a richness of knowledge, varieties of viewpoints and a camaraderie that provides a seed for change. With due respect to the company present, we are very different from the more homogenous group of General Practitioners who paved our way into this great career. Not in terms of talent, or drive or sense of adventure – but there is an individual diversity, which did not exist before. As I have said, many of you as trainers have had a huge influence on us and we are grateful for that. However, how we see our lives and our daily role in general practice may not be the more traditional role that our predecessors before us have worked so hard at.

Just as parents make sacrifices for their children to have a better future, all that which has gone before – the hard grind to modernise, computerise and form co-ops, leaves us in a privileged position where we may have more time and energy to bring our strengths and our talents to tackle the
uncertain future ahead. We have the ability to drive general practice to meet the challenges that face us with a flair and creativity that we have been given the opportunity to foster. This is particularly important as we try to meet head on the needs of a health system that itself is struggling with its own diversification and identity in a changing Ireland. And instead of seeing all these things as negatives, as they are too often portrayed, as feeding the manpower crisis that is undoubtedly ahead, it is this great dynamic, this mix of talents, backgrounds and clashing viewpoints that makes the future of general practice so bright.

If we are the trainers of the future, then our trainees will be moulded by this diversity, as we establish with them those unique teaching relationships and group dynamics of which I spoke earlier. One only needs to sit on a GP training scheme interview panel, which I had the opportunity to do a couple of years ago, to understand that we will need to keep our game up – for each new group of doctors is constantly pushing the boundaries in terms of their skills and interests, both within the world of medicine and without. We will need to be flexible in meeting their learning needs, in using our collective experience to provide an environment where they can become General Practitioners who can rise to the challenge of the rapidly changing needs of both our patients and society.

And a final thought ... it is of people, individuals, who leave their mark, who open doors, who give one a glimpse of what is possible; people like the late Dr Michael Flynn, my own trainers, my classmates, the patients we meet everyday. It is an immeasurable fleeting thing, this dynamic that allows us to feed on the strengths of others, while also contributing some of our own, a collaboration central to the art of general practice and which gives it a future in which I am excited to play a part.
Properly planned and carefully conducted medical education is the foundation of a comprehensive health service.

Report of the Inter-Departmental Committee on Medical Schools, The Goodenough Report 1944

Introduction

It is a rare privilege to have the opportunity to speak at an event celebrating the life, profession and contribution of a colleague such as Dr Michael Flynn. I first met Michael when as a trainee in the Eastern Regional General Practice Vocational Training Scheme (ERGPVTS), I learned about the fundamentals of medicine in general and general practice in particular from Dr Manné Berber, Dr Michael Flynn and a team of visionaries who quietly influenced generations of doctors in training. I begin this reflection on the place of medical education with a moment, which I believe, summarises much of Michael's character and role in medicine – the moment of Michael handing the chain of office of the President of the ICGP to his successor.

For me, this moment captures the essence of Michael's contribution to general practice – handing on the mantle to others. As an educator, Michael questioned sometimes, challenged often and encouraged always – he expected his students at all levels to discover their own potential and to develop themselves as individuals and as doctors in order to achieve that potential.

It is in that spirit of striving to achieve the most for ourselves, our patients and the health system in which we work, that this piece outlines the developing roles of the HSE's Medical Education and Training Unit.

Background and context

In 1944, Britain's Goodenough Report on Medical Education drew an important conclusion about the links between medical education and health service provision – quality in the latter depends on excellence in the former. Ireland's 2004 Health Act formally acknowledged this truth by requiring the newly established Health Service Executive to facilitate medical education and training; the 2007 Medical Practitioners Act followed this up by setting out detailed roles and responsibilities for the HSE in relation to medical education and training. The HSE established the Medical Education, Training and Research Unit (METR) within the CEO's office in 2007 and I was appointed as its first Director in 2009. The 'R' (for research) will be the responsibility of a separate health research unit within the HSE in the coming year – the area is far too important to be managed as an appendage to medical education.

Ireland now has a significant statutory framework within which to provide medical education and training – the Health Act 2004 (HA04), the Medical Practitioners Act 2007 (MPA07) and the 2005 Fottrell and Buttimer Reports provide a mandate for development of medical education which is integrated, of high quality and oriented to the needs of students and patients. To that end, MET has adopted a simple slogan – ‘Fit for purpose, in the Irish health service’. MET will work closely with all of those involved in medical education.
to ensure the high standards of Irish medical education are maintained, in order to equip the Irish health service with the numbers, types and grades of doctors it requires.

The goals of medical education
Excellent communication and collaboration between all of the agencies involved in medical education is essential to this mission – but will be a complex process when considered in terms of overall goals, types of education and training, accreditation and funding arrangements: multiple agencies contribute to decision making across these four domains and the potential for confused governance arrangements is clear. Perhaps the key educational demand at this stage is for an agreed set of goals - I propose one initial step towards meeting the target of our new MET slogan and simultaneously introducing an overarching set of goals: the adoption of CanMeds.7

The CanMeds framework was developed as a set of essential domains of competence for specialist training in Canada in the mid-90s. It has since been recognised as an effective model for the education and training of many health professionals – the challenge lies in identifying the relevant competencies and in effectively teaching and assessing them. Models such as CanMeds, the Scottish Doctor8, the GMC’s Good Medical Practice project9 and others are available to guide us – but the development of agreed goals for medical education in Ireland is, I believe, an achievable and worthwhile strategic aim. An important argument for such cohesion is summarised in Table 1. Many agencies, sites and frameworks are being used to address the needs of medical students, interns and doctors in specialist training – clarity of purpose would benefit all.

Resources – manpower and funds
It is equally important to consider purpose in terms of the considerable state funding invested in medical education. The MPA07 transferred the funding responsibilities of the former Postgraduate Medical and Dental Education Board to the HSE; MET will implement these responsibilities in the disbursement of a multi-million euro budget in 2009; postgraduate training bodies and 24 newly established Academic Clinician posts are two of the headline recipients.

Workforce planning may not be perceived as a key component of medical education but it is nonetheless of great importance to strategic decision-making about the numbers and specialties and locations of future medical trainees in Ireland. The publication earlier this year of the Fás study on workforce planning in Ireland represents a milestone for evidence-based workforce planning in medicine10. Its conclusions require careful reading but show that in a scenario of continuing population growth but similarly structured health services, Ireland’s current

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7  http://rcpsc.medical.org/canmeds/index.php
8  http://www.scottishdoctor.org/
9  http://www.gmc-uk.org/guidance/good_medical_practice.asp
Table 1. Irish medical education 2009 – Types and settings

<table>
<thead>
<tr>
<th>Agencies</th>
<th>Undergraduate</th>
<th>Intern division</th>
<th>Specialist training division</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>6 medical schools</td>
<td>33 hospitals</td>
<td>13 postgraduate training bodies</td>
</tr>
<tr>
<td></td>
<td>615 EU students – ? number non-EU</td>
<td>508 posts</td>
<td>? 3,500 posts</td>
</tr>
</tbody>
</table>

production of graduates from Higher Specialist Training schemes will meet demands, except in a small number of key areas, one of which is general practice. The challenge for general practice is simply put – at present, 120 graduates leave general practice training programmes annually, but the country requires 160 per year. How should the medical education sector respond? Should solutions include increasing the scale of current postgraduate training programmes in general practice or introducing innovative systems for Recognition of Prior Learning or importing trained general practitioners? Of equal urgency is the need to examine the future roles of those GPs in the Irish health service of the 2020s – is current or projected training appropriate for those needs?

These are among the issues to be addressed by MET, working closely with all of the partners involved. Other sources of evidence and experience may also help us to chart the future course of medical education in Ireland. NHS Education Scotland (NES) offers important lessons in the rapid development of a national, integrated agency for the education and training of all health professionals. The RCGP’s scheme for membership by assessment of performance is a important reflection of links between postgraduate training, validation and the quality of our care for patients on a day-to-day basis. By contrast, the well-meant efforts to comprehensively re-structure all postgraduate medical training in the UK led to major organisational problems in 2006. All of these issues, and many others, will influence our work.

Doctors in Specialist Training 2010

A key component of the MPA07 is the establishment by the Medical Council of new General, Specialist and Trainee Divisions. The Trainee Specialist Division is restricted to doctors enrolled in recognised training programmes, in numbered (identifiable) posts, which have been proposed by the HSE to the Medical Council as ones required by the Irish health services. The registers were established by the Medical Council in March 2009 but are likely to be robustly in place in mid-2010. The Irish health service currently employs 4,800 NCHDs – a major task currently underway in the MET Unit is the appraisal of these posts to identify those suitable for designation as the training posts required by the service. This task is likely to be one of the most serious undertaken in postgraduate training in many years, with major implications for the medical profession and the delivery of healthcare in Ireland. A further implication of this task and of recent employment legislation changes, is that many NCHDs who are not enrolled in specialist training programmes may be entitled to ‘Contracts of Indefinite Duration’ and will immediately become a permanent practitioner grade within hospital services. The training and broader support needs of this group must be rapidly identified.

We embark on these tasks aware of their significance and implications but confident that, in partnership with the postgraduate bodies, the Medical Council and HSE units, a stronger and better postgraduate training system will emerge. Perhaps some simple reflections of these changes would be the adoption of the title ‘Doctor in Specialist Training’ rather than ‘NCHD’ for trainees and ‘Staff Grade Doctor’ for those with Contracts of Indefinite Duration.

In conclusion

The challenges facing medical education at all levels in Ireland in 2009 require leadership, commitment and vision. Michael Flynn led by example – we need look no further to see how best to address those challenges.

11 NES. http://www.nes.scot.nhs.uk/
12 RCGP. http://www.rcgp.org.uk/gp_training/imap.aspx
13 http://www.mmcinquiry.org.uk/
The presentations we have enjoyed this evening have been entertaining, enlightening and educational, and as such, a fitting tribute to the memory of our good friend and colleague, Dr Michael Flynn.

On behalf of us all, I wish to convey our warmest thanks to Brendan, Fergus, Afric and Gerry for the enormous amount of time and thought that obviously went into their presentations. It is notable that although the Colloquium was to honour Michael’s memory and therefore inevitably cast a backward glance, the message coming through strongly is the optimism for the future and the clear evidence that this Training Programme will not rest on its laurels and stultify, but move forward to introduce and embrace change. I think that Michael would have encouraged and approved of this philosophy.

I am happy to have been part of these proceedings and to have contributed in some small way to the success of the evening. As always, there are people behind the scenes whose organisational talents make an occasion like this run smoothly and enjoyably. In this regard, I would particularly like to mention Audrey Murray and Anne O Cuinneagain. Others from the Training Programme itself and the wider Department of Public Health and Primary Care also played their part and I take this opportunity to thank them all.

Of course this evening would not have been possible without the support of Francis Lynch and A Menarini Pharmaceuticals. Francis and Michael knew each other over the course of their professional careers and I thank Francis and the company on your behalf.

I hope that Tess and Michael’s friends found some comfort in the obvious esteem in which Michael was held by his colleagues, the wider GP family and the medical profession.
A FITTING TRIBUTE