Editorial

Leadership from the floor up

Dara Gantly looks at the Minister for Health's latest plans to bring dynamic leadership into the management of the health service

One of the great quotes about leadership is that one should not follow where the path may lead, but instead go where there is no path and leave a trail. I'm not sure who first said that, but I wonder if the Minister for Health knows it too.

Last week, **Dr James Reilly** announced that the first Diploma in Leadership and Quality in Healthcare programme would be rolled out to ensure that all health-service leaders participate in this new critical training initiative.

This eight-month, part-time training programme, aimed at senior clinicians and healthcare leaders, began through the HSE in October 2011 under the leadership of **Dr Philip Crowley** and in partnership with the RCPI, and will be repeated with funding provided by the Special Delivery Unit (SDU).

Dr Reilly apparently wants every senior clinical or managerial leader to go through this course by the end of 2014, and he says that being a graduate of this programme should become a requirement for everyone seeking a leadership position from 2013 onwards. And about time too, I hear many of you say.

On a cursory inspection, the areas to be addressed do seem right on the money, as they focus on strategies to reduce rates of harm, patient flow across health systems, the science of quality improvement, and leadership itself, among others. But is there a danger of promoting a top-down approach to solving our health service ills, when leadership from the floor up may be just as important?

It is nearly two years since the HSE/Department of Health announced its new clinical programmes, as part of the Quality and Clinical Directorate led by **Dr Barry White.** The programmes, which are led by a multi-disciplinary, frontline team of clinicians, were set up to define the ideal care for patients so that it could be implemented across the country. Some excellent work has been done, but it has been two years! Are we seeing enough change on the ground, and quick enough?

I don't think any reader would argue with the view that we have an excellent collection of individuals as 'leaders', who are experts in their field, honing the various strategies. But are we bridging the theory/practice gap at a sufficient pace?

Such a leadership training programme makes complete sense, and will ensure that we can no longer complain that health management doesn't get the training required. All health services throughout the world are coming to recognise the importance of training their staff in fundamental concepts of continual quality improvement in order to get more for less, and this initiative should go some way towards achieving that.

And contrary to what Minister Reilly said at a special briefing on the SDU in January, it is not completely accurate to say that no jurisdiction in the Western world is improving quality against the backdrop of significantly reduced budgets. Ireland may be hurting more than most, but money is tight for all governments at the moment, and no health minister worth their salt should be neglecting quality drives in the face of the current global economic challenge. But I digress.

Leadership on quality initiatives is indeed vital, but what form that leadership takes could prove equally critical. Could we end up with a cohort of managers with the tools and techniques for change management, but without the staff engagement to back them up? Translating this knowledge into real and meaningful change on the ground isn't easy, but the chances of success can only be improved if all frontline staff believe they are the people who are the experts.

Perhaps the culture of our healthcare system needs to change first to give frontline staff the autonomy to change what needs to be changed.

As well as a clinical 'lead' system, do we not need a clinical 'follow' system too? If we employ a 'see one, do one, teach one' approach, we could have a whole army of problem solvers in the health service. And certainly we've enough problems to solve. Lead on.

GP IT

Data-sharing study looking for GP input

Dear Editor,

I am writing to invite readers of *Irish Medical Times* to participate in a national survey of GPs. I am a GP myself from Dublin 14 and, as part of a Masters in Healthcare Informatics in UCD, I am investigating GPs' attitudes to data sharing.

I have drawn up a short questionnaire that should take no more than 10 minutes to complete. There are three specific aspects on which I would like to get GPs' input:

1. National summary care records;
2. Patient access to primary care records; and
3. Patient-held personal health records.

I have already emailed just under 1,000 GPs and am sending out a postal questionnaire to another hundred, but if any *IMT* reader has not received either email or letter and would like to take part in the brief survey, they can do so at: https://www.surveymonkey.com/s/gpdatasharing.

If readers have any questions about the survey, they can email me at the address below.

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web threads

"It is deplorable that our children's educational needs are dependent on yet another report! Not to mention the additional stress caused to those who through no fault of their own cannot resist the urges to sleep due to narcolepsy, which obviously will effect their academic determination and future careers, not to mention the social, moral and legal rights of the children concerned."

Anna-Maria, mother of child suffering from narcolepsy and member of SOUND, comments on our article 'Report on human swine flu jab to be published before Easter'.

"I don't think Minister Reilly or any of the persons involved in moving this along has any idea of the unbearable pressure and frustration that is being placed on the children and parents through no fault of their own. It's time now to step up to the mark…"

Sandra Leavy adds her voice to the same debate.

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Bahrain

One simple question: will the King of Bahrain implement the recommendations of the BICI?

Dear Editor,

Mr Mohammed A Al-Muharraqi has once again had an attack of garrulous self-righteousness (*IMT*, 02.03.2012), which needs to be interpreted in the context that he is an employee of the two institutions that have come in for the most severe censure in Bahrain.

The first is the Medical Defence Force (where he is a consultant Maxillo Facial Surgeon) which was specifically indicted by the Bahrain Independent Commission of Inquiry (BICI), and the second is RCSI-Bahrain (where he is a Senior Lecturer), which has not only been accused of complicity with the Bahrain regime by the editor of the *British Medical Journal* but has failed rather miserably to justify its actions in Bahrain to its own government's Joint Committee on Foreign Affairs, as has been reported succinctly in the same edition by your columnist **Dr Ruairi Hanley** (*IMT*, 02.03.2012).

Leaving aside the content of Mr Al-Muharraqi's letter, what is clear from his many efforts to justify the action of the Bahrain government is that he simply cannot come to terms with the fact that the BICI had no hesitation accusing the Public Security Forces of violating human rights by forcibly entering and ransacking houses without arrest warrants, and subjecting detainees to blindfolding, enforced standing for prolonged periods, electrocution, sleep-deprivation and threats of rape with the purpose of obtaining incriminating statements or confessions. Taken with forensic medical evidence, the BICI adjudged that torture was common and that such practices were a flagrant disregard, both of Bahrain and international human rights law.

So regardless of whether some doctors were or were not involved in political protest, international democracy cannot condone kidnapping, torture and detention without trial. In particular, I would direct Mr Al-Muharraqi to the warning from the commissioners that "the state should never again resort to detention without prompt access to lawyers" and access to the outside world.

However daunting these criticisms may be of the security forces' use of internecine practices, a more worrying aspect for the many doctors and others in Bahrain who still stand accused and who are still being tried, is the serious criticism of the Bahrain judicial system by the BICI, which must call into question the validity of sentences previously passed.

The commission viewed the "lack of accountability" of the judicial and prosecutorial personnel in the National Safety Court as "a subject of great concern", compounded by the acceptance of forced confessions in criminal proceedings in both special courts and ordinary criminal courts.

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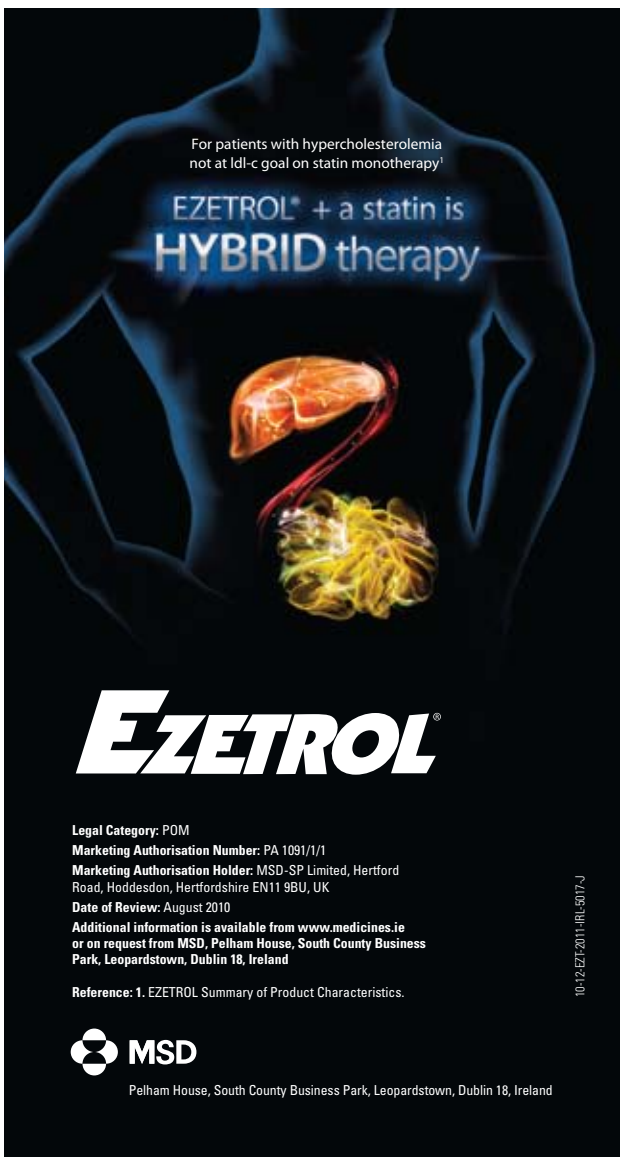

Bahrain

Will King implement BICI report?

Continued from page 19

The commissioners went on to recommend that sentences should be dropped, or at least reviewed, for those charged with offences involving political expression, or victims of torture, ill-treatment or prolonged incommunicado detention, and that victims of human rights abuse should be compensated and that dismissed employees should be reinstated and compensated. This recommendation has not been enacted – the farcical trials of doctors continues; one observer had this to say at the most recent trials the other week: "I must confess to breaking courtroom protocol by cracking up at the caption alleging 'misuse of hospital mattresses'" (See http://bit.ly/GCaCL5).

So in the light of these damning indictments by the BICI, rather than worrying about what employees of RCSI-Bahrain or the officers of RCSI Dublin may say in their attempts to justify indefensible actions, I have just one question to direct to the King of Bahrain: can his Highness assure the world that those doctors and other citizens of Bahrain who have been sentenced by a dysfunctional judicial system (according to both international and Bahrain legal standards as adjudged by the BICI) will be pardoned and compensated?

If this is not done the BICI (which the King commissioned) will be seen as a fatuous exercise contrived to appease international criticism of a corrupt government.

Eoin O'Brien,
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University College Dublin.

Out and about in Dublin

First malaria vaccine clinical trial underway

Pictured at the RCSI Education and Research Centre, Beaumont Hospital, Dublin, from left-right: Prof Samuel McConkey, Principal Investigator of the first Irish malaria vaccine trial and Head of the Department of International Health and Tropical Medicine, RCSI; Ann Collins, Research Nurse, RCSI; Liz Fogarty, Research Nurse, RCSI; Kerrie Hennigan, Research Assistant, RCSI; and Dr Eoghan de Barra, Research Fellow, RCSI

Picture credit: Ray Lohan/RCSI

Forceps, swabs, sutures...
Irish Medical Times. Exactly what the doctor ordered to surgically examine the Irish health service.

ABC The **Average Net Circulation** per issue for the audit period 1st January 2010 to 31st December 2010 was **7,152**. The highest audited circulation for any medical newspaper.

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"This article is highly inaccurate. Stem cells are not yet used in the direct clinical treatment of "many diseases". We stand at nine including leukaemia, lymphoma, some rare blood diseases and very particular conditions pertaining to the eye and skin. It is mistakenly inferred that all stem cells are more or less the same and only differ slightly in potency. This is incorrect. There are wide discrepancies not only in the ability to isolate and expand certain stem cell types over others, but also completely different potentials both in terms of developmental biology and clinical usage.
This article also seems to assume the clinical utility of cord blood storage for many conditions, which is certainly not the case. In most cases, traditional bone marrow transplants will offer significantly higher chances of a positive clinical outcome due to the considerably higher number of haematopoietic and mesenchymal stem cells."

Dr Stephen Sullivan, Chief Scientific Officer, Irish Stem Cell Foundation, comments on our recent medico-legal article 'Stem-cell preservation: biological insurance or money racket?'

"The article is indeed interesting. But regarding the comment by Dr Sullivan, to set the record correct for Irish readers – to date there are in fact over 70 validated diseases treatable by umbilical cord blood around the world and more than 15 additional new clinical treatments using cord blood. Although the first treatments were in the area of serious blood disorders, this was quickly followed by the use in immune system disease. Groups like my own have also developed clinical trials using umbilical cord, placental and related tissues for non-blood diseases, including for children with cerebral palsy, facial bone malformations and we have used cord blood to create many different tissues including liver, pancreas and brain-related tissues.
What Dr Sullivan is also sadly ill-informed about is that umbilical cord blood has not only better results as an alternative to bone marrow transplants, in fact in most cases, the long-term side effects are also lower, with a higher overall outcome.
Dr Sullivan is also behind in his knowledge of clinical expansion of umbilical cord blood units. Successful clinical treatments using expanded cord blood have been taking place for years. Cord blood also has the advantage that it is extremely rich in the required stem cells for bone marrow replacement and can be used with more than one unit, to give the necessary short-term support the patient needs."

Prof Colin McGuckin of the Cell Therapy Research Institute, Lyon, responds to Dr Sullivan's comments on stem-cell therapy.

Email your Letters to:
editor@imt.ie

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