CONNECT

ANNUAL NEWSLETTER OF THE MRII

Issue 5 ▪ July 2014

PRESIDENT'S WELCOME

Ms Linda McMahon, MRII President 2013 – 2015

NATIONAL CONFERENCE 2014

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What's inside...

CONNECT is an annual publication produced in-house by the MRII. For advertising please **contact: info@mrii.ie or 058 43955**

Prof Frank Barry, Scientific Director, REMEDI, National Conference Speaker. Prof Barry presented a fascinating update on the work carried out at REMEDI on Stem Cell Therapy

President's Welcome

Ms Linda McMahon, MRII President 2013 – 2015

As we enjoy another beautiful summer, I am very pleased you have taken time out to read your copy of CONNECT.

I have commenced the second of my two year term. Our very successful National Conference was held in May, our business sessions were of a very high standard. Council and I have taken on board feedback from our members. Many wish to attend the National Conference each year but find the time and financial commitment difficult to meet. In 2015 we will change the format to a one day event in Dublin. Dublin members will have the option to attend as residents or non-residents, there will be just one overnight stay for those attending as residents. I look forward to bringing you further details in due course.

Another item of change which we bring to our student members is in relation to the Examination. In 2015 the Examination will move to Dublin and it will change to Saturday to avoid time off territory. The 2015 Examination will be held on March 28 2015.

Our strength is in our membership, your membership. We offer those who are engaged in customer facing roles within the life sciences sector an opportunity to join with us and to stay strong as a profession working with all your industry colleagues.

Thank you all for your feedback and encouragement. Your interaction with me, my Council and our office is crucial as we as an organisation and industry colleagues continue to navigate through change.

In particular, thanks must go to all the members, both past and present who have built the MRII on a very solid footing within our industry.

We are very fortunate to have a very loyal base of supporters and sponsors. Their contribution is crucial, you will find a 'pull out and keep' exhibitor listing on the back cover – remembering these businesses during the year ahead should be a priority for as many of you as is possible.

Our industry partners' support continues through challenging times. We are indebted also to these companies, listed on page 7.

We are working for a sector that is extremely important to Ireland's economy, your active involvement during the year ahead will form an integral part of the Institutes successes and growth during 2014/15.

I look forward to working with our members, supporters and friends once again this year.

Linda

MRII Diary Dates 2014/15

Meetings resume in the Autumn.
Full details will be available on www.mrii.ie
Meetings open to members and non-members.

"INTRODUCTION TO BIOPHARMA"
Saturday July 5 and Saturday July 12.

"INTRODUCTION TO PHARMACOLOGY"
Saturday August 9 and Saturday August 16.

Both courses are full days in the Heritage Hotel, Portlaoise - see inside front cover for full details.

"LET'S TALK PENSIONS"
Pensions and Investment Guidelines, James Finucane, Invesco, October 1, 4.30pm, Citywest Hotel.

"HEALTHCARE COMPLIANCE AND WHAT IT MEANS FOR ME"
Fiona Lynch, Medical Manager, Janssen-Cilag, September 25, 4.30pm Cork, Clarion Hotel.

MRII EXAMINATION 2015
March 28, 2015, Dublin.
(Venue to be confirmed)

IPHA Medal Winner 2014

Mr Francis Lynch, President of the Irish Pharmaceutical Healthcare Association (IPHA) and Mr Ted Queally, CNS/ Palliative Care, Teva Pharmaceuticals Ireland Ltd. Mr Queally was the IPHA Medal winner for the highest scoring candidate in the MRII Examination 2014.

Past Presidents of the MRII

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John McCarthy;	1987 - 1988
Kevin Kelly;	1988 - 1989
Paddy Dyar;	1989 - 1990
Pat Kinsella;	1990 - 1991
Ciarán O'Kelly;	1991 - 1992
Sinéad Cadden;	1992 - 1993
Michael O'Brien;	1993 - 1994
Robin Ward;	1994 - 1995
Peter Sheedy;	1995 - 1996
Andrew O'Regan;	1996 - 1997
Noeleen Byrne;	1997 - 1998
John Carr;	1998 - 1999
John McCarthy;	1999 - 2000
Daragh Moran;	2000 - 2001
Howard Simpson;	2001 - 2002
Nuala O'Connell;	2002 - 2003
Donal Curran;	2003 - 2004
Ciaran MacFadden;	2004 - 2005
Mary Thérèse O'Connell;	2005 - 2006
John Fenlon;	2006 - 2007
Tony Glynn;	2007 - 2008
Pamela Large;	2008 - 2009
Kelvina Galavan;	2009 - 2010
Gareth Fair;	2010 - 2011
Alison O'Keeffe;	2011 - 2013

MRII Council

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The Medical Technology Industry – embracing the change

Sarah-Jane Larkin - IMSTA Interim CEO

"It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change."
Charles Darwin

What a time of change Healthcare and Healthcare companies are living through, when all the apparatus of the Irish Health system is changing around us. The programme for Government promised the most fundamental reform of our health service in the history of the state. At the end of 2012 the Minister for Health Dr James Reilly launched Future Health – A Strategic Framework for Reform of the Health Service 2012-2015, to deliver on this promise

We have seen change at hospital level with the advent of the Hospital Groups. At the funding level with the proposed introduction of Universal Health Insurance and the imminent arrival of Money Follows the Patient. At the structural level with the Department of Health taking back significant responsibilities from the HSE. At the procurement level, with the introduction of new EU procurement legislation aimed at simplifying and bringing more flexibility to the procurement process.

The work of IMSTA since the beginning of this year has concentrated on these changes, making the position of the Medical Technology Industry known to Government and the Department of Health and readying members for the implications of these changes for medical supply companies.

The year started with the development of the IMSTA position paper on Money Follows the Patient. This new way of funding hospitals using a DRG system will have an impact on how Medical Technology is procured, particularly new innovative technologies, which may change the setting of care or significantly impact on current procedures. IMSTA followed up this work with productive meetings with the officials responsible for developing and implementing the new funding model, to impress our views on how innovation should be accommodated within the new system.

Recently IMSTA responded to the Governments request for feedback and submissions on their plans for Universal Health Insurance. Our submission detailed concerns regarding the standard basket of goods and ensuring that this was procedure rather than product based. We also requested that where new technologies cannot immediately be accommodated in the basket that mechanisms would exist in the UHI system to ensure patient access and choice. We believe that these are vital mechanisms in any UHI system to ensure that patient access to medical devices is not restricted.

We are finalising a procurement whitepaper in conjunction with Dr Paul Davis of DCU. This document outlines the benefits of structured evaluation for devices and a procurement forum between the HSE and industry, particularly in light of the changes the new EU procurement legislation will bring to bear on the processes used to procure medical technology. We will also make this case in our 2015 Pre-Budget Submission.

All in all a busy six months, where most of IMSTA's key positions have been advanced. The new healthcare landscape will require a shift in the way the medical device industry does business. The network of collective experience of IMSTA members can help increase the understanding of all stakeholders of the crucial role of medical technology and new innovative approaches to delivering healthcare. This will ensure that patients receive the most appropriate medical technology for them in the long term, not just the cheapest.

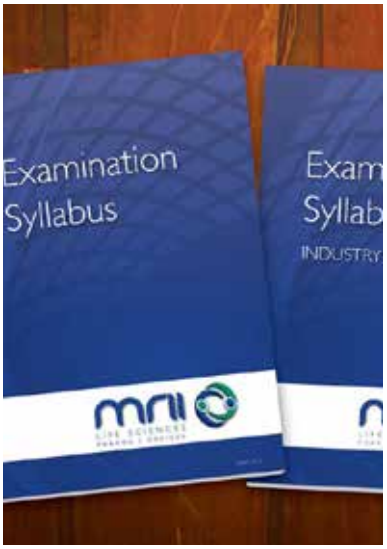
MRII Examination

venue change to Dublin

The next sitting of the MRII Membership Examination will be on March 28th 2015 in Dublin (venue to be confirmed).

Healthcare Sales Professionals come from a variety of backgrounds. Some are graduates and some are not, some are science graduates and nurses and some are not. In an effort to standardise the background educational level of Healthcare Sales Professionals the MRII Membership Examination is offered as a general standard. By sitting and passing it Healthcare Sales Professionals have shown an in-depth knowledge of Anatomy, Physiology, Clinical Medicine and Pharmacology. Surgical Techniques have also recently been added to our syllabus. In addition they will have demonstrated an up to date understanding of the industry in which they work/propose to work.

The benefits are enhanced credibility and respect from their employers and the medical profession by giving them a strong grounding in the areas mentioned above. Also the Healthcare Sales Professional will have the confidence in the knowledge that they have the fundamentals for all future training both internally and externally through their company products and therapeutic areas.



The Pharmaceutical Industry – bringing health and economic growth to Ireland

Philip Hannon, Communications and Public Affairs Manager, Irish Pharmaceutical Healthcare Association (IPHA)

Over the past 40 years, Ireland has established itself as a centre of excellence for the pharmaceutical industry. For a country of just over 4.5 million people, we punch well above our weight in the dynamic world of international pharmaceutical production and development. For many years, successive Governments have fostered a supportive environment which has allowed the industry to prosper and to thrive. A low corporation tax, a balanced regulatory environment, together with a highly educated workforce, have created the conditions where 8 of the top 10 global pharmaceutical companies, producing 5 of the top 20 global blockbuster medicines, are located here.

Likewise, 7 of the top 10 global biopharmaceutical companies have a presence in Ireland.

As well as being a very significant contributor to the exchequer through taxation, the pharmaceutical industry employs almost 50,000 people, both directly and indirectly and along with the medical device sector, is responsible for over 50% of Ireland's exports. Ireland's economy is predicted to expand by 3.5% in 2014, the fastest rate of growth in seven years with the Economic & Social Research Institute (ESRI) forecasting additional growth of 3.7% in 2015. Much of this economic growth can be directly linked to the pharmaceutical industry.

Between 2011 and 2013, for example, €1.7 billion was invested in the sector, creating an additional 1,500 jobs at a time when the country's unemployment rate was at a cripplingly high rate.

The value of the pharmaceutical industry to Ireland and, in particular, to Ireland's continuing economic revival was clearly evident in the ESRI report on the Irish economy in 2009 when the country was languishing in the grip of the economic recession.

During that time the pharmaceutical industry continued to invest and pharmaceutical products accounted for 34.5% of total gross industrial output in 2009, by far the largest contributor. Computer and electronic products accounted for 17.2%, and food accounted for 16.5% in the same period.

As well as supporting highly skilled jobs through taxation and exports, the research based pharmaceutical industry in particular continues to work with the State to ensure that innovative medicines can be made available to patients at affordable prices. Since 2007, the industry has helped the HSE to secure savings of at least €800m in the medicines bill.

National Conference 2014 Speakers: Mr Barry Heavey, Head of Life Sciences at IDA Ireland, Dr Gerard Crotty, Consultant Haematologist, Mr Peter Murchan, Consultant Surgeon

Industry Supporters

Without the loyal support we receive from our industry colleagues our continuing efforts would not be possible. Thank you to each and every one of the following:

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This has been achieved through average price reductions of 30% per item reimbursed under the various State community drugs schemes. The average cost per item of medicine is now running at 2001/2002 levels.

The 2012 pricing Agreement between the industry and the State contains mechanisms to yield a further €400 million in savings by the end of 2015.

The robust contribution of the pharmaceutical industry to the economic strength of the nation is very apparent, and the benefits in terms of better health outcomes should not be underestimated. Ground-breaking medicines and vaccines developed and produced by companies with a presence in Ireland are improving survival rates and facilitating the better management of chronic illness, eliminating or reducing the burden of disease and increasing life expectancy.

The OECD has recently shown that there was an increase in life expectancy in Ireland of 4 years between 2000 and 2011, with innovative medicines playing a pivotal role.

People with such conditions as diabetes, rheumatoid arthritis and HIV are able to live fuller lives as a result of new medicines. Much success has been achieved in treating cancer in Ireland, with long-term survival rates improving significantly in the past decade – from 42% in the period 1994-1999 to 60% in 2005-2009 in men and from 52% to 62% over the same period in women, due in part to innovative medicines.

As Ireland emerges from a torrid period in our economic history there are very real grounds for optimism. Although our national debt remains high and emigration continues, economic growth has returned and unemployment has fallen significantly.

The IDA continues its impressive work in attracting new foreign direct investment to Ireland bolstering an industrial base that is becoming more diverse.

At the heart of this industrial base remains the pharmaceutical industry, which is woven into the fabric of our country and for a nation State not yet a century in existence, it is something of which we should be very proud.

ipha
IRISH PHARMACEUTICAL HEALTHCARE ASSOCIATION

Spot Prizes

The following provided our 2014 National Conference spot prizes. We thank all sincerely for their generosity:

- Athlone Springs Hotel
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- Castle Leslie
- Citywest Hotel
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- Clyde Court Hotel
- Cliff House Hotel
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- Finnstown House Hotel
- Fitzpatrick Hotel
- Galway Pen Company
- Glenlo Abbey Hotel
- Glenroyal Hotel
- Hotel Meyrick
- Kilkenny Ormonde
- O'Callaghan Hotels Dublin
- Osprey Hotel Naas
- Radisson Blu Hotel and Spa Galway
- Rochestown Park Hotel
- Royal Marine
- Savoy Limerick
- Sheraton Athlone Hotel
- Waterford Castle

Breaking the Procrastination Habit

Participants on our programmes say that procrastination is the number one habit they would love to break. It features on most people's self-improvement wish lists. People of all ages and from all walks of life repeatedly fall into the procrastination trap on a daily basis. Despite attending various courses and making numerous resolutions to stop procrastinating, the habit persists. The funny thing is that we can't necessarily tell a procrastinator from the outside. Like ourselves, they will always look very busy, but we won't know if they are busy doing something, nothing, or anything but what they should be doing. However, we do know all too clearly when we ourselves are procrastinating, as it always produces *unhappiness and dissatisfaction* within and *gross inefficiency* without.

So why do we keep on doing it? Would we ever encourage our friends or colleagues to procrastinate? No! Yet we ourselves keep falling into the procrastination trap. The reason for this is that deep down we must believe that procrastinating is bringing us value. We think if we put the job off until later we will somehow be in a better position to do it. But is this ever the case? Let's look at an example. There is something to do, a phone call, it needs to be done but for some reason we don't want to do it, we put it off for now, we tell ourselves that "it will be better if we put it off till later", "we'll be more prepared", "we'll have more time", "we'll be more relaxed the next day it's pushed further out" and so we proceed until the last possible opportunity. While our initial postponing may well grant us an immediate sense of relief, it doesn't last long. Shortly after postponing whatever it is that needed to be done, the relief is replaced with agitation, confusion and mental clutter all of which become more intense and distracting (even panic) as the deadline draws near. This noise in the head is further compounded with a litany of all the other things (apart from the phone call) that we have to do. This all creates the illusion that I am very busy; and when we are asked by others how we are out pour the usual replies: "oh very busy", "not enough hours in the day" etc. This is the big lie we tell ourselves and others. This busy thinking is also a considerable drain on our energy supply and explains why we can be so exhausted at the end of an ordinary day's work. It also impacts negatively on everything else that we have to attend to both personally and professionally – not a lot going for it!

There is an important point in all of this, and one which we must realise, that is, the I am busy feeling is not the result of all I have to do, it is the result of all that I am not doing. When the job or task is eventually tackled, it is never as bad as we imagined, we experience great relief and wonder at our own stupidity in putting it off in the first place.

Procrastinating is never the right response. It is being out of tune with the world, out of step with the natural flow of events. This may sound a little strong but procrastination is actually quite cowardly because it involves shirking or not facing up to our responsibilities. There is only one time to catch the bus and that is when it is in front of you, all that is required is one simple and effortless step. However, procrastinating is like trying to catch the bus after it leaves the station: complicated, unproductive and a great energy-waster. How much of our day is spent trying to catch the bus after it has left the station?

We postpone and delay tasks based on what we like and don't like – our preferences. We put off what we dislike and we engage fully with what we like. Writing lists and scheduling tasks are often seen as the solution and we may give much time to writing, rewriting and general list management, telling ourselves that we are getting more organised. But if we are honest, most of our list writing is often nothing more than an accurate account of what we are not doing. Lists and schedules, by themselves, do not solve the problem because they don't address the real cause.

The cause of procrastination is an internal one, it's an inside job. Procrastination happens when we are governed by our preferences rather than the needs of the situation. Our internal compass is set on the wrong course and no amount of lists will correct this error. We need to shift the course away from me and my preferences and on to the need right now.

How? The antidote is both surprising and simple and comes in the form of a short question: What is the need right now? This question rids our mind of preferences and clarifies the need of the moment which can then be attended to simply and efficiently, without loss of energy. So don't procrastinate anymore, instead ask yourself the question what is the need right now? and faithfully follow the answer. If not now, then when?

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The MRII is committed to the promotion of professionalism and best practice for all its members. Providing Gold standard education, career development and networking opportunities for those working in customer facing roles within the healthcare sector.

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Marion Ward, Ciara Shovlin, Wards Cornerstore

Mick O'Leary, Ashfield with Sean Moynihan (Phoenix Labs)

Ann Shanahan, Killarney Convention Centre

Meet a Member

Eddie O'Callaghan

My Role and What it Involves

I am privileged to work at Lundbeck Ireland for the past 5 years with truly gifted people whom have been very supportive to me. I am a Territory Manager covering General Practitioners, Practice Nurses and Pharmacists in the Southwest specialising in Psychiatry and Neurology. Lundbeck is unique amongst pharmaceutical companies, by focusing 100% of its research, production and marketing activities on products for the treatment of the Central Nervous System (CNS).

Challenges

This market place is becoming more challenging across all sectors of the industry. Patient focus and wellbeing has always been to the fore yet the consistent focus on delivering more with less is extremely challenging and something you notice on a daily basis. The quality and empathy of our Healthcare Professionals are second to none. As a result of the ongoing challenges and cutbacks we see many talented people leaving our shores, this is sad as indeed is the effect on patients seeking to gain same day services.

Opportunities

The quality of services and medical practices have greatly improved over the past number of years. Many practices are now doing their own diagnostics. Physiotherapy, Nutritionist, and Counsellor Services also provide a quality resource with a focussed approach on prevention and wellbeing for patients.

Strengths

People. I truly enjoy meeting and engaging with people. It is something I have always enjoyed from a young age pulling pints in a pub. I love interacting with people and must say I am privileged in my role at Lundbeck Ireland to call to so many General Practitioners, Practices Nurses and Pharmacists. I gain a lot of my strength from the people around me whom have been so supportive, friends, family and colleagues. I have learnt over time that you are only as good as those people around you and I am grateful to them all. "We'll keep her lit"

MRII Ambassador Role

I am currently on the Ambassador programme for the MRII. The MRII is committed to the promotion of professionalism and best practice for all Healthcare Sales Professionals providing educational and social opportunities for all members to interact. I have gained many meaningful relationships over the past number of years and found the support and guidance I received from MRII members both in advance and indeed during the Institute examination most beneficial. I feel it is only right that I offer others the same support and guidance that was afforded to me.

Before Joining the Pharmaceutical Industry

I was on somewhat of a different road in that as a young fella I did jobs like helping the milkman to sorting bottles and barrels and pulling pints in a pub to qualifying as a Plasterer. Following breaking my ankle playing football I did a Sales and Marketing course as a result at Samco in Cork before gaining 4 weeks work experience at Cadbury. These 4 weeks became 17 years where I worked at various levels within the organisation before joining the pharmaceutical industry in 2009. The transition from FMCG to Pharmaceuticals was very stimulating in that it greatly increased my knowledge base and challenged me greatly to do so. I have also been of the belief that there is nothing that you cannot do or achieve in life it is more about how you adapt and apply yourself to various tasks and roles. Without question I had to lean on people I value and respect greatly. I truly can't thank them enough.

Favourite Places to Stay

West Cork has got it all. Rugged unspoiled and great craic.

The Brehon Hotel Killarney is a stone's throw from home, their staff are extremely friendly kind and welcoming. (Even to a Corkman).

Best country visited

My favourite place visited has to be Portugal. The most beautiful beaches, restaurants and the people are so friendly and hospitable.

Interests & Hobbies

Family - my wife and I have three children. It's great to watch them grow and develop and in many ways their interests and hobbies have become ours. When I do get a chance to chill out I enjoy cycling and road running, great ways to switch off and recharge!

Favourite Quotes

"A man without a goal is like a ship without a rudder" Thomas Carlyle.

"Your influence like your shadow extends to where you may never be."

"You will never persuade anyone to buy anything unless you know exactly what it is you are selling."

Linda McMahon, MRII President 2013-15, Mr Francis Lynch, President of the Irish Pharmaceutical Healthcare Association (IPHA)

Linda McMahon, MRII President, Mr Ted Queally, Teva Pharmaceuticals

Pádraic Ó Máille, National Conference Speaker 2014

Some of our exhibitors who joined us for the Gala Dinner 2014

National Conference 2014

Pre-Gala Dinner 2014

Enda Darcy - MSD, Mr Peter Murchan, Consultant Surgeon

Pre-Gala Dinner 2014

Joan and John Moloughney

Leona Lau, Pfizer, Linda McMahon, MRII, John Woods, Eurosurgical

Kathryn and Alice Carney

Grainne Brennan, MRII who successfully completed the MRII Examination 2014'

Maria Delaney, Eddie and Susan O'Callaghan, Liz Gardiner

Joe Duane - Galway Natural Health Co, Pádraic Ó Máille, Andrea Gaffney and LindaMcMahon - MRII

MRII LAPEL PIN

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Addiction in Ireland

MR. ROLANDE ANDERSON, B.S.S. (HON.), C.Q.S.W., Alcohol/Addiction Counsellor. Dublin 2. Former National Alcohol Project Director (2000-2011) for the Irish College of General Practitioners and author of "Living with a Problem Drinker – Your survival Guide (2010) Sheldon Press

Introduction

Do you like the title of this piece? Should I have written 'Ireland in addiction'?! Our little country has a serious problem with addictive substances and behaviours. I am going to concentrate on alcohol dependence and alcohol problems. However, I fear that we are in for a tsunami of other addictions too. In particular we are seeing more people presenting with gaming and gambling problems as well as an increase in internet porn and other forms of sexual addiction. It is frighteningly easy to access all forms of pornography and have you noticed the proliferation of gambling advertisements on television? Gambling has become too easy and in a couple of 'clicks' you can literally lose a fortune.

Context

Addiction, in all its forms, is all around us and yet it is often badly missed in the medical arena. Medical practitioners are very busy, stressed out these days and in some local areas have little support due to the absence of referral sources and treatment options. In addition, Doctors have the added problems of;

- Poor undergraduate training in this area (incredible to think how little training is provided when addiction takes up so much of the workload when qualified)
- Lack of time and heavy workloads, (to repeat)
- A fear of opening 'Pandora's box' (especially at primary care level)
- The belief that what they do will make no difference
- And to emphasise the point already made, poor local resources and difficulty accessing suitable treatment for patients and their families

These are all very genuine issues and there are of course many other factors at play too. Another striking problem is that addiction often has to be uncovered at consultations because patients and family members are ashamed and guilty. However, there is no stereotype of what someone with an addiction problem looks like, sounds like or smells like except in the extreme presentations. If Doctors have some inappropriate stereotype in their minds they will 'miss' many people with significant problems.

What is addiction?

When is an addiction an addiction? And -- Can you be addicted to anything? Well no! -- we have to distinguish between healthy pursuits and the negative effects of addiction to substances and harmful behaviours. For me the signs of dependence on any substance, activity or behaviour involve some or all of the following at least;

- Progressive deterioration in health and appearance with increasing obsession and compulsion
- Detrimental change of personality
- Severe suffering on the part of the individual and his/her family
- An inability to control the behaviour or the ingestion of that substance
- Denial and covering up
- Compromising one's own value system
- The presence of guilt or shame
- Furtiveness or secret 'indulgence'
- Neglect of self, family and other interests

This is not an exhaustive list but it's not bad as a simple guideline and gives some of the criteria to keep a watch out for.

Symptoms/signs that may also indicate the possible presence of addiction;

General Health; blood pressure, headaches, tiredness, vague symptoms, infections, liver problems, gout, heart problems, skin disorders, weight loss/gain etc

Sexual health; pregnancy and fertility problems, foetal alcohol syndrome, STI's, morning after pills, assaults and rape

Occupational Health; absenteeism, 'presenteeism' (at work but not really there!), accidents, incidents, fraud etc.

Mental Health; depression, suicidal ideation, anxiety, phobias, confusion, mood swings, and insomnia

Other; marital problems, domestic violence, child sexual abuse, etc

And again lots more besides.

Alcohol

We have a terrible problem with our use and abuse of alcohol. Most of the international leagues put us near or at the top for consumption levels and binge drinking. In simple terms we drink too much, for too long and too often, over relatively short periods of time with severe consequences in the short medium or long term for many people. Acute problems and incidents as well as chronic illness occur as a direct consequence of the amount and patterns of our drinking. Women and girls are at greater risk as are younger and older people. When drunk, younger people are much more at risk of experimenting with other drugs and so are at further risk of more complicated addictions. The 'Go on, go on go on' culture made famous by Mrs. Doyle in the TV comedy 'Father Ted' is alive and well for pushing tea and alcohol! There is horrendous social pressure on people to imbibe. In my work I regularly spend a lot of time helping patients who are in the process of recovery to be comfortable with a 'story' as to why they are not drinking to resist pressure and to stay sober. The phrase 'have one' or 'not to be a stick in the mud' or some such gets worse at the end of drinking evenings and events as people get 'tanked up' and lose sensitivity and tact.

For some the medical consequences are the 'wake-up' call and they get help but sadly for many the medical sequeala are terminal or result in chronic illness. The medical consequences come much later for others and allow folk to fool themselves into believing they are 'bullet

proof'. Long before the medical difficulties arise people who are drinking in a harmful or dependent manner show signs of a developing problem that are regularly unnoticed. Part of this blind eye is due to a cultural tolerance of heavy drinking. I have known families to report domestic violence, secretive drinking, bizarre behaviour, chronic memory loss and much more and to NOT associate these signs as alcohol related. Many people in the throes of addictive drinking are also unaware of the developing problem. I suppose back in the day this was called classic denial. Partners, spouse and children suffer dreadfully in addiction. They live with inconsistency, volatile moods, uncertainty, neglect and abuse to varying degrees and in some cases to alarming extents. The untold story in Ireland is the amount of torment and harm that children have experienced due to parental alcohol problems. Many experience significant trauma in the home.

Recently most of these issues above were confronted by the National Drug Misuse strategy which reported on its two year deliberations in February 2012. For the first time alcohol was included in the drug strategy and that itself was remarkable and indicated progress. There were numerous suggestions and plans as to how we could tackle our national predilection but as readers will have noticed the report was not received well by many sections of the community and in certain political areas despite it including almost all of the leading 'experts' in the field. It should be pointed out that the Drinks industry were part of the group and issued a minority report as well as lobbying politicians before the ink was dry on the conclusions.

We need strong political leadership to confront the vested interests if we want to implement real change. We also need perhaps to focus more on harm reduction as in keeping with the strategy on other drugs. Readers of this newsletter will be interested to hear that a new drug will shortly be launched to reduce consumption for patients with alcohol dependence. I am hopeful that this might help some people to reduce the harm that is caused for themselves and their families. Selincro (Nalmefene) produced by Lundbeck has been available in Europe with interesting positive results and may help patients who will not or cannot stop drinking. I must declare that I helped Lundbeck to develop BRIEFcases, a comprehensive resource pack about psychosocial interventions to support primary care in helping patients with alcohol problems. I am delighted with the response we have been getting from primary care. The idea is based on Brief Interventions. The B stands for Begin, R for Reassure, I for Intervene, E for Engage and F for Finish. It provides GPs with all they need to assess alcohol problems and includes patient information leaflets, drink diaries etc. The resource helps to end confusion over many issues including standard drinks. There is huge ignorance amongst the population around what constitutes a standard drink and many people are drinking over low risk weekly guidelines regularly. 'Wine O'clock' on a Friday is the norm in many households where more than a bottle each is consumed.

Conclusions

Addictions are increasing at an alarming rate. Alcohol continues to be the main problem. Poly drug use and abuse is worryingly common among younger people. Those suffering from addiction are not easy to detect by medical and para-medical personnel unless they are in an advanced state. If we could help patients to reduce their drinking, so that they have less harmful consequences, it would be an enormous improvement on the current situation. We must also help those who are dependent and provide more support for families and children. Greater treatment resources for patients especially people without private health insurance are badly needed. Finally, we need to actively support our healthcare professionals to do this important work. A big help would be to provide adequate training modules for Doctors on addiction at undergraduate level.

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Amgen	Brendan Balfe
Ashfield Healthcare	Emma Randall
AstraZeneca (Irl) Ltd.	David Malone
Boehringer Ingelheim Ltd.	Pam Large
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MRII Ambassador

We are fortunate to now have a team of 30 dedicated Ambassadors in place. This role has quickly been established as prestigious leadership involvement with the MRII.

Our objective is to have full MRII membership from all Healthcare Sales Professionals in customer facing roles and to have a clear communication channel between the MRII and all companies. Is your company represented? If not, interested parties (you must be a current Full member of the MRII) should email info@mrii.ie for further details.

We are mindful of everyone's workload and do not wish to add to this. The Ambassador will have full support from Council and our office.

The role includes:

- Being the main point of contact between the Institute and your company
- Seeking opportunities to inform your colleagues and managers of the benefits of MRII membership
- Delivering updates to your colleagues on the MRII in relation to current events, courses and regional educational meetings
- Assisting with generating as full an attendance at our National Conference each year from your company

Dr. Brendan O'Connor, Senior Lecturer in Biochemistry at DCU (centre), pictured with attendees at the MRII Pharmacology Course, January 2014. Included in the group are; Vanessa Hardy - A. Menarini; Emma Randall Quinn - Ashfield Healthcare; Erik Jackman - Grunenthal; Lee Corbett - Grunenthal; Thomas Murphy - Janssen Cilag; Mick Fleming - Janssen Cilag; John Elliott - Pfizer; Deirdre Parlon - Sanofi Aventis; Vivienne Martin - Sanofi Aventis; Shane O'Connor - Sanofi Aventis; Ronan Walsh - Sanofi Aventis; Natasha Caulfield - Tillotts; Nicola Walsh - Tillotts; Saundra Flynn - Teva; David Fitzpatrick; Gary Glennon - B Braun Medical, John Woods – Eurosurgical.

Pictured at the IMSTA Annual Conference, March 2014, Garrett May - Council Member MRII and Andrea Gaffney - National Co-ordinator MRII

Robotic assisted radical prostatectomy

- a new development in the treatment of prostate cancer in Ireland

Mr P O'Malley, Consultant Urologist, Galway Clinic.

Robotic Assisted Radical Prostatectomy (RARP) is a newly developed technology in the surgical treatment of organ confined prostate cancer. The procedure was first performed in Ireland at the Galway Clinic in 2007. To date over 500 cases have been performed with excellent patient outcomes and results matching the best international standards.

For men with prostate cancer suitable for radical surgical treatment a number of approaches are available. Prior to advances in surgical technology the open approach of radical retropubic prostatectomy was used. Minimally invasive techniques have developed a standard laparoscopic approach to radical prostatectomy and most recently robotic assisted radical prostatectomy. All approaches aim to achieve cure with oncological clearance of the tumour whilst preserving urinary continence and erectile function.

What is robotic assisted surgery?

Robotic assisted techniques were developed by NASA and the American military in the late 1980s with view to providing surgical treatment to front line personnel from a remote location. Refinement of these systems led to the development of a "master- slave" device consisting of a robotic surgical arm (slave) controlled from a surgical console (master) linked by a computer interface. The daVinci® Surgical System (Intuitive Surgical Inc., Sunnyvale, California) is the leading commercially available surgical robot. Robotic assisted surgery has been adopted by many surgical specialties including paediatric surgery, cardiothoracic surgery, obstetrics and gynaecology but initially it was in the field of urology and specifically radical prostatectomy that surgical techniques were developed. The first totally laparoscopic telerobotic radical prostatectomies were performed in May 2000 at Frankfurt University. The first 10 cases were published by Binder and Kramer [1] formerly open surgeons with little laparoscopic background.

How does robotic surgery work ?

Sitting at the surgical console the surgeon manipulates the controls using a processor that filters, scales and relays the exact movements of the surgeon's hands and fingers to the endoscopic instruments. There is no measurable delay between the movement of the surgeon's controls and the mirrored movement of the instruments. The surgeon visualises the surgical field via a binocular camera. Alternation between camera and instrument control is regulated by foot pedals which also contain a clutch mechanism and surgical diathermy control. The surgeon at all times directs the surgical instruments during the surgery with no independent action performed by the robot. The primary surgeon is aided by a bed side assistant who changes the robotic instruments and introduces sutures etc when required.

What are the advantages of robotic surgery?

The perceived advantages of RARP can be broadly divided into benefits to the patient and advantages afforded to the surgeon during the procedure.

Vision:

From the surgical perspective the procedure is performed with three dimensional binocular vision allowing accurate depth perception of the surgical field. The binocular magnification can be adjusted from ten to fifteen times normal thus significantly improving identification of vital structures. The latest model is currently fitted with the added advantage of a digital zoom technology allowing maximum focus particularly at the extremes of the surgical field. This allows microsurgical technology to be used on a macroscopic scale.

Ergonomics and acquirement of skill:

The surgical ergonomics of this technology has also been shown to be advantageous. Apart from the surgeon being seated in a comfortable position during the procedure there is an easier transferral of open surgical skills to the robotic assisted method. This method of surgery is completely intuitive meaning that the surgical movements made by the surgeon are directly mirrored by the robotic arms and instruments. Conventional laparoscopic surgery is counterintuitive. The surgical instrument operates about a fulcrum (chop-stick effect) and the movement of the instruments are directly opposite

Fig 1. Surgeon seated at the robotic console with the robotic cart housing the surgical instruments.

to the movements of the surgeons hand ie surgeons hand moves down the instrument tip moves upwards in the surgical field. Indeed, robot-assisted laparoscopy allows for faster learning of suturing and dexterity skills than does manual laparoscopy [2,3]. Therefore, the training for a novice laparoscopist learning complex laparoscopic procedures like RP is considered shorter when using the daVinci device [4]. More importantly, recognised fellowship training in robotic surgery will reproduce the impressive results accepted as the international standard.

Dexterity:

The human hand has what are termed five "degrees of freedom" in relation to movement and dexterity. The robotic instrumentation contains an endowrist which allows the surgeon eight degrees of freedom in relation to complex movement at the surgical site. This is achieved by the surgeon moving his/her own hand into a position of maximum pronation for example and then, by employing the clutch mechanism, his hand can assume a neutral position without the surgical instrument moving. He / she can then proceed to further move the instrument about the same axis up to 540 degrees of rotation. This is a huge advance in surgical dexterity allowing complex manoeuvres such as laparoscopic suturing be easily mastered and improved. The robotic interface provides the adept open surgeon with the tools necessary to transfer his/her skills into a laparoscopic arena. It also provides a better platform for even the moderately and well skilled laparoscopic surgeon to work with greater accuracy and perhaps improved efficiency.

Fig 2. Surgical endowrist mirroring surgical hand movement with eight degrees of freedom.

Motion scaling and tremor filter:

The robotic interface allows adjustment of motion scaling resulting in extremely fine and delicate movement at the instrument tips at a rotio ranging from 5 to 15 :1 depending on the setting. This enables the surgeons movements to be downscaled depending on the required surgical task. All physiological tremor in the surgeons hand is filtered out.

Pneumoperitoneum:

The insufflation of carbon dioxide into the peritoneal cavity forms the pneumo-peritoneum. This provides haemostatic tamponade allowing a better visualization of structures including the neurovascular bundle unobscured by bleeding. This results in minimal blood loss. The robotic dissection of the neurovascular bundle in an antegrade fashion from bladder neck to apex with less traction on provides a surgical advantage.The absolute control of bleeding from the dorsal vein complex at robotics permits an astonishingly precise dissection of the sphincter musculature at the prostatic apex. This makes apical dissection much more refine (a site commonly associated with positive margins) and also facilitates sphincteric preservation.

Patient benefits:

Patients receive the benefits of minimally invasive surgery. This is translated into a shorter hospital stay with less post operative pain medication. Early mobilisation allows for earlier return to normal activities. Many institutions have reported earlier return to and improved continence rates along with improved rates of postoperative erectile function whilst improving on the positive margin rates compared to the open surgical rates from the same centres.[5]

Results:

The results at the Galway Clinic have been encouraging. Oncological outcomes with complete cancer removal have been excellent with well over 90% of men cured with surgery alone. Interoperative blood loss has been extremely low (less than 200mls) with no patient requiring a blood transfusion following surgery. Patients can expect to be discharged on the second post-operative day thus improving their recovery in the familiar environment of their own home. Functional outcomes are again very encouraging. Urinary incontinence is now a very rare problem after this type of surgery but more importantly the recovery of urinary control occurs very quickly following surgery. Sexual function is preserved in cases where a nerve sparing procedure can be carried out allowing normal erectile function postoperatively.

Instillation:

The instillation of the DaVinci system required an initial investment of two million euro based on an activity business case over the lifetime of the machine. New technology developments are expensive from the outset, like all technology, time will improve refinement and price reduction. The overall health economics of this procedure needs to take into account the reduced hospital stay along with the early return to normal activity.

Surgeons who operate the DaVinci robot are fellowship trained in the procedure of robotic assisted radical prostatectomy. Structured training is essential and has been shown to translate into better outcomes [6] .Theatre nursing staff are specially trained in the setup, procedure and device maintenance ensuring familiarity and short setup times.

Robotic assisted surgery is futuristic and has shown encouraging results compared to most open surgical series. Initial financial costs are high but proper training allied with a safe and structured program set up has achieved impressive outcomes for patients who choose this method of treatment for their prostate cancer.

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Work Smarter, Work Together

Nuala Hannon, director Hannon Oncology Education Ltd

I share a vision.

'Ireland will have a system of cancer control which will reduce our cancer incidence, morbidity and mortality rates relative to other EU15 countries by 2015. Irish people will know and practice health promoting and cancer-preventing behaviours and will have increased awareness of and access to early cancer detection and screening. Ireland will have a network of equitably accessible state-of-the-art cancer treatment facilities and we will become an internationally recognised location for education and research into all aspects of cancer.'
Cancer Control Strategy 2006.

Introduction

I do have a vision, and am committed to achieving excellent services for patients, because I am a nurse and that's what nurses endeavour to do. But we do not do it alone and everyone's contribution to achieving the big vision is welcome and important. Demands on cancer services are rising. The "multi-disciplinary team" need help. I see Healthcare Sales Professionals as part of that broader team and can play a key role in bringing scientific developments to the staff that support and educate the patients. This article aims to show how Healthcare Sales Professionals can support HCP's to develop knowledge and in doing so facilitate the pursuit of excellence sought by all.

Nurse

I have 20 years nursing experience, 15 of which dealing directly with cancer patients. Now, as an educator I am using my clinical expertise and knowledge to deliver bespoke training and education. I am familiar with the challenges patients face when diagnosed with this disease. I know that the services patients require are stretched and routes to treatments challenging. I have seen firsthand the fear, pain and angst experienced by families. Patients need accurate clinical information, delivered sensitively, by caring professionals. HCP's also need accurate clinical information delivered by caring professionals. Healthcare Sales Professionals have excellent opportunities to bring international knowledge to HCP's who can then use it to deliver excellence in patient care.

Healthcare Sales Professional

Healthcare Sales Professionals have been contributing to the educational needs of HCP's for as long as my career remembers. Breakfast meeting updates, lunch-time journal clubs, conference support and evening meetings with expert speakers have all contributed to the body of knowledge that aims to improve practices and treatments.

But nothing lasts forever and in changing times new ways of disseminating information need to be smart and creative. Like new therapies education delivery must be clever, targeted at the right audience and effective in achieving results, in other words bespoke.

Creativity in healthcare

Creativity in tackling difficult healthcare issues is not a new concept. One inspiring politician did so many years ago. Sometimes it helps to look back when looking to the future and examine the once radical ideas that are now taken for granted.

Dr. Noel Browne was elected minister for Health in 1948 and was a highly controversial figure in Irish politics. Born in Waterford his father was an inspector for the National Society for the Prevention of Cruelty to Children and, partly as a result of this work, all of the Browne family became infected with tuberculosis. Both parents died of the disease during the 1920s, and several of Browne's siblings also succumbed. Browne himself suffered a resurgence of TB while a medical student in Trinity College Dublin. After his recovery he worked in many sanatoria in Ireland and England and soon recognized that to affect real change, politics was the only way. At that time in Ireland this was a radical concept. After his election to politics he introduced mass free screening for tuberculosis sufferers and sold department assets to finance his campaign. This, with the introduction of streptomycin, helped dramatically reduce the incidence of tuberculosis in Ireland. Dr. Browne's contribution to healthcare was radical and it is fair to say that he pushed the boundaries on his quest for health excellence.

Current situation

Today, it is a normal expectation that politicians shape healthcare. What radical thinking needs to be introduced in this era that will be written about 60+ years from now? Science and research firmly form the basis for healthcare decisions and the National Control Programme 2006, recognises that health technology assessment has a vital role in;

"Ensuring that care technologies, including drugs, are used in a manner appropriate to their ability to maximise health gain and achieve value for money."

Would you dare attend your meetings without the relevant research paper to support your sales approach and costing? Must not your knowledge be evidence based and as fluent as the HCP you are meeting? The language of clinical trials, MABs', Anti-Egfr's, TKI's, genetic mutations is now the native language of a Healthcare Sales Professional in oncology and essential in order to communicate effectively. My programmes include all aspects of oncology training and include targeted therapy management.

The Future

How can you translate scientific knowledge into practice to affect meaningful outcomes for your therapies? Traditional methods of sharing information remain very valuable but are increasingly harder to achieve. Tighter controls on incentives, increased pressure on HCP's time and freely available information has changed the role of the rep. Cancer figures are rising. Statistics from the National Cancer Registry are frightening. The report on cancer projections for Ireland 2015-2040 shows that the incidence of cancer in Ireland is expected to double by 2040.

Integrating scientific knowledge into practice and using new drugs will require fibre power efficiency. This is where I see the role of the Healthcare Sales Professional developing not disappearing.

Information packages with details of clinical trials, new targeted therapies, translational cancer research developments and patient support programmes will need to be delivered to HCP's in the form of "speed updates" and "hot reporting". Using apps, teleconferencing and international conference feedback mechanisms will enable HCP's to pass on the information to each other and to patients. Often when I have been treating patients for whom the future appears bleak, news of a breakthrough, however small offered great hope to that person. It is essential that patients too are hearing of advances in research.

One novel form of learning technology I have used has been proven in clinical trials to increase knowledge retention by up to 170%. Randomized trials have shown that the principles of spaced education and testing can improve long-term retention, boost learner engagement and most importantly improve patient care. Training is delivered via questions sent to a user's mobile device over spaced intervals, and done in a manner that promotes competition and fun amongst learners. It's almost like a game! Is playing games to enhance learning about cancer radical? Progressive? Smart?

Conclusion

Commitment to excellence in patient services is a common goal for all who contribute to cancer care. The challenges for patients, HCP's and Healthcare Sales Professionals are many. Creative efforts by all to bring international best practice to every patient are called for. Education and learning techniques need to be smart, targeted and modern. Healthcare Sales Professionals want to deliver the scientific evidence to their customers, while HCP's naturally want to deliver the best services they can to their patients. Healthcare Sales Professionals and HCP's can collaborate to get scientific knowledge from the bench to the bedside more effectively. It's not that radical. I can help you do it.

Work smarter, work together!

Connect with me on LinkedIn or contact me via www.hannononcologyeducation.ie if you are passionate about Education in Healthcare, Oncology, or if you believe creativity is the solution to many of our healthcare problems.

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ONCOLOGY EDUCATION

Health check recommended for free GP care for under sixes!

By Gerard Slevin, Health Economist

Economics is the social science that studies the behaviour of individuals, households and organisations, when they manage or use scarce resources, which have alternative uses, to achieve desired ends. We assume that people will behave rationally, with the aim to maximise their utility from these scarce means.

We would all agree that the ideal scenario would be if we had free healthcare for everyone and could remove any financial barrier to attending the GP, but that simply can't happen as resources are limited. The percentage of GDP absorbed by health care expenditure in the OECD countries has doubled since the 1960s. This combined with the current economic climate where the health service executive is behind budget suggests that if the Government is willing to pay for these services then these provisions are coming from some other area of the system. This may also indicate that other vulnerable patients may be affected and put in a queue behind those who are healthy and can afford to pay. It would seem unethical to select children of high earners for free GP care over patients with chronic diseases, lower income and those who are considered vulnerable. Basing medical cards on date of birth rather than income seems to be a strange selection criterion.

From a cost perspective it is hard to understand why one would reduce child benefit in recent years for those who are in need and redistribute some of that income to those who are not in need. Under the current system this age cohort already receives free vaccinations which are a significant health benefit. What are the specific health targets behind the current proposal and how will they be measured? Remember there is an opportunity cost involved in such a decision - will the tangible health benefits of this decision outweigh the benefits if the money was spent elsewhere?

If recent reports are true then General Practice in Ireland is at breaking point with many struggling and some on the verge of insolvency. Many people forget that GPs are business owners, just like your local supermarket. They have all the regular bills of any business owner as well as being responsible for employing appropriate medical and administrative staff to provide an acceptable service to patients. The two main factors in running any business are income and costs. In any private business if the marginal cost exceeds marginal revenue in producing one extra unit of a good or service then the business is destined for failure.

It is estimated that 240,000 children across the country will benefit from the proposed change in public health policy. The Government will provide additional funding of €37 million to meet the cost. Recently, the Irish Medical Organisation has stated that visits will increase by approximately 16%. In economics there is a concept called moral hazard which suggests that people will increase the use of a service when they do not have to experience the full consequences and responsibilities of their actions. In essence, there will be more GP visits when people are getting the service for free.

Potentially four major problems lie ahead. It seems that there is little or no spare capacity in general practice as currently structured. More GP visits will require more investment in resources which will incur additional costs on the current stressed system. From the distributed figures, calculations would indicate that the marginal cost will exceed the marginal revenue for GPs and those with good business acumen will back away from such a deal. To integrate change in any organisation there must be a common consensus from all parties involved and it seems that the GPs have yet to buy into the proposed changes. Same day access may become a commodity of the past as GPs may not be able to facilitate everyone in need. Finally, the Government may realise that when the cost benefit analysis is completed down the line greater health outcomes may be realised elsewhere.

If the Government is to get the all clear for this proposal further investigations are recommended.

No sweetness in rising costs of Diabetes

By Gerard Slevin, Health Economist

Diabetes is a chronic disease that occurs when the pancreas does not produce enough insulin, or when the body cannot effectively use the insulin it produces. It consists of both type 1 (a person who is insulin dependent) and type 2 (a person who does not have enough insulin or the insulin is not working properly) is a public-health issue of significant epidemiological and economic importance because of its chronic nature, high and rapidly increasing prevalence, serious complications and the need for patients to receive long-term care. Type 2 accounts for around 90% of all diabetes worldwide. The causes are complex but the rapid increase in obesity and lack of physical activity has a major role to play.

Globally the incidence of diabetes is likely to exceed 250 million people by 2025. Ireland is playing its part in this figure and as the incidence of diabetes increases (approximately 200,000 people have the disease in Ireland at present) the disease is taking an ever increasing fraction of the Government's budget. People who do not have a close association with the disease may not be aware of the vast costs associated with such a chronic illness.

It is a common misconception that prescription medications contribute to the majority of the costs. The reality is that they account for less than 50% of the total cost. To calculate the total cost of a chronic illness we need to look at it from a societal perspective. The costs are made up of direct costs (medication, hospitalisation and delivery of clinical services and are usually borne by public or private health systems), indirect costs (the value of changes in productivity in the work force or the value of non-work time that is valued by individuals and employers) and intangible costs (quality of life being affected because of pain, suffering, anxiety and stress). Society at times does not account for the many days missed from work, the lack of sleep due to pain or the stress of organising transport to a specialist. The costs don't stop there as diabetes is associated with many complications such as ulcers and foot infections. It is also a leading cause of blindness, amputations and kidney function issues. This is compounded by the disease having many other secondary complications (cardiovascular, neurological and renal issues are such examples) which all bring high costs and put more strain on limited resources.

To address such costs, which are spiralling out of control, our Government needs short, medium and long term strategies in place. A national screening programme, a promotional campaign highlighting the benefits of regular checkups with your local GP and a greater emphasis on education about the disease would help enormously. There are thousands of people who have yet to be diagnosed and as a result their complications are getting worse. Our schools need more help and direction in highlighting the risk factors and symptoms while presenting the advantages of both a good diet and regular exercise. Recently it was proposed that Physical Education should become an exam subject. If it does come to fruition then it may be an ideal stage to highlight the detrimental effects of all chronic diseases from both a micro and macro perspective.

As budgets tighten further and demand for services continue to grow collective responsibility, from each individual and policy makers, is required to address cost containment of this chronic illness. If we continue to ignore this responsibility there will be serious social repercussions in the medium and longer term. In recent years we have all unfortunately become only too aware of the scarce resources which exist within the health system and it up to each and every citizen to act rationally to maximise the outcomes that can be achieved from such resources. No amount of sugar coating can disguise this fact.

MRII National Conference 2014 Business Session

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