



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

TCD/HSE

Specialist Training Programme in General Practice

**Celebrating our
30th Anniversary**

16 September 2005



Acknowledgements

We are grateful to all who worked so hard to contribute to the success of the 30 year celebration, which we are now pleased to mark again with this monograph.

Our speakers gave freely and generously of their time and managed to entertain and edify.

Anne Ó Cuinneagáin, Assistant Director of the Training Programme and her assistant Patrice Purcell put in an enormous amount of work behind the scenes.

We are grateful to MERCK Pharmaceuticals and GlaxoSmithKline for their sponsorship, without which this event would not have been possible.

We would like to dedicate this monograph to the memory of Professor James Stevenson McCormick, who died in January 2007.

Prof Tom O'Dowd, Chair

Prof Fergus O'Kelly, Director

Department of Public Health and Primary Care

Trinity College Centre for Health Sciences

AMINCH

Tallaght

Dublin 24

September 2007

Sub-editing: Deirdre Handy

Design: Janine Handy

Contents

Foreword	4
30th Anniversary Academic Programme	5
Biography of Dr Martyn Manné Berber	6
Introduction	8
In the beginning	10
Fit for the purpose	14
The changing face of General Practice	18
Manné Berber Lecture Introductory comment	36
Manné Berber Lecture	37

Foreword

From Manné to Fergus – the journey

The Eastern Regional General Practice Training Programme was established as the Dublin Regional Vocational Training Scheme in 1975 with an intake of four trainees. It has grown and developed over the last thirty years, into a highly regarded, successful and much sought after Training Programme with an annual intake of 12 trainees. This has been greatly assisted by the active support of the relevant Health Boards and latterly the Health Service Executive. In recent years the association with the Department of Public Health and Primary Care at Trinity College Dublin has deepened to a point where the Programme is now an integral part of the Department and hence the name is now the TCD/HSE Specialist Training Programme in General Practice (TCD/HSE Scheme).

The associated department in Trinity College has had a similar long and tortuous evolution. The Department of Public Health & Primary Care, a constituent discipline of the Trinity College Medical School, was established as the Department of Social Medicine in 1952, in line with developments in the United Kingdom and Europe. In the 1970s under the stewardship of James McCormick, it became the Department of Community Health, which allowed it to take a population view of medicine – unusual in Ireland at that time. In the 1990s it became the Department of Community Health and General Practice with the appointment of a Professor of General Practice in 1993. The Department has since been renamed as the Department of Public Health and Primary Care, to reflect the nature of the work of the department, changes in Ireland and in the wider world.

Since the 1970s there have been strong links between the Scheme and the department with James McCormick and Aengus O'Rourke having feet in both camps. Indeed this meeting was the last one James spoke at and as usual he and everyone loved it. In 2004 the Department's close relationship with the Eastern Regional General Practice Training Programme as it had become, led to the Programme being integrated with the Department, within accommodation on the Tallaght Hospital campus – just in time for us to participate fully in the celebration of 30 years of general practice training, in September 2005.

The thirty year celebration marks a sizeable contribution to general practice and patient care with over 300 fully trained GPs as alumni. Manné Berber who was so often mentioned on the day could not have foreseen the success or indeed longevity of the scheme. It is not wise to predict what the next thirty years will bring but there is a lot to build on and under the current leadership of Professor Fergus O'Kelly and his team the formation of the next generation of general practitioners is in good hands.

Tom O'Dowd
Chair of Steering Committee

Eastern Regional General Practice Training Programme

30th Anniversary Celebrations

16th September 2005

Robert Smith Theatre,
Trinity Centre for Health Sciences,
St James's Hospital

Academic Programme

Session 1

Thirty years a-growing – the past, present and future of GP training

Introduction – Prof Fergus O'Kelly

In the beginning – Prof James McCormick

Fit for the purpose – Prof Gerard Bury

The changing face of General Practice
– Dr Brid Hollywood

Session 2

Annual Manné Berber Lecture

Introductory comments – Dr Zita O'Reilly

Manné Berber Lecture – Dr Muiris Houston

Dr Martyn Manné Berber

1928 – 1988

Dr Manné Berber, born in Glasgow in 1928, was educated in Dublin and graduated from Trinity College Dublin in 1952. Following hospital training in Dublin and Kent, he returned to Dublin and joined Dr John Freedman's practice in 1954. A year later Manné opened a private practice in Churchtown, where he quickly established himself as an able and caring physician. The poor were often treated free of charge, and it was not unknown for him to leave a donation when he visited a home in obvious need. "What's the good giving them antibiotics? They need food!" he once exclaimed after leaving 10 shillings with a mother who could not afford milk for her sick baby.

Most Irish doctors of the time were members or associate members of the Royal College of General Practitioners. Manné became a Member in 1964 and was elected to Fellowship in 1972. He was at the forefront in campaigning for an Irish college. Soon after joining the East of Ireland Faculty of the RCGP in 1965 he was appointed its only tutor. His duties took him around the country lecturing to the different faculties, and when the Irish College of General Practitioners was established in the 1980s he became Director of Training for its Dublin Region.

Manné served on numerous committees. His ability and reputation earned him many honours and he became Provost of the East of Ireland Faculty of the RCGP, Chairman of the Irish Council and a ministerial appointee to both the Medical Council and the Postgraduate Medical and Dental Board. He was a member of the Consultative Medical Council on General Medical Practice from 1972 to 1973 and a member of the Irish Institute of General Practice from 1975 to 1984.



Dr Manné Berber

His service to the RCGP was regarded as 'incalculable' and his tireless efforts did much to improve the image of the general practitioner. At the age of fifty-nine he became the first Jewish Vice-President-Elect of the ICGP, which ensured automatic Presidency the following year; two weeks later death deprived him of the honour. As a mark of their respect for Manné, the ICGP presented his widow Marie Berber, with the badge she would have received as the President's wife, had he survived to fill the post.

From 1974 he was a Clinical Tutor in the Health Sciences Faculty at Trinity College and involved in lecturing to medical students, extending his memorable and non-directive style to undergraduate as well as postgraduate medical education. He was a major force in academic general practice in Ireland and pioneered the Dublin Vocational Training Scheme as well as taking active part in general practice

research on the wider European scene. His interest and ability in teaching was evidenced by the invitation to become a visiting assistant professor at the Department of Family Medicine in the University of Western Ontario.

With such a busy professional life he could have been forgiven for avoiding non-medical commitments, but such was not the case. Listing just four of his community activities gives an idea of the breadth of his interests, for as well as serving presidential terms with B'nai Brith and the Dublin Jewish students' union, he was an executive member of the Northern Relief Fund Co-Ordination Committee and for three years Chairman of the Churchtown Community Care Committee.

But it is principally because of his tireless energy and commitment to the organisation of vocational training in the Eastern Health Board region, of which he became the first course director in 1975, that we celebrate him with the annual Manné Berber lecture. His dedication to his task, in spite of many difficulties, kept the scheme going, and more than thirty years on, we still marvel at his skill, diplomacy and tenacity.

Deirdre Handy

Sources:

Ray Rivlin. Shalom Ireland A social history of Jews in modern Ireland. Dublin. Gill and Macmillan 2003.
John Mason. Manné Berber: an obituary. Forum, Journal of the Irish College of General Practitioners, 1988 August.
JFF. Martyn Manné Berber: an appreciation. Irish Medical Times, 1988 August.
GP's death a great loss to vocational training [editorial]. Irish Medical Times, 1988 August.

Introduction

Prof Fergus O’Kelly
– Director

Graduates, colleagues and friends, welcome to this celebration of our 30th anniversary – thirty years of GP training. We have an interesting series of talks for you this afternoon and I will introduce our first speaker soon, but first some opening remarks

At this point I would like to thank our organising committee for their hard work over the last year – I would especially like to thank Patrice Purcell, the scheme secretary for all her hard work delivered in a calm, happy and helpful way; Anne Ó Cuinnegáin for her close support and keen eye for detail; Deirdre Handy for all her help in innumerable ways; Walter Cullen who suggested the format and organised today’s seminar, and finally Professor Tom O’Dowd – Chair of our Steering Committee – for his active support and good counsel.

Thirty years of GP training – it is hard to believe! – it went so fast. Michael Flynn has been involved with the scheme since its inception and has been invaluable to its development. He was initially sent to the scheme as an IMA spy, liked what he saw and stayed! He is now of course President of the ICGP (2005-2006).

I was part of the first intake of trainees onto the scheme and like Michael, haven’t left. I have been a trainee, undergraduate tutor, trainer, tutor, Associate Director and, for the last few years, Director. We owe much to the visionaries who organised the scheme in the early days but especially to Manné Berber our first director and to Owen Clarke our second director.

So how did it all start? Well from my perspective it started with a handwritten postcard on the notice board of the Richmond Hospital (now a district court) *“Anyone interested in GP training please attend at 2 PM on Wednesday in the Board Room of the Mater Hospital”* I went along and was asked to write a letter and send a CV. A CV? I wasn’t sure what it was, so I asked the guys – no help there. So I asked the girls – even then they knew more than the guys!

My CV was one side of A5 hospital notepaper and half of it concerned my prowess on the field of sport.

The next two years comprised of fortnightly evening meetings – you got your own hospital post and then out to Greystones for a year as a GP trainee in Cyril McNulty’s practice. I enjoyed every moment of it.

We have come a long way from that time. We have over 250 graduates of the highest calibre – yes, that is you! We have come a long way from the early days of supernumary posts in hospitals, looked upon with suspicion and even derision by our specialist colleagues. There was fear and loathing by some established GPs who saw no need for GP training. So what has been the result of these 30 years of GP training? Well, we have clearly raised the standard of clinical practice in general practice. We are now more likely to practice from purpose built or purpose adapted premises, have secretarial support, practice nurses

and even practice managers. Gone are the days of a lock-up surgery over a shop or in the front room of your home.

We offer a wider range of services to our patients and are more aware and better able to address their needs. We remain highly regarded as a professional group by the public. We are one part of the healthcare service that isn’t broken. Nearly 50% of all GPs are involved in teaching, taking students or supervising GP Registrars in practice.

Two of the five Professors of General Practice are graduates of the scheme, as are two of the Directors of GP training. Many of our graduates have academic posts either as Lecturers or Associate Directors.

As a scheme we have been dynamic and innovative. Graduates of the scheme were closely involved in setting up the ‘out-of-hours’ co-op movement which has 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. These developments in GP education are looked upon in awe and some envy by our specialist colleagues. They refer to our system of training as the ‘gold standard’.

Gone are the days when our trainees were supernumary in hospital posts. Now our consultant colleagues are beating a path to our door, offering us many more hospital posts than we need. Such is the reputation and high calibre of our GP Trainees. Last year again, this scheme attracted more applicants than any other training scheme. Yes, we can truly be proud of our scheme and its achievements. However, we will not rest on our laurels. This is an energetic and forward-looking scheme, ably guided by an active, interested steering committee.

We look forward to further developing the training scheme in line with the best of international practice. As Buzz Lightyear would say “To infinity and beyond!”

In the beginning

Prof James McCormick

I was flattered and delighted to make a contribution to the thirty year anniversary and celebration of Manné's training scheme.

I qualified in June 1950 more than fifty five years ago, which guarantees that I have well passed my 'sell by' date.

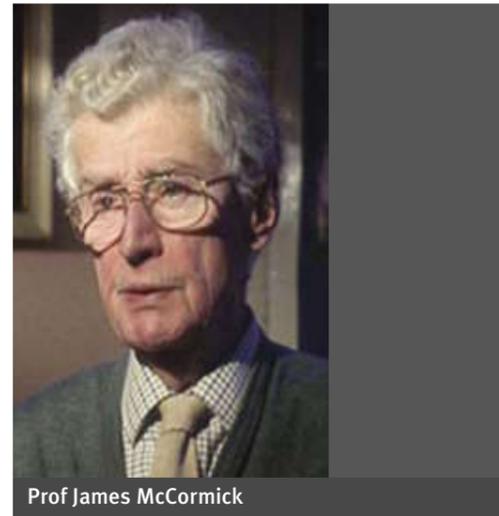
My newly acquired MB entitled me, without any further experience of any kind, to embark on a career in general practice. The pre-registration year had not yet been invented.

In 1950, by comparison with today, therapeutic impotence was the norm. We had sulphanomides and penicillin and soon streptomycin but no tetracyclines or other antibiotics. No tranquillisers; amylobarbitone. No antidepressants. No NSAIDs, no steroids. No cimetidine, the treatment of peptic ulcer was partial gastrectomy and subsequently added vagotomy. No proton pump inhibitors. Perhaps most important – no 'pill'.

Acute rheumatism was still common and many people were crippled by the resultant cardiac damage. The first mitral valvotomy was in the future, as were joint replacements and good cataract surgery.

We did silly things, but no more than today. As a house physician I carried out autohaemotherapy as a remedy for psoriasis. This involved taking 10ccs, as they were then, of blood from the antecubital fossa and injecting it into the buttock of the unfortunate. This I am sure did as much good as homeopathy and was thought to stimulate the phagocytes.

I was not a skillful house surgeon but there was one operation which was delegated to me and which I carried out with skill and one hundred per cent success. This was to relieve the pain of intermittent claudication by cutting the Achilles tendon, which got rid of the pain, but at what a price!



In 1950 there was no nonsense about risk markers for coronary heart disease. We immunised against diphtheria and tetanus and later on polio, but no measles and no pertussis.

In 1950 we did not know about cigarettes and lung cancer.

In 1953 I was working in wards at St. Mary's which were attached to Alexander Fleming's laboratories. While there I began for the first time, to cure tuberculous meningitis by the intrathecal injection of streptomycin. Biddy was the charge nurse and we have been together ever since!

In the late forties and early fifties there were the first stirrings towards a college for general practice. Interestingly two of the leaders, John Hunt and John Fry were both 'failed specialists'. John Hunt was a Member of the College of Physicians and John Fry a Fellow of the College of Surgeons, but consultant posts in the new NHS were in short supply. John Hunt, later Lord Hunt, had a fashionable west end private practice adjacent to the embryo college of which he was the honorary secretary for many years.

The college was founded in 1952. It was, and still is, structured around regional faculties and there were four in Ireland, one for each province.

Membership of the college was achieved by completing an application form and the payment of a subscription, – no examination. There was however, a ludicrous Board of Censors on which I subsequently served, which scrutinised application forms to no useful purpose.

In the early sixties I became the East of Ireland Faculty representative on College Council. After five years I was elected from the body of the college and continued on Council until the seventies.

While Donald Irvine, subsequently Sir Donald and President of the General Medical Council, was chairman of council he began to explore postgraduate training for general practice. While the President is the titular head of the college the Chairman of Council is the effective head. He immediately ran into a problem – no one would accept general practice as a specialty, something that has dogged us for years, and a new term was coined – vocational training.

This new vocational training was at that time standardised as two years of further, allegedly relevant, hospital experience after the intern year, followed by a year in general practice.

This grossly unsatisfactory pattern became set in tablets of stone and persisted for far longer than it should have done. It is only now that we are beginning to experiment with four year training including two years in general practice.

In time we in Ireland recognised the need for further specific training and in the Republic the main movers were Manné Berber in Dublin and Bill Shannon in Cork.

Manné was an orthodox Jew. The contribution of Jewry to our discipline can hardly be overstated. It includes John Fry, Paul Freeling, Stuart Carne, Clifford Kay and Marshall Marinker. One's first impression of Manné was of a gentle man with a delightful smile. There was nothing bombastic or aggressive in his manner, yet underneath was a steely resolve which he needed in order to achieve his objective.

Manné had the problem of establishing training in a city which had three medical schools and no undergraduate departments. Although a Trinity graduate he wisely and cleverly avoided his scheme being identified with any one school. This was no mean achievement. Those who have been taught by Manné still speak with reverence about his contribution to their learning. Sadly he died suddenly while still far too young. We are his inheritors.

The next major development was Michael Boland's Irish College. I have said Michael Boland's college because it was his faith, enthusiasm and drive which brought the college into existence. His child had such godparents as Cormac Macnamara and John Mason, who as presidents of the infant college played a major part. They are both much missed. The College has gone from strength to strength and success in its examination now entitles the candidate to specialist recognition.

We also have undergraduate departments in all our medical schools. I take sly pleasure from the fact that the heads of departments of general practice in our National University, Gerry Bury, Colin Bradley and Andrew Murphy, are all my ex-students.

Having idiosyncratically galloped through the past, what of the future?

It seems certain that for the next decade or so, four year training will become the norm but it would be sad if that was seen as an adequate response to need. We should cultivate postgraduate electives to polish special interests including research, which for most people is a futile shibboleth. The full effects of the manpower crisis are not far distant. In 1972 what became known as the

McCormick report foresaw a replacement need of 60-70 a year. This in the interim was never met and together with the feminisation of the discipline means that there is a huge and growing unmet need and no prospect of a quick fix. Our President, Michael Flynn had some wise words on this subject in a recent Forum¹.

Hospital medicine is disease medicine.

General practice is people medicine.

The rewards of general practice are not usually diagnostic nor therapeutic wizardry. The rewards of general practice derive from our relationship with those people who are our patients. Being a personal doctor is something which general practice uniquely offers. It is also something of value to both physician and patient. If it disappears the main *raison d'être* for general practice dies with it.

Practising hospital medicine in the community is by and large an unsatisfactory activity, whereas being a personal doctor brings great rewards.

Those of you embarking on your chosen career face difficulties in creating the opportunity for continuity of care which is a prerequisite for personal care. Continuity does not mean being available for 24 hours a day, 365 days a year, but it does mean an attempt to be reasonably accessible to those who seek your help.

There is one quality you will need in order to fulfil your potential to help people. Scepticism. Scepticism is not a synonym for cynicism, but it is the "scalpel which frees accessible truth from the dead tissue of unfounded belief and wishful thinking".

Bertolt Brecht's Galileo said "The chief cause of poverty in science is imaginary wealth. The chief aim of science is not to open a door to infinite wisdom but to set a limit to infinite error." The chief cause of poverty in medicine is also imaginary wealth. Scepticism is a tool in its identification.

Epidemiology is responsible for much imaginary wealth. For example – there is no good evidence that what we eat determines whether or not we die of coronary heart disease. There are no good randomised controlled trials of dietary manipulation (not an easy thing to do). Nevertheless the role of diet in coronary heart disease is an example of wishful thinking, not something supported by evidence. Butter and cream are good for you and taste nice as well. Statins don't work by lowering cholesterol, higher cholesterol are good for older people and so on and so on.

Only scepticism provides a degree of protection against the fashionable which is doubtful and orthodoxy which perpetuates error.

I have been lucky to have practised medicine when it was relatively easy and am glad not to be now beginning my career. General practice is not easy, it was not easy when I was practising, and it has become more difficult. More difficult because of the change in patients' expectations, the possibility of litigation and the complexity of advancing knowledge.

Nevertheless general practice is a marvellous job. Go well! And enjoy it!

¹ Flynn M. Growing complexity of GP training [Editorial]. Forum September 2005; 22(9):5.

Fit for the purpose

Prof Gerard Bury

Professionalism – a suitable case for training?

‘Becoming a general practitioner needs someone not only to fill the knowledge pot through training but to light the fire under it through education’¹

Robin Hull

Introduction

As a graduate of the programme, the opportunity to acknowledge its 30 year contribution to Irish general practice is a welcome one. I had the privilege of being a trainee in the then Dublin Regional VTS between 1982 and 1985 and benefited greatly from that opportunity. The leadership of Dr Manné Berber in establishing the programme and setting the educational themes was particularly important and set the standards for the future development of the scheme.

One of Manné’s key contributions was to encourage learning by reflection. He demonstrated the importance of that reflection not only as a teacher but also as a researcher. In one of his publications on the morbidity profile of Irish general practice, he emphasised key points about the nature of practice:

‘These tables are important in that they show the difference between the range of illness in the hospital compared with that in general practice. It is against these different backgrounds that the probability of diagnosis must be made.’

This is one of the most important adjustments of attitudes that entrants to general practice must make if they are to succeed.’²

He concluded:

‘I would recommend similar exercises to my colleagues. The information gathered from a number of varied and scattered practices throughout Ireland could allow us to assess our present state and our future needs’

The future needs of general practice – Manné, as ever, pointed us in 1974 to reflect on our roles as general practitioners and to consider how those roles would evolve. Professionalism in medicine is one such role and its importance in the general practice of the 21st century is an issue which I believe Manné would commend to us.

How does professionalism impact on training for general practice in the 21st century?

A new healthcare profession

In the last year I have had the privilege of working with Ireland’s newest healthcare profession – Advanced Paramedics in the ambulance services. The opportunity has given me much to consider about what professionalism means in medicine. In 1993, a Department of Health Report on the Ambulance Services recommended that Ireland should have paramedics trained to administer drugs and carry out key interventions for patients who are seriously ill or injured. Ireland’s health service has taken the 12 years since then to fulfil this recommendation but in 2005 the first cohorts

of Advanced Paramedics completed their training and entered the newly established professional register.

Emergency Medical Technicians and paramedics share many characteristics with GPs in Ireland – they number around 2,000 practitioners, often work in ones or twos and have a workload characteristic of primary care – patients define when they call for help and for which problems. They have also a limited evidence and research base for their roles but a significant potential to develop such information.

I have been strongly reminded:

- of the value of continuity in general practice – single stressful episodes of care lasting minutes have extreme limitations
- that consultations take many forms
- that clinical competencies are transferable within healthcare professions

What lessons can we learn from this emerging profession?

First, about absolute determination to achieve a task. To establish a fledgling profession, legislation was needed for a statutory body to be its regulator – the Pre-Hospital Emergency Care Council.³ The PHECC is responsible for the education and registration of Advanced Paramedics, sets their Code of Conduct, provides a disciplinary process accessible to the public and develops evidence

based Clinical Practice Guidelines. It has taken much patience and considerable skill to establish the supervisory structures associated with what is only the sixth healthcare professional grouping (after doctors, nurses, dentists, pharmacists and opticians). Politicians, civil servants, doctors and members of the profession itself have all had to be convinced that a benefit to the public would result. The sense of purpose required has been considerable.

Next, about dedication to clinical purpose. The first cohorts of Advanced Paramedics have had to explore their role ‘on the hoof’ and that role is a most demanding one. APs deal with people at their most vulnerable – 5% to 10% of all contacts are with patients who are dead or dying and most others involve acute cardiac emergencies, hypoglycemia, seizures or serious injuries.

Thirdly, about reflective learning. Members of this developing profession have been rigorous – and sometimes ruthless – in identifying the road map for their framework of development and for the characteristics they want to be identified with their work. High quality work, accountability, CPD and contributions from other professions are among the issues they have identified and incorporated.

How are these themes reflected in medicine in Ireland?

Professionalism in medicine

In 2002, the Lancet and Annals of Internal Medicine took the unusual step of jointly publishing 'Medical Professionalism in the New Millennium: A Physician Charter'.⁴ The charter is founded on three core principles. The first is the primacy of a patient's welfare, the second the autonomy of individual patients and the third, social justice, calls on doctors to work actively for the equitable distribution of health-care resources. Commitment to the well-being of patients, empowering informed treatment decisions, eliminating discrimination in healthcare – are these the fundamentals on which we plan and run our practices?

The responsibilities which flow from these principles include commitments to:

- professional competence
- patients' confidentiality
- maintaining appropriate relationships with patients
- improving quality of care
- improving access to care
- a just distribution of finite resources
- scientific knowledge
- maintaining trust by managing conflicts of interest
- professional responsibilities

If these principles and the associated responsibilities are to be accepted in Irish medicine, they must be examined and implemented. If they are to be the fundamentals of practice, they must also become the fundamentals of training in medicine.

The Royal College of Physicians and Surgeons of Canada has actively worked towards transforming these principles into working themes, both for training and practice. The CanMEDS Project

has evolved since 1996 as a 'Canadian Medical Education Directives for Specialists' framework of core competencies for all doctors.⁵ The framework places 'medical expertise' at the centre of the framework but surrounds it with themes such as collaborator, communicator, scholar, professional, health advocate and manager (Figure 1).

An Irish general practice framework?

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.⁶ It outlines what might be seen as a job description for the general practitioner of the next decade with roles including:

- Clinical expert
- Community health action
- Shifted specialist care
- Disability rehabilitation
- Team leader/team member
- Population prevention
- Information management
- Audit/monitoring/QA
- Resources manager

I would argue that the themes outlined in the Physician Charter on Professionalism are the framework within which these and other roles in general practice will succeed. Without such a framework, these tasks represent increasingly diverse technical challenges which we may become very proficient at, but whose purpose may be lost. The purposes of medicine include the very issues highlighted by the Charter – the primacy of our patients' welfare, the autonomy of individuals and

a socially just setting in which those with most need receive most care.

These themes underpin the goals set out by Manné Berber and his colleagues when they established vocational training for Irish general practice in the 1970s.

Do these goals remain at the forefront of postgraduate training for general practice in the Ireland of the early 21st century? I believe they do but that their urgency and importance may have taken a back seat, perhaps beset by the pressures of educational theory, economics, accreditation, accountability and accountancy and multiple demands on trainers and doctors in training.

The Dublin VTS of the 1970s and now the ERGPTP of the 21st century has contributed much to Irish general practice. I believe it has the capacity and willingness to put these themes back into the forefront of postgraduate training in general practice and thereby to reinforce the importance of these goals for medicine in Ireland. The leadership and professionalism of the ERGPTP has faced many challenges in the past and succeeded with each – here perhaps is a more serious challenge than many we have faced before and one I am confident will be addressed by the ERGPTP of the future.

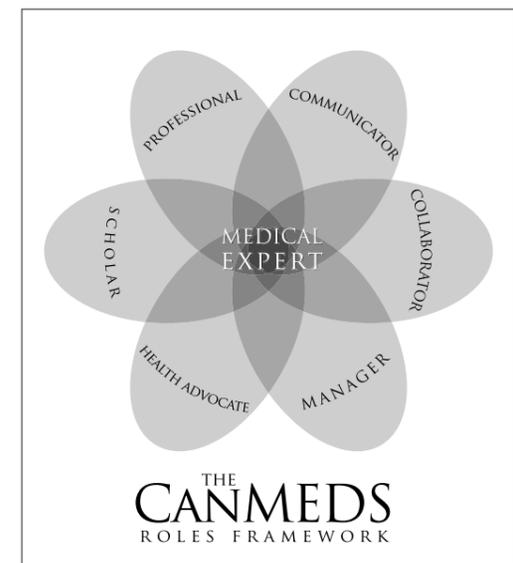


Figure 1: The CanMeds roles framework

1 Berber M. Irish general practice. JIMA 1974;67:169-172.
2 Hull R. Education for general practice. BMJ 1989;299:996
3 Statutory Instrument 21/2000. Establishment of the Pre-Hospital Emergency Care Council.
4 Medical Professionalism in the New Millennium: A Physician Charter. Lancet 2002;336:244-246.
5 CanMEDS. RCPSC, 2005.
6 Primary Care Strategy. Department of Health & Children, 1999.

The changing face of General Practice

Dr Brid Hollywood

I was honoured at being asked to speak at this meeting and also feel very privileged to be part of this scheme. I was what was then called a 'trainee' twenty years ago. I would like to introduce you to my registrar from the scheme who is sitting in the audience training, Dr Seoighe Ni Rua.



Dr Seoighe Ni Rua

Before I start I would like to introduce Fiona Bradley to anyone of you who do not know her.

Fiona was a graduate of this scheme and we worked very closely together for 7 years. She died three years ago. She contributed enormously to general practice and also to my life. I would like to dedicate this talk to her.



Dr Fiona Bradley 28/9/1961 – 25/11/2002

This talk is in no way intended to be autobiographical, but a little about myself is not a bad introduction to the changing face of general practice.

I started my life in this house – I don't remember it – it was the house of a DMO, a district medical officer as GPs were then called. It was owned at that stage by the corporation and given at a minimum rent to the GP. It was built on the edge of bog on the street of Carna, in Connemara.



Brid Hollywood's childhood home in Connemara

You can see how over 46 years later it has changed. Dr Casey runs a great show from here and he was responsible for building this purpose built health centre.



Dr Casey's home and purpose built health centre

My parents moved to Athenry of the Fields of Athenry fame. We lived in this house, again owned by the corporation.



Living in 'the fields of Athenry'

The patients were seen in the house in the front room on the left and they waited in the hall. The family was involved in 24-hour care, answering doors and phones. The phone number was Athenry 34. At least in the beginning, the phone was a party line – this meant that the five owners of phones in the town were contacted by one ring for one, two for another etc. Each could listen in on the other. At least the current discussions on confidentiality and general practice do not face this problem!

The GP was a presence in the house and we got to know our father very well. He took the current pre-school child on all house calls giving my mother some rest until we went to school. The brother of a classmate died in this front room from croup. In my class were twins, one of whom was less intelligent than the other. I knew why but never told. The mother had been in obstructed labour and the midwife called my father. The first child was delivered and he was about to do a decapitation of the second child to deliver her, rather than lose the

mother's life, when the midwife heard a heartbeat. They took down the door of the woman's bedroom and carried her to the car. My father drove her to Galway where my friend was delivered by section. Confidentiality was inbred in us and if we slipped up, it was beaten into us.

The public patients were seen across the road in what was called the dispensary. Another name for the GP was the dispensary doctor. In 1972, that changed when the first GMS contract was signed. After that, private and public patients had to be treated the same.



The doctor's daughter

While it was a very happy, and by local standards a privileged childhood, being the doctor's daughter was very claustrophobic. For example I was goalie in our local school camogie team and overheard Fr O Grady, the vice principal say, "Jaysus the doctor's daughter has a great puc!"

I felt a great sadness when we left Athenry at the age of 14. However, I embraced the feeling of anonymity which Dublin offered and felt hugely liberated. I would never again be 'the doctor's daughter'.

I graduated from this scheme when Manné Berber was still the Course Director. I started my GP life in Wicklow with Neil Golden as a trainer.



Drs. Fergus O'Kelly, Neil Golden, Fiona Bradley and Michael Flynn

Neil is second on the left – it was a fantastic practice and very advanced for its day. I loved every daylight moment of it, loved the driving, the countryside and the house calls, but found the out-of-hours calls very hard.



Top left to right: Training in Neil Golden's practice and driving to house calls
Bottom left to right: Making a house call and the new premises

The doctors in this practice who have now moved into this new premises have done 24 hour on call ever since. They do not know what it is to get seven nights in a row sleep. This has made getting partners, women doctors or locums difficult.

Next Friday they join Carlow Doc, the nearest co-op and Dr Nick Byrne tells me he cannot wait. His life will entirely change.

The changing out-of-hours cover which is now in place in many places in Ireland, in addition to offering GPs a hugely better life, will continue to have wide reaching effects on retention of general practitioners, particularly in rural areas.

I spent one year working in James's Street in Dublin and a number of years abroad. In the 80s while we were away, many of you will remember there was a moratorium on GMS posts and none were being advertised.

I was lucky enough to return to a part-time five year lecturing job in Trinity with Prof Tom O'Dowd and worked as an assistant with Patrick McGrath who is on this training scheme and then Deena Ramiah in Clondalkin in this surgery.



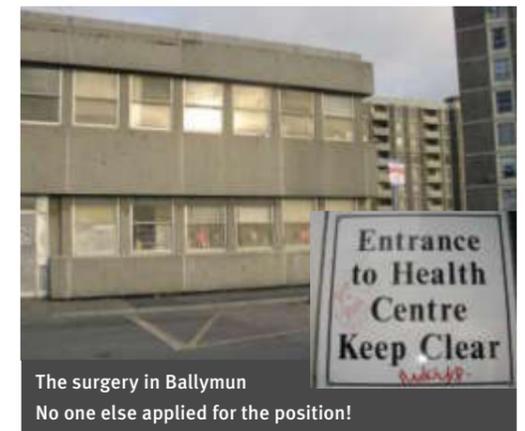
Left: Prof Tom O'Dowd
Right: Deena's old surgery

I loved teaching and even liked creating a research question and gathering data. Writing a paper however, filled me with a boredom I could taste. I had to face it – the P values I had been most interested in until then were getting these three out of nappies and to school age.



Left to right: Aoife, Patrick and Niamh Hollywood

With Fiona Bradley's encouragement, I bit the bullet and interviewed for a GMS list in Ballymun.



The surgery in Ballymun
No one else applied for the position!

I came first in the interview because no one else applied for that particular position. I got a list of 600 GMS patients who had been very well looked after by my predecessor Dr Muiris Houson. There was literally no room for me in the building. I put my eye on the men's toilet – the greatest bit of persuasion I have ever done in my life, and I would not mind it on my epitaph, was to persuade the health board to allow me convert the toilet into a surgery.



Left to right: The men's toilet door, the men's toilet, from toilet to surgery!

Some of my male colleagues were not impressed as they now had to share the ladies' toilet, but they recovered. Ballymun had to be a place of equal opportunities I felt.

At that time, I met Dr Pippet who had been the senior partner in my training practice. We were at some social 'do', both well dressed. He asked me where I worked. I told him "Ballymun Health Centre". There was a pause and then he said "Oh Brid and I thought you had such great potential!"

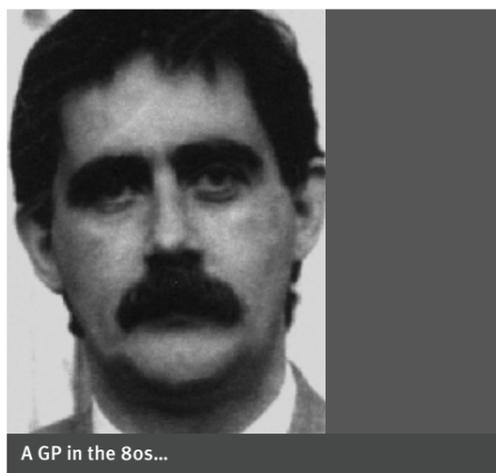


A window with potential in the Ballymun surgery!

There have been huge changes in general practice and huge changes in society over the last 30 years. The time will allow me to visit only some. Also this talk took on a life of its own. With the help of a wonderful medical student, Clare, I gathered all the information I needed for a very erudite and academic talk. Then I rang a few GPs and family members for photos – as they arrived, I kept re-writing the script to suit the photos – that is also

the story of my life so it is nothing new for me. However, in advance, I may need to apologise to a few people for what I am about to say and show! Please forgive me.

Feminisation of General Practice



A GP in the 80s...



...and now ...Arthur Courtney and colleagues

I know that it is expected of me to speak on this topic and indeed it one of many sociological shifts that have taken place in general practice. Walk into any GP's surgery in Ireland, and there's a good chance that you'll be seeing a female doctor. Thirty years ago, the graduation classes would have been 70% men.



1985, a watershed year!

1985 was a watershed year, not just because Fergus Mason is sitting in the top row 2nd from the right hand side, Arthur Courtney is top row, 5th from right, Muiris Houston, third row, 10th from right and Marie Scully, as one would expect, sitting in the first row, 1st person – but in this year there were 50: 50 men and women qualifying.

Apparently there were only two men in a recent medical year in Galway – could this be true?

More women doctors are choosing GP as a career than men. Why? – well the obvious reason – it is a more flexible profession and there is not the same need to go abroad. Secondly when they do apply for GP training schemes, they seem to do better in the application process – why? Good communication skills, skills of listening, empathy and a high degree of emotional intelligence are attributes that we tend to look for in a GP. They are attributes which are most often associated, and I think wrongly, with being female. This may be frightening men from considering general practice as a career.

Certainly they are attributes, which at interview we look for when taking people on to the training schemes. I interviewed two years ago with the UCD training scheme. A male GP who had spent three weeks with us and whom I know to be fantastic with patients, was not able at interview

to persuade us that he possessed these attributes. While at interview the girls were all genuine stars. We may have to change the criteria at the interview process. This is not the same as being biased in favour of men; it would merely be recognition that current interview processes may be biased in favour of women.

What are the implications of the feminisation that is taking place?

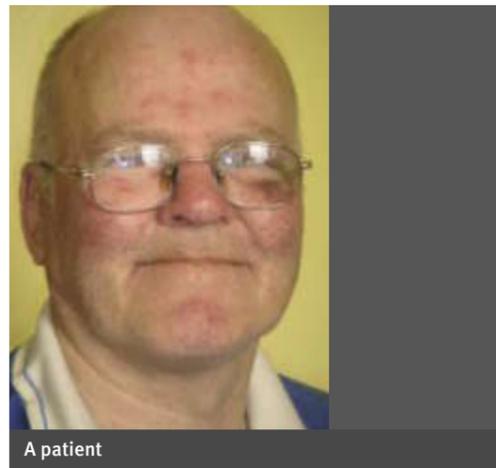
The first and obvious one is the need to retain women in practice or otherwise the manpower crisis will get worse. The solution to that is to support women a little during the few years when they need flexibility – by having part-time partnerships, part-time GMS contracts and good out-of-hours work arrangements. The broader implications for the future of general practice are less easy to predict. Professor Carol Black, President of the Royal College of Physicians in the UK makes the controversial argument that medicine as a whole may lose status, may deprofessionalise if it comes to be seen by the public as a profession dominated by women. I agree that there may be a 'man' power crisis and I suppose the challenge is to find more men! However, I would certainly like to disagree with the suggestion that a predominantly female profession will cause a deprofessionalisation of the whole profession. Not when Doctors Maria Wilson, Zita O'Reilly, Seoighe Ni Rua and all the other wonderful women GPs sitting in this room here today are around.

What is the impact on the patients?

Well that is an interesting one. A sort of apartheid has developed in general practice – we feel that women should look after women and men after men. What a nonsense and a dangerous one as it leads to de-skilling. There has been a huge

pendulum swing that even the men have bought into. This change of perception is a challenge for training and the training schemes. This is a sociological shift, a pendulum swing but will the pendulum swing back?

And in case any one of you very young registrars listening to this talk think that you have a monopoly on fun and that it does not get better, I would like to let you know that if you love fun as a child, you will love it as an adult.



A patient

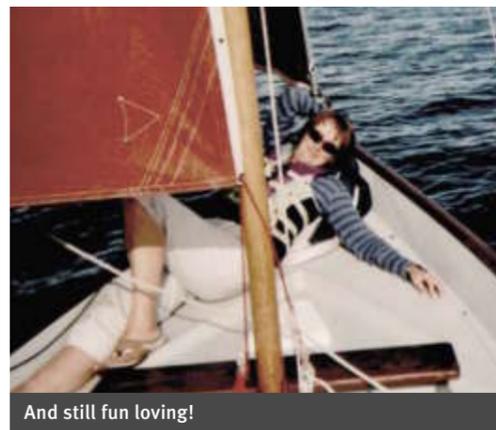


A young Dr Zita...

Should general practice become a mainly female profession, some of the fun would be lost.



At college...



And still fun loving!



And afterwards...

When I was in St. Louis School in Rathmines, it was not unusual for girls to consider entering the convent. A friend of mine, just in case God was calling her, went to see the Medical Missionaries of Ireland. She interviewed them and they her. She was a bit of a character and after spending some time talking to them, she said. "I don't think it is for me sister, I would miss the old sex!"

I think that whatever one's sexual orientation, heterosexual, homosexual or lesbian, that we can intellectualise it any way we want, if general practice becomes a totally female profession, it will be a pity and we will miss the old men.

Many people were very helpful to me and sent me wonderful slides. Dr Maria Scully has a practice manager and he was wonderful altogether. He was so good that I asked him to send me his picture.



Dr Scully's very helpful practice manager

When it arrived my daughter said to me – eyes lighting up – "What are you doing with that picture?" I said "It is a picture of Maria Scully's receptionist". "That's Brad Pitt" She said. "It's not" I told her – "that is Maria Scully's receptionist" and I still think it is Maria Scully's receptionist!

As you all know, in the audience at the moment is Muiris Houston and I have a very good Idea – Zita Dillon and I might ask Muiris if we can write next Saturday's column on what's hot and what's cold in the Irish Times – he might have a bit of pull. What's Hot? – having a male practice receptionist who looks like Brad Pitt. What's Cold? – the feminisation of general practice.

Premises



Abbey Medical Centre pre-1991

The manner in which the bricks and mortar of general practice are funded is under much debate. For planning permission reasons and generally for the sanity of a family, GPs tend not to set up in their own houses any more. This is the story of Dr Marie Scully's changing practice and is the pattern for many practices. This is enviable, something that has taken years of sweat and team building. But how do you fund it?



Dr Marie Scully: A doctor in waiting; after years of blood, sweat and tears qualified at last



Not forgetting to have a drink along the way!



Expansion continues – the search for new premises



...when that's all done, it's back to the hard work!



The new Ballymun Health Centre



You expand: Abbey House Medical Centre 1991-2005



Abbey House moves again in 2005

At the winter meeting of the ICGP, future models of funding for general practice were debated. Dr Garret Igoe opened with a marvellous presentation of the Virginia Primary Care Strategy and certainly it was the envy of all who attended the meeting. In this case the state funded the building, which houses the primary care strategy group.

The state has not given an undertaking to build very many further premises for general practice.

Dr Ronan Boland presented the model favoured by the IMO. The overriding message here is “Make sure you own your own business” – he advocated the development of primary care centres throughout the country owned and managed by the GP. Dr Marie Scully’s is an excellent example of this.



Virginia Primary Care Strategy Group



Then you expand the partnership



Sing and dance and build team morale and...

We in Ballymun like the Virginia practice hope to move into this building, which is totally State owned.



Kilcock Health Centre



The message was that we best understand our own business so why not run it? This can be funded from the bank or perhaps by rent from others, such as dentist or pharmacy.



The third presentation was by Fergus Hoban. He aims to build 60 large centres around the country each housing six GPs. He will take all the risk, do all the work, and leave the GPs autonomous. They will own their own surgeries and pay less than the market value to do this. He has spent a lot of time on designing a model, which keeps an ethical distance from the pharmacy.

What is certain now is that a GP with a list of 600 GMS and 600 private patients cannot afford to open in many parts of the country without looking at some type of economic model. What we are seeing is General Practice changing from a cottage industry run in our own houses by single handed GPs to group practices run either in state owned premises or as part of a business model. Not everyone is happy with this. One institution in general practice called Dr Cyril Daly, who has not and never will change, feels that there is a new stratum of medical care being introduced – an organic growth he calls it, and he is not sure that it is desirable. He suggests that the shape and size and quality of general practice are now being determined not by patient needs, not by the wish of many doctors, but by a vigorous entrepreneurialism. However as much as one may laugh at what he writes, there is a point that can be made. We are building lovely big buildings – and we think/hope that they will provide better care. However Dr Marie Wilson has chosen to stay in this premises – and is very proud of the care that is provided from this house.



The quality of general practice is probably not determined by the building only, although it must be a big factor but is determined by the people and the services they facilitate. However, it is fantastic to see the infrastructure of general practice improve.

Primary Care Strategy



In the September issue of Forum, Dr Igoe of Virginia Primary Care Strategy said that he felt that too much time has been spent discussing the infrastructure and not enough on how teams work together in general practice. The idea of the Primary Care Strategy was that a team of people would work together on complex problems. Any member could refer to any other and clients could self refer. There are only 10 pilot teams around the country. And we are privileged in Ballymun to be one of them.

What we are able to offer our patients as a result of working in a true team is huge. Twenty years ago when doing the GP Membership, all right answers to patient care seemed to involve a team. Despite working in many areas since and being on good terms with local public health nurses, social workers and other health providers, the only team times were conferences held about problem families.

These as we all know usually occur in the middle of the day and seem to be attended by very good people who have much more time than ourselves to solve problems. The primary care strategy was the first real effort to create a team and creating a team is not easy.

Barriers to team work include the different cultures that exist between the health board and us as GPs. We are used to taking decisions quickly and acting on them – no minutes – done and dusted. There is another culture with time for meetings, coffee, and review of minutes, which belongs to a different world. A huge barrier is the fact that public health nurses remain geographically based rather than based around a practice or a group of practices. Dr Garrett Igoe suggests, and I would agree with him, that all patients should register with a team, which is not geographical but serves a number of GP populations. It is very hard in one practice to have patients excluded because of geography.

While it looks as though there is not funding to roll out the primary care strategy in the way it had been planned – huge lessons can be learnt from working as a real team and I believe that there are huge potential benefits for patients. Because the primary care strategy is expensive and progress is slow – it may not change the face of Irish General Practice, however many of us privileged enough to work as part of a primary care team would like more thought given to this area as we believe that our patients greatly benefit.

Chronic Illness



General practitioners always looked after chronic illness. However there are more treatments available now and more people developing illness such as diabetes. The known prevalence of many chronic illnesses may be greater because of better diagnostic tools and greater perception on the part of the general population that asthma, hypertension, hyperlipidaemia and heart disease exist.

We are a country of pilots. The pilot in diabetic care in the north side of Dublin run by Susan Smith was an unmitigated success – financially, from a health point of view, and from the point of view of the doctors and nurses taking part. This pilot crashed, as it was no longer funded. Heartwatch is a success – again cost effective, showing good results, no reason to suspect that there are any waiting lists. We in Ballymun have a sexual health clinic with full STI services run by GPs and nurses and while this may not be chronic disease management, it prevents chronic disease – no waiting list. Many practices have an asthma clinic – no waiting lists. Over and over again, GPs around the country have shown that they can look after chronic illness, effectively, efficiently and at lower costs and without waiting lists.

Drug addiction can be considered a chronic illness. The methadone protocol has been written once and modified twice. It is followed nationally and each participant is audited annually. Again, this protocol and the manner in which it is carried out has over the last years demonstrated how well a co-ordinated programme can be carried out in general practice.

For some reason there has been no co-ordinated plan as of yet, for chronic disease – perhaps the new contract will change this.

It is always of huge disappointment to me that our representatives in the IMO speak so loudly about remuneration and so little about quality. It is a huge disappointment to me also that the Department of Health speaks so much about quality and will not address remuneration. Sometimes they seem to me like people in boats – passing in the wind, going in all directions.



What general practice has proven with pilot after pilot is that we can look after chronic illness, we want to look after our patients with chronic illness and that we would welcome non-paternalistic debate in this area.

Doctors' Health in General Practice

As general practice changes, are we looking after our families and ourselves any better? I thought it was appropriate to bring up this topic as one of the few certainties we have is that we will get older and that we need to take care of ourselves.

I introduced Fiona Bradley at the beginning of this talk. One day I was sitting in my surgery and Fiona was next door and she rang me and said she had a little problem and she had had it for some time now. In fact she had entirely ignored her 'little problem' for a long time. Fiona received attention the following day and really never returned to work in any very active way after that, even though she lived for a number of very full years before dying of breast cancer. Fiona neglected herself....why?

My own father graduated from Medical School over 55 years ago.



Dr Roibeard O'Chuinn – 15th September 2005

He retired from general practice at the age of 70 when his last child Diarmuid left university. He could not afford to retire before then as he had invested all his money in our education instead of his pension. The following week, he took the time to go to an optician. The sight in one eye was entirely gone and the other was at risk. Over ten years later he is alive and well. However driving is a problem with one eye, as is pouring wine. Why did he neglect himself?



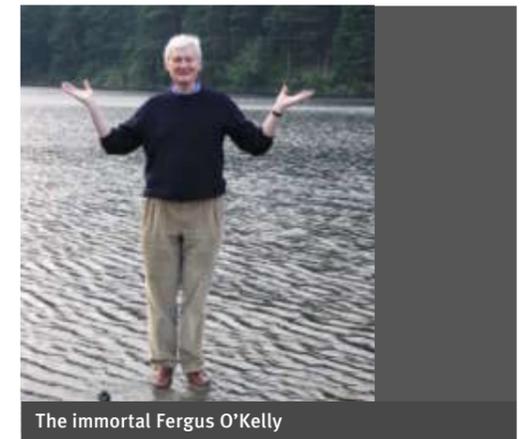
Pouring wine is problematic with only one eye!

It is still true that we neglect ourselves, that many of us do not have our own general practitioners, that many of us treat our own children. I think that there is very little evidence to suggest that this has changed. Why do we do this?

The answers to these questions are complex but the shoe-maker no longer has to go without shoes. What has changed is that there is help at hand.

Highlights of change

Even though I am sure that we will continue to neglect ourselves, there has been a recognition that when we do seek help that we may have a chance of getting it. This help is now at hand. THIS IS A HUGE AND IMPORTANT CHANGE. What is certain is that we are getting older and will eventually die, that is of course unless you are Fergus O Kelly and can walk on water.



The immortal Fergus O'Kelly



The ICGP have a Health In Practice programme whose mission statement is "to promote and maintain good physical health, occupational health and psychological health and wellbeing for GPs and their families". The programme is called the HiP programme.

The Hip encourages GPs and their families to address their health concerns in a number of very practical ways.

HiP provides confidential healthcare through four networks. The four networks are:

Network GPs – a GP for GP service.

Network Occupational Physicians – for occupational health advice.

Network Psychiatrists – for when you might need one.

Network Counsellors, Psychologists and Psychotherapists – developing solutions, life management skills and coping resources to help resolve your work-related and personal problems.

The first conference in Ireland in this area was held recently.

Much more has changed – quality assurance – still voluntary but on its way.

Litigation – increasing – as are complaints against general practice.

Collegiality – general practice is no longer a lonely occupation – largely due to the huge network that the Irish College has set up.

Education – again the College has a huge role to play here – it would be possible to spend almost every evening at some form of educational activity.

GP Training – always striving to improve.

Medical cards and the new contract – I was afraid to speak about this because there was a real risk that I would wake this morning and find that there was a fifth type of medical card which I had not included in this talk and that you all knew about already.

What Has Not Changed?

However what has not changed for me is that in general practice you make new friends – who remain old friends...



Young Deirdre Handy

Older Deirdre Handy

That there are supportive people who are always ready to listen and help...



Always ready to listen and help

There is the collegiality – this is a picture of some of us in Ballymun and David Gibney has just told us about a patient who came to complain about her child’s spelling. ‘What sort of word can he not spell?’ – he asks mum. ‘He cannot even spell ‘spragetti’” she says. Someone else tells about the young lady who was a little more up-market than many of our patients. When asked if she used contraception, she straightened up and proudly said that they used ‘condominiums’.



Collegiality

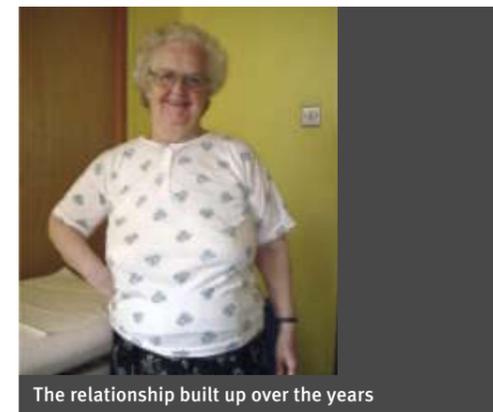
But reassuringly what is the same for me in general practice is the great pleasure it is to be a general practitioner. There is the closeness of the consultation; the continuity – the relationship built over years; the challenge – I hope to see this little girl safely through adolescence and beyond; there is the sharing of success – “look, no needle marks and I am working”; being there when the going is rough; and the huge pleasure of sharing the happy times.



The closeness of the consultation



The sharing of success...



The relationship built up over the years



Being there when the going gets tough



The challenge of seeing this little girl grow safely...

I would like to say to anyone setting out on what is undoubtedly a hard career with many frustrations, that at a very profound level I feel we make a difference to individual people’s lives. We share the intimate consultation, the normal, being given out to, the successes, the sorrow and the joy. I feel privileged, even in this changing world, honoured to be a GP.

Introductory comments

Dr Zita O'Reilly

Manné Berber – Teacher, Mentor, Wise Man

Those of us who were fortunate enough to train in the discipline of general practice, under the direction of Manné Berber, will never forget him.

His calm demeanour was striking and had the instant effect of soothing those in his company. His sharp mind asked us to question ourselves and those around us, never to assume. He instilled in us recognition for the importance of minding body, soul and mind – demonstrating his Canadian air-force callisthenics that he began the day with – much to our amusement!

How could we care for others if we did not know how to care for ourselves in the first place?

Manné was no pushover and he knew how to get what he wanted done with some 'gentle persuasion'. This 'persuasion' was used to good effect when he had to negotiate hospital posts for the scheme. He would be proud of the fact that the general practice candidates became recognized for their calibre over the years and rightly so.

He was visionary when it came to the development of general practice and was not deflected by any set-backs that would have crushed lesser mortals. Set-backs were just challenges.

As a Teacher, he gave us his most precious commodity, his time – in abundance.

In this respect, he was generous to a fault.

The most important message he left with us, his trainees, was the practice of what he called U.P.R.

“unconditional positive/personal regard” for others. If we had this for our patients and in all of our interactions with others in life – we would be successful as GPs and as humans.

In essence, Manné was a saint – someone who cared deeply about others and carried that passion into all aspects of his life. He translated his vision and his passion into reality.

General practice has grown with vigour having been so well planted in fertile soil.

We, his trainees, are now trainers and keep alive his memory and principles by passing them onto our future GPs.

How lucky are we to have known a truly wise man who inspired us then and whose spirit continues to guide us in our daily tasks.

Zita O'Reilly

Manné Berber Lecture

Dr Muiris Houston

Thank you very much for the invitation to present the Manné Berber Lecture on this the occasion of the 30th Anniversary of the Eastern Regional General Practice Training Programme.

I first met Manné, along with my fellow 1st year trainees in early July 1986.

Those of you who were lucky enough to know Manné can picture the scene. The neophyte trainees had gathered at the old Postgraduate Centre on the other side of this campus; we were soon joined by an avuncular, bearded man who radiated gentleness.

He soon put us at our ease and invited us to gather round our chairs to form a circle. Any of us expecting a didactic lecture on a hard topic in medicine were in for a surprise. Manné took out Michael Balint's book, “The Doctor, his Patient and the Illness” and began to explain how different our learning would be on the Thursday afternoon half day release programme.

We gradually realised that patients' feelings were just as important as their clinical signs; that it was OK for doctors to have feelings too and how important it was for the GP to be aware of these. And how it was possible to make a diagnosis at several different levels in the same patient. Manné introduced us to the importance of listening to patients and the therapeutic role of the doctor-patient relationship. We returned to the battle stations of casualty and hectic labour wards with new insights. Manné asked us to bring cases back on Thursdays, encounters which he skilfully peeled back to reveal the many layers of interactions between us neophytes and our patients.

I found it stimulating when he dissected away at an apparently straightforward case of an exacerbation of COPD that I had treated in the Mater Casualty department to reveal the many diagnostic possibilities underneath.

Of course, we were bounced back into busy hospital jobs and difficult on call rotas the next day, but in quieter moments we reflected on his teaching and our new understanding. And most importantly of all, we questioned the absolute diagnostic processes of hospital medicine. We had begun to learn the necessary skills to question this absolutist approach which up to that point was all we knew.

I don't know about you, but I found Balint a difficult book to read. It has very useful concepts, and it was these that Manné successfully got across to us. Balint writes about the doctor's Apostolic Function in a rather lofty manner. For me, the best way of learning about your own personality traits and peculiarities was to analyze a video of a consultation or even role play, two new 'tricks' that Manné and Michael Flynn soon introduced us to.

But I have to admit that the introduction to Balint was unlike anything else I had experienced as a medical student or intern and the book and its ideas were a real eye-opener to the world of general practice. However, it was Manné Berber, through his gentle teaching, who really taught me the value of the art of listening.

But then we discovered heart-sink patients! How could we ever tolerate these lower forms of life that had been sent to scourge us? Couldn't they

understand that we had nothing to offer them? And why, oh why, did they visit so often? Again it was Manné who helped put it all into perspective. During a group conversation in which we trainees were venting our frustration at heart sinkers we had treated, Manné paused and said; “I used to feel the same way about heart sink patients. Then one day, as I saw one frequent attender come up the driveway to my surgery in Churchtown, I stopped and thought “She has just passed by over a dozen other general practices to come and see me. She could have called into any one of them. But she has chosen me as her doctor, and has happily come to see me today”.

In other words, this woman was gaining some hitherto ill-defined benefit from consulting her GP, Dr Berber. This realisation, Manné told us, helped him look at that patient, and others, in a new light. And while it didn't turn all heart sink patients into saints overnight, it was a helpful insight into how we could view these consultations differently and more constructively.

By June 1988, we had enjoyed two years of Manné's company and benefited greatly from his gentle style of teaching. Our thoughts were turning to the summer break when on Sunday, June 5th, the terrible news came through that Manné had died suddenly during the night. Buried quickly as is the tradition of the Jewish faith, our mentor and new guide was suddenly gone from our lives.

Both the scheme and individual trainees soldiered on. But the loss of the first course director was a major blow to the scheme, which took some years to recover.

Manné was missed both as a teacher and a skilled administrator. He had made a unique contribution to Irish general practice for over 20 years.

All of us who benefited directly from Manné's teaching learned to appreciate his wisdom and kindness. To those of you who came through after his passing, his legacy lives on in the style and approach of the current tutors, programme directors and trainers of what is now the Trinity College GP Scheme. Indeed, he would have been particularly proud of this association as he himself was a 1952 graduate of TCD.

For medicine to have artistic possibilities, as demonstrated by Manné Berber, represented a huge bonus of GP training for me personally. A reluctant scientist, I was much more at home with the kind of medicine espoused by the Royal College of General Practitioners in its logo: *Cum Scientiae Caritas*. People were people, and not machines. The infected leg ulcer of the surgeon belonged to a person with a life story.

The ‘tonsillitis’ in bed 2 was an adoptee – did that mean he had no family history? And so Manné taught us to value and be curious about each patient's story and to use time and the ongoing relationship you have with patients to add to this narrative.

It could be argued that the recording of narrative in medicine is in some danger. The skill of history taking, I suspect, seems less essential to a new generation of doctors with improved technology. It is rare for the MRI scanner to lie, so why expend so much energy listening carefully to the patient's story?

Regretfully, this may be a logical approach in hospital medicine, but for those who work in general practice and psychiatry, in particular, narrative and the patient's story must retain its primary role. We must continue to listen carefully, to reflect aspects of the story back to the patient in a conscious effort to help them reformulate their story.

This process has been likened to the passing of information back and forth across a bridge, often in the form of multiple levels of traffic. In being open to participate in this process you are enabling the patient to modify the lived experience he or she has had. It helps you modify your medical understanding of what the person sitting opposite you has gone through.

Episodes of sickness are important milestones in the enacted narratives of patients' lives. The narrative provides meaning and perspective for the predicament the patient feels. Ultimately, it offers a true understanding of why that patient has arrived to see you at that particular moment with that actual problem he presents to you.

There is nothing as powerful as the patient's story in the first person. Many of you will be familiar with Robert Mc Crum, the literary editor of the Observer. His description of having a stroke in his book; “My Year Off” is a powerful one. Here is an extract:

“No one will ever know exactly what happened in my head on that summer night 3 years ago, but probably it went something like this. First, a surreptitious clot began to form deep inside one of my cerebral arteries, cutting off the blood supply to the one organ in the body that, next to the heart, is greediest for blood. Eventually, perhaps some hours later, the clot burst in the right side of my brain – an uncontrolled “bleed” that would result in irreversible destruction of the brain tissue. I was unaware of this cerebral drama: all I knew was that when I went to bed I had a raging headache, and then, the next morning, I could hardly move. Overnight, I had suffered what a specialist called a “right-hemisphere haemorrhagic infarct”, or what the world knows as “a stroke” – a word whose Old English origin connotes “a blow” and “a calamity”.

It was just another Saturday morning when I found myself in bed, alone and unable to get up at home in Islington, north London. My wife, Sarah Lyall, a journalist, was in San Francisco. It was odd to be on my own and odder still to be so helpless, but I was in no pain and, in retrospect, I realise that I was barely half conscious. Downstairs, the grandfather clock was chiming the hour: 8 o'clock. I could see that beyond the heavy maroon curtains it was a lovely day. I was supposed to drive to Cambridge to visit my parents. So, it was time to get up. But I could not move my left side. My body had become a dead weight of nearly 15 stone. I thrashed about in bed trying to sit upright, and wishing Sarah were with me. I experienced no anxiety – just irritation and puzzlement.

With difficulty I rolled to the edge of our big brass bed. Then I was falling heavily to the floor, dragged over the edge of the bed by the dead weight that was my left side. I was shocked and dismayed, and my first thought was to telephone for help. There was a phone on the bedside table, but it was now out of reach. So there I was: naked and cut off. I suppose I passed out, because when I came to again the street was noisier and busier, and the sun was high. Then the telephone rang briefly, maddeningly, and stopped. I knew that the answering machine would be clicking into action. Up here in the bedroom, it was out of earshot.

Time blurred. When I heard the clock chime again, it was three. Lying on the floor, I became obsessed with my missed rendezvous with my parents. At times, bizarrely persuaded by the remaining strength in my right side, I imagined hobbling across the street to my car, somehow driving with one arm. I was like a rat on a wheel, revolving desperate escape plans. Then the phone rang again. Somehow, I knew I had to get to the phone on the floor of the living room. With what I now see must have been an extraordinary effort, I dragged myself over the carpet to the head of the stairs”...

As you would expect from an experienced writer, McCrum's descriptions are polished as well as vivid. But our patients describe things vividly also; maybe not as eloquently as a professional author, but they offer us unique insight, via patches of narrative that I believe are worth recording. And by recording I mean using inverted commas to record the actual words.

I know this goes against the notion of keeping concise notes. I know it probably seems Luddite in this era of paperless, computerised practices. But computers have an inverted comma function. Why not use it, even sparingly? Train your brain to pick up the central nugget of the patient's story and preserve it. Repeat the exercise some consultations later. Watch how the narrative changes as the person's experience and perceptions of their illness deepens.

I must admit this is not a strategy I really made much use of in my years as a GP.

OK, I recorded patient's actual words, but strangely I recall doing this more readily when a medico legal report seemed likely rather than as a genuine effort to record the person's narrative. It wasn't until I became a journalist that I appreciated the importance of quotation marks. Partly because recording a person's actual words, is part of the journalistic craft. But primarily because my ear has become tuned to the key words offered by the interviewee. Now, these words and phrases jump out as they are uttered. They literally scream at you: write me down.

I believe GPs and their patients would benefit from the recording of stories in quotations. And unlike journalists, you won't have to match up tenses and leave out libellous phrases!

You can faithfully record the actual words of your patients, including expletives, local dialects, non

sequiturs and neologisms. Free of the demon sub editor, you can record in the raw.

Why should you do this? Well I believe that it will help your understanding of why a patient has presented that particular problem at this time. It will provide meaning, context and perspective for that patient's dilemma. It defines how, why and in what way the patient is ill.

Indeed by recording a series of such narratives, it will help define how the person's perception of their illness is changing. Looking back on such notes will help us, as doctors, to remain in tune with our patients. It will help reveal new diagnostic and therapeutic options that might otherwise have remained hidden. Recording patient narrative is essentially adding value to the process of listening. Because the doctor is listening intently for key phrases and words he is more likely to reach a deeper understanding of the consultation. And with this deeper understanding comes a therapeutic effect quite separate from the prescription of drugs. It was this important concept that Manné Berber instilled in all of us during his last years teaching trainees. I am sure he did the same for all of you who came through the VTS before I did. Michael Balint may have written the book but it was Manné Berber who made the concepts come alive for all of us.

Tomas O Criomhthain wrote one of the great books about life on the Blasket Islands. It is called Fíche Bliain Ag Fás- Twenty years a Growing.

Well this august training scheme is now 30 years old. It has been thirty years a growing and continues to go from strength to strength.

And it is fitting that we should this afternoon acknowledge the seeds so carefully sown by its first programme director, Dr Manné Berber.

At a personal level I have to acknowledge the influence Manné and the training scheme have had

on my career. Without being switched on to the importance of listening would I be an Irish Times journalist today? If Manné had not fed my desire to explore the artistic side of medicine, would I, during my fourth age, have experienced the irresistible urge to write?

While I cannot deny the genetic inheritance of writerly genes in my family, I must also acknowledge the environmental influence of key teachers in my medical training. Manné Berber was one of the greatest of these. He taught me the art of listening, one of the most useful skills a writer can have. Without listening, you have no stories. Without stories you have nothing to write.

And without Manné Berber this training scheme might not be celebrating its 30th birthday today.



