Ulster Medical Society

13 January 2011
The GP as a 'Canary in the Coal Mine'
Professor Tom O'Dowd
Trinity College Dublin

Professor Margaret Cupples:

Can I say welcome and good evening to the first meeting of the 2011 Ulster Medical Society series, and you're all very welcome, especially our speaker Professor O'Dowd who has come up from Dublin today.

But let me first of all tell you two things: there is a society's Certificate of Attendance for you all at the end of this evening, that you may, those of you who are still active in practice, add to your appraisal folders, to impress your next appraiser and continue your efforts to improve your professionalism and that will be sitting ready for collection at the end of the meeting. You have to put in your own name; we have not done that for you!

The next issue that we do apologize, that we haven't actually managed to get you the invitations to the dinner specifically yet, but it is on the program of events of the year so I hope you are all aware that it's happening on Friday the 4th of February, and this evening Dr Craig has given us a forewarning of what should arrive in the post tomorrow morning with you. So for those of you would like to be ahead of the game there will be some copies of this also available at the end of the evening, which is information both about the dinner and the golf event later on in the year.

Just to give you an update of what happened. Our last meeting took place in Derry, a joint meeting with the practitioners in the West of the province, on a night on which the temperature was minus 8 and the roads were rather icy, but we had a successful meeting and we were very grateful to Professor Martin Rowland who came over from Cambridge to speak at that meeting, and he talked about something that was relevant to general practitioners. He talked about the evidence that financial incentive had improved practice, and he also talked about the relevance of this to improving practice in hospital, i.e. the provision of financial incentive, and he finished up by saying really doctors were quite difficult to get together in a consensual approach towards improving quality, and it was a bit like herding cats and he actually showed us a video of successful cat herders!—cowboys on the range! I don't know how he did it or where he got it from! But he also showed us something of the political influence and how that can actually change events, and he showed us a reminder of the clip that you may or may not remember it, of a live interview with Tony Blair, when someone in the audience asked him about 24 hour access for GPs, that i.e., she had tried on several occasions to phone up to get an appointment two weeks ahead for her child, and could not do it because we were giving appointments on the day of contact, and Mr Blair thought this was an absolute ludicrousy, he didn't think such things existed. I think that was the last of his live interviews on anything to do with the health service. So it was quite nice to see that, and apart from that, all of what Professor Rowland talked about in a seminar that he gave to the Centre of Excellence for Public Health in Queen's that afternoon is on the Centre of Excellence website; and it's very nice to see how the quality of outcomes framework has improved certain things that can be measured but it had not improved things that perhaps are much more important, in terms of doctor patient contact, and cannot be easily measured.

So he put forward a very thoughtful view, thoughtful perspective, for us all who heard him, and tonight I'm quite sure that Professor O'Dowd is going to also give us a thoughtful few minutes of reflection on various items that are relevant to practice. He is an active GP, he's also Professor of General Practice in Dublin in Trinity College, he has experience of working both within the Republic of Ireland and in other parts of the UK, including Cardiff and Nottingham. He's a champion of professionalism and has been thus over the years and I look forward to what he's going to say. You may or may not have heard him before about a year ago when he was the chief exposer of practices that were not professional within the Tallaght General Hospital, so he will say something I think about that later, and I can be happy to hand the floor to him now, thank you.

Professor Tom O'Dowd:

Thank you very much Margaret, it's very nice to see so many old friends here. When Margaret asked me to do this lecture I was in the throes of the Tallaght Hospital thing which I will talk about later, and I said "Ah, I know what I'll do, I'll talk about the GP as the canary in the coal mine", and I've since regretted that title. But one of your colleagues, who won't be mentioned, said "Well nobody sticks to the title in this society anyway", so, and then the second half of the title comes from … I had a neighbour who was an ENT surgeon, I might add a very retired ENT surgeon, and he collared me one day and he says what actually do you do anyway? What does a Professor of General Practice do? He's quite old school that didn't think very much of academic general practice I gathered. So I thought I'd give a structure as much to organise myself as to organise anybody else because I'm going to … I suppose there will be a series of vignettes that may or may not come to a point, and I'm interested as well in what this lecture is going to say so you know, we're all in it together, and I have a starting point and I'm delighted to meet Dr Russell who … I will be using one of his papers. I'll talk a little bit about the challenges for academic general practice and indeed for academics in general in medicine, some stuff I've been involved in in medical education and local roles for academics which I think are interesting, and then a bit about financing health care and I've written down … I had actually written down the future but I haven't quite dealt with the future so I thought we'd go back to the canary's at the end if that's alright.

So this picture—I was wondering how … it's come out alright I think—this is a picture of the canary in the coal mine, which was actually the safety check they had, they were the only safety checks they had, and when the canary starts swinging the next phase of his life is that his feet falls off his perch and he dies. So it's a nice way to go, and that was how I felt for a bit of last year. And I wanted to go back to where we've come from and Alun Evans—I see Alun squinting at this—Alun introduced me to the history of dispensary doctors in Ireland many years ago and the country was very much divided up into dispensary areas and serviced by dispensary doctors, and they really had a terrible time. Some of you may have had relatives who were dispensary doctors, and they were elected to their positions, which of course leads to all kinds of conflicts and the poor salary then lead to conflicts of interest. The interesting thing is if you tax people too much or you pay them too little, they find ways of finding a level that they think is their worth, and the Royal Commission in 1910 said that they were paid to hold their tongues and take no notice of dirt and disease within their districts. So it was a fairly … there wasn't much of the canary which they could be, and this is—if you do these PowerPoint slides this is exactly the way you shouldn't do it—but it's so well written that I couldn't think of how to trim it in any way and the reference here is, I have the reference in: Russell M, the Ulster Medical Journal in 1983, and this is a quotation from an editorial in the Irish News, that was in 1937, so this was after the Royal Commission reported on … and I'll read it out to you, because I think it's very well written. "The dispensary medical officer may not have the glamour of the surgeon or the renown of the specialist, maybe one of the forgotten men of medicine" (it's a 'he', note), "moving obscurely about a country district on an unremitting round of duty night and day in fine weather and in foul, his name achieving the accolade of print but once a year when he applies for his annual holidays to the local board, but ultimately he is the guardian of the health of the people. These men often lead an arduous life, harassed by circumstances, red tape ignorance, but on the whole they put a lot more into their work than they ever get out of it, do a lot more than they are ever thanked for, perform wonders in adversity, that are forgotten as soon as they are done. They are the servants of the poor, outposts against disease, indispensable units of our social organisation." And it's the kind of thing you would like to have said about you really, it's a very fine … accolade really for people who are our predecessors as general practitioners, I know there are non-general practitioners in the audience but that's where we've come from.

I was interested then … my colleague whom some of know, Graham Watt in Edinburgh, who struggles with … Graham has gizmos in his mind that other people don't have and he struggles with quite big issues in most interesting ways, and this is an email that he wrote to me and he said "I would be interested to know what you now think about what academic general practice and primary care can achieve in the battle against systems based on secondary care. It seems to me that we have numerous examples of successful individual careers surviving in the university environment but have been less successful in influencing the world outside and general practice in particular". And that's quite profound actually. It's … and it's interesting in these days of research and research assessment exercises and what I thought I would do is take that as a theme for the kind of stuff that I've been involved in, non-referenced … I've got lots of other publications and one thing and another and I thought I would view with some of the … influencing the world outside and general practice in particular.

So going back to what my ENT neighbour said to me, "What does an academic GP do anyway?" Well if you look at … it depends how you look at it, if you look at the definition of academic, the one we would all like to have is that it's relating to teaching and scholarship. I like the word scholarship, it's much broader than research, but for people that don't think much of us, they tend to prefer the reference that it's not relating to real and practical situations therefore irrelevant and you will hear presidents of universities talking about all this very academic so they purely go for the second definition.

Marshall Marinker whom some of you will remember, Marshall shared this ability that academics of this generation had is that they could write very well, very contentiously, very memorably and when Marshall was appointed to the chair in Leicester he choose as his lecture, the title of his lecture … now he'd just been hired and cost the university a fortune, and the title he choose for his inaugural lecture was "Should general practice be represented in the university medical school?" You would have thought it was a shortcut to a P45; clearly he had a good contract. He then introduced the kind of stuff that you couldn't be against really; the danger for general practice, for medicine I think, and in general, as well he meant, and for the care which the patients will receive, is that this new university subject may trade adventure, risk taking and innovation for respectability. It's again the kind of anxieties that people in our discipline have had.

This story that I always tell about one of the first people who taught general practice in Trinity was somebody who went off to become a restaurateur afterwards, Aengus O'Rourke, and in 1971 he was the first person, first GP, to talk to the students in Trinity, and the Dean of the day, who was a very nice gentleman, was walking him down the corridor and Aengus told me afterwards that the corridor seemed to get longer and longer the closer he got to the lecture theatre, and he turned to the Dean and he says "What do you want me to talk to them about?" The Dean was very taken aback and he made the memorable reply "Oh anything, money, income tax and things like that", because when the Dean was in the company of GPs, all they were ever talking about was ways to avoid income tax, and money. They say that when you get a group of artists together they talk about money, when

you get a group of bank managers … well, you used to get a group of bank managers together, they talked about art. So I said to my Dean when I was appointed, I was getting calls from the media and whatever, and I said "How do you want me to handle this, do you want me to keep my head down and stay out of it or whatever", and he said "Oh well no, only speak out if you know what you're talking about", and I've taken that as a kind of benchmark really, I thought it was good advice to speak out when I knew what I was talking about. Mind you the most interesting things you say are always about when you don't really know you're talking about anyway, that's another matter.

So the academic task then, is it influencing the world outside as Graham Watt talks about, or is influencing general practice, and I'll come back to these, or being the canary in the coal mine, and I'll come back to that one. The other one is the voice in the village square where … our public health colleagues are very adept at being the voice in the public square, a very important role. But for us in general practice our canvas isn't as big so it's very much a village square, and do we have a role in the national life? I like to think I have a role in the national life. It's actually easier, believe it or not, to have a role in the international world. All politics is local and academics, there's a lot of politics in it, and it's often much more difficult to have a role in the national life, or the role in the local life, than it is internationally.

Julian Tudor Hart is another general practitioner that many of you will have heard about, and Julian has written extraordinary well, again of that generation, well-educated people, and Julian is opinionated. Strong opinions expressed well, they're irresistible, and he talks about medical education still designed to produce community clinicians only as a by-product, an afterthought following a core curriculum designed by and for specialists, and he called his lecture, or his paper, "Turning the World Upside Down", and this is how it was, and this is always the basis that I tell our students, the basis, the rationale for what we do. These are, you're all familiar with the health diaries that are kept, and this is just an indicative way of expressing this, by 1000 people over a month, and 800 will report symptoms, 300-odd would consider going to the doctor and actually about 200 will go to the doctor. Then you filter down the visit in outpatients, the visit in emergency department, and eventually they end up here, and one of this 800 will end up in the university teaching hospital and of course that's where I and many people here spent our undergraduate medical education, but actually we have to work out here this grey area, which is very different, the disease is starting and the disease is finishing or nobody wants to know about the disease or whatever, but it certainly is very compelling for our students to see this. And when a student sees anaemia here it means the person has got a very serious disease but when they see anaemia out here it's most likely to be dietary. So these are the kind of numerators that I try and get them interested in, and in, certainly my part of Ireland, I spent five years as Chair of our education committee in the Medical Counsel and I actually went on very reluctantly—I was put on because nobody else wanted to do it—and I thought well, I'll get myself elected to be Chair of medical education.

I thought it was terrible when I went back to work in Dublin, it hadn't changed for years. So myself and Gerry Bury, who's my opposite number in UCD, we began a series of visits to our medical schools and I heard afterwards that some of the Deans were very unkind to us; they used to call it the Tom and Gerry show, and in fact in one university they refused to give us any data because they said they didn't … you wouldn't know what they'd do with it, and the kind of data we were looking for was, "How many medical students do you have?", and they thought no, we shouldn't tell them that. So by the time we finished with them, they would tell us that and a lot more. We had, at that time, ten years, less than ten years ago now, it's actually six or seven years ago, chronic underfunding, and in order to pay my salary and everybody else's salary we take in over half our class as non-EU students, because they pay quite a lot of money, and we teach them about the Irish healthcare system, and we teach them about heart disease and cancer, and we take them to radiology places that have MRI scanners, and this, and then they go back to their own countries and they don't have any of this equipment, so we weren't making any attempt to modify our education in any way that would suit them. The curriculum in other words didn't match, but that hasn't stopped them wanting to come. Capacity is the … the manpower needs—unlike Calman, who started all the stuff in the UK—our manpower needs and our medical school outputs are not aligned at all, so it's always been a big problem.

When our visits showed that essentially our graduates were getting degrees in hospital medicine the universities got very upset about that; they said they're degrees in medicine and we said no, they're degrees in hospital medicine, because the hospitals were very, very strong. This will remind those older ones of you here that this is how it used to be. Most of our medical schools at that time were struggling, capacity was a big issue, students were warehoused in lecture theatres, and there was no education input. But actually I realised when we were doing this that everybody else had said that before for the previous 50 years, so how do you make a difference? What we did, we first of all … in the south if you want to make a difference I discovered you get people from outside the state, and if you're lucky they will take the flak and you can take the plaudits. So we engaged Maurice Savage of this parish, who Drew introduced me to, and who greatly enjoyed his time with us, and Gordon Page who was an educationalist from Vancouver, and what we decided was we would report to the public, which is if you haven't done it is very powerful. We reported directly to the public about the state of medical education, and I wrote this myself on the kitchen table on the Sunday morning, and it says "We have not looked after medical education in a manner that allows us to reassure the public that all is well",

and another sentence says, “There are real concerns about the quality of medical education in Ireland”, and I got Gerry to put his name to it as the President and he insisted I put my name on it as well but I thought it would look good coming from him, and this is what happened. Within a year they set up a commission under Patrick Fottrell, who used to be the President of NUI Galway, and it’s led, I’ve estimated, to about 200 million Euro investment in medical education. We’ve a new graduate-entrant medical school in Limerick, which takes in students to a four year course of which six months is spent in general practice. We’ve had several new appointments including three professors of general practice and one in public health, and we’ve had the professionalization of medical education with education units in all the medical schools, and primary care is now on a par with the other specialities, and I thought that was a very useful lesson to have is to how you want to make … how you want to have impact.

Just moving onto another vignette, Trinity has a strategy of engagement with society where innovation is derived from academic activities. Their understanding of this I suspect are things like genomics and proteomics and that kind of thing, I’m no help to them with that. But the other one they have is developing Dublin as a place to live and work and I think that’s pretty laudable, that a university should actually say we have a responsibility to the place that we are actually located in, so that is part of the strategy. But when you look at our medical schools, our hospitals are mainly in deprived areas and the professional staff drive in in the morning and drive out in the evening, and we have very grateful populations. But grateful doesn’t mean that they’re enabled and it doesn’t mean they’re in any way in control of what goes on. They have very little representation in the health care that they get, and the cranes are always busy overhead, and they used to be always busy. One of the markers of our Celtic Tigers years was how many cranes you had in your district and I used to see this and then I’d go round all these primary care places that we had, converted garages or whatever, never any cranes, not even a skip outside. So I thought that was very telling. So I worked with a colleague who’s unfortunately no longer with us, John Keveney, whom Alun will remember, who had a great facility, he liked working in developing countries, he just had a facility for that and he introduced me to health needs assessment, which are done by local people, and I thought this was actually a very interesting way to go.

For primary care in our Celtic Tiger years, the last decade, we have had really very little political support, we’ve had a strategy for primary care but we’ve had very little political support, because our electorate on the doorstep talked health to all their parliamentary people but they voted wealth. People tend to do this in the absence of credible policies and leadership, they talk health but they vote wealth. The primary care facilities in the catchment area of our university in Trinity are very rundown buildings. One of my colleague actually worked in a basement that he had vacate on time to allow the nurse to come in to take the bloods. Very harassed single-handed GPs, the lot of the difficulties in the inner cities, and secondary care providing primary care. This drives me mad. If you want me to bore you to tears I can go on for hours about secondary care providing primary care. It’s the most expensive and inappropriate care that you can think of. And our communities, because they’re not enabled, not doing anything really, just being grateful for whatever care they have.

So we got local communities to do these health needs assessments and we got money together to make the reports look well. They went out and collected the data, they prioritized the data, some of them actually we taught how to analyse data. So quite a big project, and we started here with my own area in Tallaght and then the people in Finglas asked us would we come out and do something there. So we did and then the people in the inner city just around Trinity … it wasn’t Trinity that asked us, it was the people themselves that asked us, we helped them to codify their diseases to help them to lobby for better health facilities. And the difficulty we had, I realised after this one, when they had a launch I was very keen that we write this methodology up. It’s been written up frequently before but that doesn’t stop academics wanting to write it again with a different twist. The local communities said “No, no, no, that takes too long”, so they hired a hall and they got loaves of white bread and make loads of cheese and ham sandwiches and invited a minister to launch the report and extracted promises from him. Very effectively, because this health centre from the very first one … it was the first one that was built in one of the most deprived areas that we had, and this is the health centre I work in and spend many hours down there on your right, and this was in West Tallaght, which was built on foot, and actually within about 18 months of the report coming out. It was quite astonishing, the politicians all came in behind it because it was codified information that was used by the public themselves. This is the latest one that was opened and it was very interesting. This chap here is a paediatrician who was our CEO of our health service, Brendan Drumm, who’s a great opponent of primary care, and they opened it without a politician, which I thought was very, very interesting—they got the HSC to open it and this is the staff that was in it. This is just round the corner from where we are, and this is another one that was just opened earlier in the year, and all these have arisen from this “town and gown” interaction and arisen really from borrowing the techniques of the developing world. They’re now very well-functioning, I suspect this one is too small already but it was in a very tight site.

Then I want to go onto the next chapter, I want to go onto the … and I call this slide … which is the efforts we put in to having a health centre built in the most deprived area and we have never managed to get anybody from the hospital to visit it. We’ve had to duplicate services, it’s been an appalling time really, and I’ve called this slide “When your local hospital lets

you down always", and it was actually sparked by this 24 year old woman who came to see me two years ago. She was a regular sun-bed user and she had a dark mole on her back, which I excised, and I think the pathologists have it in for GPs excising things because the reports always come back saying suspicious or inadequate margins, so this came back and it's one way of getting us moving very quickly. So I spoke with the registrars who told me to write to the consultant and I wrote two letters to the consultant, this woman was beside herself with anxiety, and heard nothing. So I eventually got her seen by Casualty, and actually I must say that when the surgeon did remove the margin there was no suspicious bits in the margin which relieved me no end. So I wrote to the CEO about this, telling him that I'd had five years of difficulties in getting my referral letters processed and, if you get a long convoluted response back you must become suspicious, and he invited me to join the committee, and I thought that wasn't good enough. So I wrote to the Chairman of the hospital and my letter to the Chairman subsequently appeared on the front page of the Irish Times, and it read very well I must say, everybody agreed it read very well, and he never acknowledged it. So I then got on to our Health Information and Quality Authority who have statutory powers really in dealing with quality and this kind of thing, and they inspected the hospital and they couldn't get information that they wanted, and I had the ludicrous situation then of complaining yet again to the Quality Authority and they told me all they could tell me was go back to the CEO. So I was stymied, to be quite honest, and I was watching the news, the Nine O'clock News, and it said that there were … when I wrote to the CEO and wrote to the Chairman at that time I thought there were 20,000 x-rays unread but actually it emerged there were 57,000 x-rays unread, and it appeared in the national news. The following morning the Irish Times had in a little paragraph said "We have learnt that a local GP wrote to the hospital in April 09 expressing his concerns about the x-rays and the letters", and I was sitting in that health centre that I showed you at a quarter to 10 the following morning, I got a phone call from RTE, which is our national radio station, and the researcher said to me "Was it you?"—and I said it was, and then began … and any of you who have been involved in these kind of media fracas, they do take over your life, and the best advice is actually to give it 24 hours and that's what I did, and out of it, I knew they were serious when they asked Morris Hayes of this parish and Patricia Borden, again a very accomplished person, along with some other people. They have produced a really … as you can gather now, I have a great soft spot for elegantly written stuff, and the Hayes enquiry as it's known, I've put a photograph of it there, I've summarized here what it says: a local GP, they didn't refer to us by names or anything like that, brought his concerns in dealing with the hospital to HIQA—the hospital fobbed them off. That's very nice language, and then, this is really … if it wasn't tragic it would be funny, the hospital decided that they would invest a fortune in IT and they put an IT system in for processing GP referral letters but could only cope with referral letters a year ahead, could only give appointments a year ahead. So if they were unprocessed and didn't fit into that computer system, they stored the letters in boxes in the administration department, unknown numbers. I reckon 30,000, they said three, one is too many, and no one said anything. Now everybody knew but nobody said anything. Then to cap it all the orthopaedic surgeons rolled into town and they decided it would be morally unacceptable—very powerful words isn't it?—morally unacceptable, they said, for them to accept any more referrals when they couldn't deal with those on their waiting lists already—they didn't know how many were on their waiting list—and they wanted ring-fenced beds. So the Hayes enquiry concluded by saying withholding services raised important ethical questions. They then went on to highlight severe systemic and other weaknesses at management level—poorly developed relationships with GPs, and this is what happens when a hospital decides that it's going to become a primary carer; it goes into competition with GPs. It's well known, it's rampant in the private sector, I mean it's rampant in the private sector. The board structures were simply not robust enough for the governance, supervision and direction required in a complex organisation, and then they concluded this really very nice paragraph. They said "We have made recommendations. So have others. There have been enough reviews and reports, what has been lacking is action and a sense of direction".

So the date on that is September 2010 and I was pleased to receive this before Christmas, which is from HIQA; the national standards for referral letters, they've really got behind this. The public were so outraged, the public never understood about referral letters, they just didn't understand it. When they thought about it the public were very upset about it and what we're now headed into is electronic referrals, everything has to be recorded, and in fact when our hospitals were measuring the waiting list they measured it from the time the patient was seen at outpatients to the time of procedure, they didn't measure that time from GP referral. So that's all going to change with this. I'm very proud of this because it's the first time in doing this kind of work I've actually been able to break into general practice. Most of the papers I've written have really very low citation among our GP colleagues, have had very little impact on their clinical lives, on their clinical work, but this work with referral letters, unreferenced, it won't appear in Index Medicus or whatever it is, but it will affect every patient in the country, every GP in the country and every consultant in the country, and I think they will pull it off, it's part of my job to make sure they pull it off.

So the difficult question then is why did local GPs put up with this? Because when it came out the GPs all rallied round and said "Yes, it's terrible, we're glad you did it", and I said to them "Why did you put up with it", and they said "Well you make do". It's this

thing of making do, and then why do patients put up with it? Patients were very complimentary about all of this kind of thing and I said "Well why did you put up with it", and they said "Well we thought every place was the same". Because patients who only use one particular system don't have—as in our case, use the public system—they don't have any other system to compare it with, so if they're treated badly they think that's the way they're treated elsewhere. Then the key question is what can you do with a failing hospital? This hospital is only 10 years old, 11 years old, it's never worked, and what can you do with it? You can't close it down; the first thing you have is you've got a hospital action committee that pull in all the TD's and MP's and whatever, to try and save it. It's politically very, very difficult. So when I say to the staff they say "We were never given a chance", but they're getting 240 million Euro a year as a budget, which to me seems like a chance, like a fair chance. When I say to the patients, they say "Well you know what that place is like". Because it's a very important employer locally, this actually is perhaps what people want, it employs 3,000 people, many of them whom are local people in jobs that are poorly paid but they're still jobs. So it's a very tricky question is what do you do with a failing hospital, very, very tricky question that I've discovered.

I want to end with this bit, which is again, I'm sure Drew and Keith have forgotten about this paper. It's been a very important paper in my life, another kind of work that we do and it's the effect of a consultation charge. My GP colleagues, I would be quite surprised if some of you don't collar me afterwards to say "What do you charge for seeing a patient?" It hasn't changed since 1971; people want to know what you charge. So this was Dermot O'Reilly, Dermot isn't here, Dermot is a very important person in this paper, and this graph, you all remember this, I'm sure Keith and Drew remember this, which is the percentage of patients who didn't attend the GP because of cost. Now these here are our GMS patients, which is equivalent to NHS patients, and a proportion of these people don't attend because of cost, maybe travel cost of whatever it is, but here we have the people who have to pay the GP and it's quite a large figure. When you see that even children, 15% of children are not brought to the GP because of cost and particularly here with young people. People in their thirties or forties, defer going to see the GP or whatever it is. Maybe it's just as well, but some of them would certainly need that kind of care and again it's much more males than females. It's quite an important barrier, and we've never been able to do anything about it, and it's quite ironic to see the entire population of the Republic of Ireland were shouting for Obama's universal health plan but when it comes to having one ourselves they work out what it's going to cost, and then they vote for wealth rather than health. It's been a very interesting dilemma, and out of that has come this work that I've been very proud to be involved with; to, in fact, commission with the Adelaide Hospital Society, and what we're promoting is social health insurance, as an option. Because even though we don't have universal health care in the South, 82% of the money spent on health comes from the government, a very small proportion comes from the private health insurance. So we're promoting this, and what it means is that individual contributions, insurance contributions, are based on income, it removes the ability-to-pay defining whether you consult the doctor or not. Insurance fund is separate from a tax fund; this was I suppose the original thing about the National Insurance fund, that it would be separate from taxation, that's the understanding behind it. The care can be delivered by public and private providers, it doesn't really matter who the providers are, and I have had the interesting experience of taking all this stuff around to the political parties, including Sinn Féin, I might add, who expressed quite a lot of interest in it. They talk about jurisdictions, they have a different language than the rest of us, but they were very interested and all the political parties, and in fact our two political parties that I suspect will be in power in a couple of months have made this their health policy. So I think that will be … it'll be wonderful if we can pull it off, I don't think it will cost any more than we're spending already.

So going back then to where I started with my canaries, I do think GPs … as GPs we, perhaps because I have been a GP in three different practices, I value very much knowledge of a community, and certainly people who have spent a long time in their community do understand their community. I do think they're able to speak in particularly strong ways about their own community, and often for generations, GPs know people for generations. They know things, GPs, I think we know things, we know about how the local society functions. It's quite astonishing, because I go round and visit lots of practices, what they know. But this syndrome of making do I think is very disabling, and I would like, I suppose, for GPs to speak out a bit more credibly on important issues than we do. I think it's very important that we … we are always in the difficulty of not wanting to break confidentiality but on the other hand patients do appreciate and they sometimes tell us things that resonate with a national or a regional agenda. It's an interesting thing and you've have this experience here in Stormont, of GPs in politics using the local hospital as their agenda rather than using your broader health agenda. I never understand it as to, it's obviously a way that pulls in votes, but it just reinforces that dependence that people have on this little institution that provides jobs and health care as a secondary factor, and of course unlike our dispensary doctors, and indeed our consultant colleagues I've discovered, we are not bound by contractual forces to stay quiet. It's a great freedom to have to be able to speak out, provided you know what you're talking about, but it is a great freedom to have, is to have that kind of contract that you can speak out.

So my final slide is about the canaries, I've put in the title I have to use it! It did mean the place was safe to work and actually most of them came back up, you

forget that, they came back up and they lived lives. They were well cared for by the miners, it's quite an endearing aspect of a group of very strong men caring for this tiny little bird and they lived what I call short meaningful lives and they swing before they fall off their perch. Now I do think if you get engaged in this work being a canary in a coal mine, you'd be surprised the toll that it does take on your lives. So I won't be surprised if you get involved in this that you have a short but meaningful life, so it depends whether you go for life or meaning.

So thank you all very much.

Professor Margaret Cupples:

Thank you very much indeed Tom, quite revealing. I would like invite a few questions from the floor, he has given us all a challenge, not just academic but all practitioners and hospital colleagues too, and I think that's a very telling slide at the end, the contractual obligations that we may have by freedom of contractual clauses to keep quiet.

Professor Tom O'Dowd:

It's still that way is it?

Professor Margaret Cupples:

Well yes, we still are independent contractors in general practice. But that's perhaps not so for all of us. So would anyone like to ask Tom a question?

Dr Keith Steele:

Tom you haven't said anything about the personal toll? Was there a personal toll for you for putting your hand up?

Professor Tom O'Dowd:

Well yes there has been and it was astonishing when I was called up by the Hayes commission to talk to them and I fell for the oldest question in the book, when Morris Hayes says "Well tell us your story", and I found it a very emotional experience because it just hit me, the toll of the whole thing, where you are very much out of your own. Because I'd spent five years battling with that, and in fact I considered giving up practice because it was so unsafe, and I actually hadn't faced that until … and it's a wonderful question, "Tell us your story", and I had prepared my facts and everything very meticulously, but I hadn't been prepared for that question, which I thought was interesting. Yes, there is a personal toll, there's no doubt about it, but I'm big and ugly!

Professor Randel Hayes:

Tom, there was so much of interest in that talk but I'm interested in the concept of social insurance, and have you had much support from your consultant colleagues with regards to social insurance?

Professor Tom O'Dowd:

Well, there is a syndrome, isn't there, where people look at the broad agenda and then the next stage is they say "How is this going to affect me?" And the last decade has been very corrupting really, extraordinarily corrupting really, where we've had this situation where many of my consultant colleagues are now in financial trouble, and it's entirely predictable, it's entirely predictable, where you invest heavily in a local private institution and doctors, GPs anyway I can say, and doctors in general, fancy themselves as businessmen. But when you come up against guys who know exactly what they're doing, they know at what rates to borrow their money, they know exactly how to get their pound of flesh from you, doctors are putty in their hands, and we have a number of doctors who have invested considerable sums in private clinics that are not doing well, and what are they going to do when these clinics fold up and they're left with big mortgages? A lot of our colleagues have a lot to weigh up, they won't be the deciding factor in this, they won't be the deciding factor, because I think people have tried money, they have voted well and it hasn't brought them any happiness and the healthcare has deteriorated, and they are now making a link between investment and outcomes and I'm hopeful, I'm ever hopeful. I'm like Thomas Paine I think we can still build the world anew and I'm hoping that … we have to do something, we can't go on as we're going, and there have been, there is huge … our professional groups in the South are very distrusted, it is really, it starts with the church, it goes onto barristers in particular, doctors. When people talk about doctors they separate hospital doctors and GPs, GPs are hugely trusted and that's, again, if we can get general practitioners to buy into it, it would be more important than getting our consultant colleagues to buy into it.

Professor Randal Hayes:

It would be helpful if they would.

Professor Tom O'Dowd:

Well we've done a lot of work on this; we've done a huge amount of work on this, because it's worth fighting for.

Professor Philip Reilly:

Tom, at Trinity you've been particularly effective at preparing the ground with work with the economists, work with ethicists and just thinking about healthcare I was impressed by some work you've done, you've even had members of Obama's health team over, but in a sense you've got to try and convert that now to a time when the Fine Gael and/or the Labour Party will run the show, amongst which there are people who think they are economists, in fact they probably are economists and certainly amongst their number are a number of doctors, so you will have to try and convert that, some of these commendable things to do this effectively, how do you think you're going to fare? I mean not you personally.

Professor Tom O'Dowd:

Yes, well we have been to see on a number of occasions Fine Gael and Labour and Sinn Féin. We have pointed them in the directions, they've been to

Holland to see how things work. The Labour Party is very keen on it, partly because I think they see themselves as getting the trade unions a fund, helping the social health insurance fund to run for their own members. So I think that, I mean it's all predicated on our economy because everybody is very, very anxious, very indebted, so it depends if … I mean we've done the figures for them, Charles Normand actually who used to work in Belfast, Charles has been absolutely astonishing with this and we've got him to do various models, the kind of Morris Minor model and the Rolls Royce model and all of these kinds of things, we've given them all these names to attract attention, and he's done costing and no matter which way you look at it you can only make social health insurance work if you involve general practitioners. You can't make it work without GPs being involved in the referral process.

The referral process is very important, if that breaks down the health care system is unaffordable, it's the gatekeeper effect, it's very important. We've done a lot with it, there's a lot going on and we'll hold them to account, I mean we hold them to account in some way or other, because it's part of their health policy.

Professor Margaret Cupples:

Can I take you back to Tallaght and ask you what has happened since the 57,000 unread x-rays were …

Professor Tom O'Dowd:

Ah well the people who didn't bloody well read them at the time have been re- employed to read them again, so they get double dipped, you know what I mean? Listen, it's been wonderful really, if you don't do your job. I remember one of my colleagues in Trinity was caught in a position with a female student that he shouldn't have been in and he was—went on national television I might add to tell everybody about it—and he was given a year of sabbatical by Trinity to get himself sorted out, and his senior lecturer was made head of the department. The senior lecturer was heard to moan that he'd lead a blameless life and he's ended up doing twice the amount of work! So I mean things have improved dramatically, it's quite astonishing to … have improved just in the safety of care and in the courtesy that people … I mean it is very, very difficult when institutions have a thing about GPs.

Professor Randal Hayes:

Did they employ more radiologists?

Professor Tom O'Dowd:

Yes, there's two more on the way and one of the guys who was involved in this was retired so he's come back to finish off the x-rays.

Professor Randal Hayes:

Can I maybe have a look at education? There was an article in the New England Journal last week about provision of health services in rural America and it was a medical school in Georgia, it seemed to be concentrating on providing positions for rural Georgia. Do you think a medical school which is trying to produce that kind of graduate should be different in any way from let's say Trinity or UCD or Queen's?

Professor Tom O'Dowd:

Well you see I do feel that medical schools have a kind of social contract with the society that they seek to serve, I feel that very strongly, and if that social contract means that you have a nice medical school in a posh part of town, well posh people need looking after too, we all do don't we? But if you have a medical school that part of its duty, or part of its mission is to look after deprived populations, well the people there need particular training. I heard this very much from John Keveney, that there are particular consultation styles or particular … I mean where I live all my neighbours are terribly worried about pensions, but where I practice nobody has a pension, they don't live long.

So those kind of factors we need to teach students, we need to have that kind of … interestingly enough we've got somebody coming over next week from Wisconsin, John Fry, to talk about primary care and how they're going to deal with it, with Obama's health care plans, because they can't deliver Obama's health care plans without primary care, and I do think primary care in New York would be very different from primary care in Wisconsin.

Audience member:

[Tom, probably the area, there are two visiting that, are Australia and Canada where they're having the medical school?] I think of Canada, I think it's the Northern Ontario medical school, and there's Vancouver, and UBC have set up a satellite school, and they basically are trying … they've realised that it's so hard to get people to work in those areas that they're actually recruiting locally generally, and then they have really [skewed?] the education to the group that are coming in in the hope that they will actually work in that area.

Professor Tom O'Dowd:

I think if you want to provide general practitioners for your area there's no doubt about it that graduate entry is the way of doing it, because people's professional lives are shorter, they don't want to go down the consultant route which will take many, many years, and I do think for example Limerick is very keen to do that because they need general practitioners there, because general practitioners tend to stay in the area in which they qualify and that's quite important.

Professor Margaret Cupples:

I'll offer our last word to some of the consultant colleagues here in case they're feeling really put upon!

Professor Tom O'Dowd:

Generally able to look after themselves!

Professor Margaret Cupples:

We do know also that general practitioners are not all perfect, not as perfect as you have painted us to be, but we are very grateful for you giving us this insight into the difficulties that there are in trying to maintain quality in practice, I think in whatever sphere we work.

Closing comments? Any from the floor? If not I will quickly remind you that our next meeting is going to be in a fortnights time on the 27th of January and at that Professor Helen Lester who is the Chair of Innovation and Teaching and Research at the College of General Practitioners, is coming to talk to us about maintaining quality in practice, and I think that the standards that she's talking about will also apply to hospital as well as general practice. So I invite you all to come and that evening we hope to have a buffet meal for all who come at seven o'clock that is before the meeting which will start at eight.

Thank you again for your attendance, thank you very much.