Comhairle na n-Ospidéal

Dermatology Services

July 1988
Comhairle na n-Ospidéal

REPORT OF THE COMMITTEE ON DERMATOLOGY SERVICES

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Section 1 – Introduction

1.1 Following an announcement by the Minister for Health in Dáil Éireann on the 19th May, 1987, a major review of acute hospital services in the country commenced. This review, which is ongoing, is being undertaken by the Hospital Services Division of the Department of Health assisted by Comhairle na n-Ospidéal. It began with a series of discussions involving the management authorities of all of the health boards and the public voluntary hospitals in the country. Arising out of these discussions a number of specific areas were identified for further indepth study. Comhairle na n-Ospidéal was requested to undertake the examination of a number of specific areas of hospital activity. One of them – dermatology services – is the subject of this particular study.

1.2 At the request of and following consultation with the Department of Health, a committee of its own members was established by the Comhairle in September, 1987, with the following terms of reference:

“To examine the existing dermatology services throughout the country; and, following consultation with the interests concerned, to make recommendations to the Comhairle on the future organisation and development of dermatology services with due regard to the necessity for an effective and efficient service within the constraints of the current level of funding available for the health services in general”.

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1.3 The following members of the Comhairle were appointed to serve on the committee:–

Dr. C. Twomey, Chairman
Dr. N. Cahill
Professor S. Doyle
Professor C. McCarthy
Dr. S. Ryan
Dr. E. Rutledge
Dr. N. Tierney
Dr. R. Towers
Mr. G.P. Martin (Chief Officer)

Due to other commitments, Drs. Cahill and Rutledge, were unable to attend meetings of the committee.

1.4 The initial meeting of the committee took place on the 19th October, 1987. At the outset, major problems with the dermatology services were identified, in particular, serious under-manning at consultant level from the national viewpoint; a disproportionate concentration of dermatological activity in the Dublin area compared to the rest of the country and the fact that a sizeable number of health board areas had very inadequate dermatology services. It was recognised that the proper development of the specialty from the national viewpoint would involve radical changes in the existing arrangements for the delivery of services.

1.5 In pursuance of its task, the committee wrote to every health board and public voluntary hospital in the country seeking details of its dermatology services in relation to the latest year available including:–

(a) number of in-patients and average duration of stay;
(b) number of day-beds, 5-day beds and 7-day beds;
(c) number of patients admitted to each bed category;
(d) location, number and frequency of out-patient clinics plus the number of first attendances and total attendances at each location;
(e) details of dermatology case-mix by disease category;
(f) details of geographical (by county) source of referral;
(g) breakdown by method of referral e.g. self-referral, by general practitioners, by consultants within the hospital, and by consultants from other hospitals,
(h) name and extent of commitment of consultant dermatologist(s) and type of appointment held (i.e. temporary, permanent, sessional),
(i) number and grade of non-consultant hospital doctors in the dermatology department,
(j) extent of laboratory and other facilities currently available to the department of dermatology.

Virtually all of the agencies contacted responded in a positive manner to this request for information. A summary of the workload statistics furnished is set out in Appendix A to this report.

1.6 Simultaneous with the information-gathering exercise, the committee decided to embark upon a consultation process which also included visits to a number of centres throughout the country. The process began with a discussion with representatives of the Irish Association of Dermatologists which was attended by all of the eight dermatologists with major commitments to the public hospital services in the country. This discussion was later followed by a joint submission on behalf of the eight dermatologists which is set out at Appendix B to this report.

1.7 The committee visited Cork and had a discussion with a management representative of the Southern Health Board. It held a joint discussion with representatives of the consultant staff of Cork Regional Hospital, the authorities of the Mercy Hospital and the South Infirmary/Victoria Hospital – this took place at St. Finbarr’s Hospital. A visit was also made to Galway Regional Hospital where a joint discussion was held with officials of the Western Health Board and representatives of the consultant staff of Galway Regional Hospital. Finally, the committee
visited Hume Street Hospital where the facilities were viewed and discussion took place with representatives of the Hospital including the consultant staff.

1.8 In addition to the above visits, a joint discussion was held in Corrigan House with the general hospitals in north Dublin which was attended by representatives of the Mater Hospital, Beaumont Hospital, James Connolly Memorial Hospital/Eastern Health Board and the Children's Hospital Temple Street. Separate discussions were held in Corrigan House with representatives of the major general hospitals in south Dublin i.e. St. Vincent’s Hospital, St. James’s Hospital, the Meath/Adelaide/National Children’s Hospitals (known as the M.A.N.C.H. group) and also with Our Lady’s Hospital for Sick Children, Crumlin. Finally, a joint discussion was held with the two cancer hospitals in Dublin i.e. St. Luke’s Hospital and St. Anne’s Hospital.

1.9 A special joint meeting was arranged with those health boards which do not have a locally-based dermatology service. This was attended by officials from the North Eastern Health Board, the Midland Health Board, the Mid-Western Health Board and the North Western Health Board – apologies for inability to attend were received from the South Eastern Health Board.

1.10 In addition to the discussions and, apart from the furnishing of factual information (see par. 1.5), written submissions containing proposals for the future development of dermatology services were received from the following:–

(i) Dr. Sarah Rogers, Medical Director, Hume Street Hospital/Dermatologist, St. Vincent’s Hospital,

(ii) Dr. Marjorie Young, Dermatologist, MANCH/St. James’s Hospitals,

(iii) St. James’s Hospital, prepared by Mr. W. P. Dunbar, Chief Executive Officer and Dr. Louise Barnes, Dermatologist,
(iv) Dr. S. O'Loughlin and Dr. F. Powell, Dermatologists, North Dublin Hospitals/North Eastern Health Board,
(v) Dr. D. J. O'Gorman, Dermatologist, Western Health Board,
(vi) St. Vincent's/St. Anne's/Hume Street Hospitals prepared by Dr. C. Meenan and Dr. S. Rogers, Dermatologists, with supplementary letters from St. Vincent's Hospital and Sister Bernadette MacMahon, Provincial, Daughters of Charity of St. Vincent de Paul,
(vii) Mid-Western Health Board,
(viii) Dr. C. Dupont, Dermatologist (in private practice and with a minor commitment to the South Eastern Health Board).

1.11 It will be clear from the preceding paragraphs that the committee was furnished with a great deal of information and views, both written and oral, in relation to the current state of the dermatology services and their future development. The members of the committee wish to acknowledge the assistance given to them by many agencies and individuals over a relatively short period. The time and effort which were devoted to helping the committee is greatly appreciated – without this impressive input, its task would have been extremely difficult.

1.12 Finally, the committee endeavoured to locate published international medical literature on the organisation of dermatology services in other countries. It seems that, aside from technical literature on dermatology itself, there is a paucity of published material on the delivery of services. However, the Irish Association of Dermatologists has supplied a copy of important guidelines issued by the Royal College of Physicians in September 1986 which are attached at Appendix C. A relevant extract from the Journal of the Royal College of Physicians of April 1986 (vol. 20 No. 2) which gives a brief description of dermatology in the United Kingdom is attached at Appendix D.
Section 2 – Description of Existing Dermatology Services

2.1 Perhaps to a greater extent than most medical or surgical specialties, dermatology is mainly an out-patient/day care activity with a small in-patient requirement. Within the relatively small in-patient bed need, the majority of patients can be treated on a 5-day basis with only a small number requiring 7-day hospitalisation. In fact, much of the residential aspects are rooted in the distance/transfer problems from the point of delivery of services to the patient’s home rather than an essential medical need for in-patient care. The Royal College of Physicians’ guideline document (Appendix C) indicates a bed requirement of 8-9 per consultant per 200,000 population which would indicate a need for about 140 beds for 3.5 million population in Ireland. The bed norm for dermatology used by the Department of Health for planning purposes is 0.015 per 1,000 population. This would indicate a need for 52 beds, but this norm, which was originally adopted in 1976, is in need of up-dating and refers to 7-day in-patient beds only.

2.2 As indicated in Section I, extensive information has been gathered by the committee and the main features of this are summarised in Appendix A. In global terms, and from the national viewpoint, the dermatology services in a full year cater for about 40,000 out-patient attendances (14,000 new patients) at 183 monthly clinics, at about 30 locations around the country. In addition, about 1,800 patients are treated on an in-patient basis in about 108 beds (68 for 5-day care and 40 for 7-day care) with an average duration of stay of around 10 days.

2.3 These services are delivered by an establishment of eleven wholetime consultant dermatologists (plus one part-time dermatologist – 6 sessions per month) supported by 13.5 non-consultant hospital doctors. Three of the permanent consultant posts are vacant at present but one of them is filled in a temporary capacity. With the exception of two consultant posts in Cork (one of which is vacant), one consultant post in Galway and one part-time post in the south–east, all of the dermatologists are
based in Dublin. With only slightly in excess of two functioning consultants outside Dublin, the serious situation in which the service finds itself at this point in time is obvious.

2.4 Apart from the maldistribution of consultant manpower in dermatology within the country, there is also under-manning at consultant level from the national viewpoint. The Irish Association of Dermatologists, supported by the Royal College of Physicians' guidelines (Appendix C) has indicated a need for one whole-time consultant dermatologist per 150,000 to 200,000 population. For the population of 3.5 million in this country, this would point to a requirement of 17.5 to 23 whole-time consultants. The inadequacy of the current establishment of 11.1 wholetime consultants, including three vacant posts, is apparent compared to even the lower level of provision within the guidelines. Combined with the maldistribution described in the previous paragraph, the net result is one of extreme under-provision of dermatology services for the two-thirds of the total population who live outside the Dublin area.

2.5 A more detailed examination of the statistics set out in Appendix A reveals the reality of the deficiencies set out above. Even more so, there is a further maldistribution of services within the Dublin area which has a population of 1.2 million within the administrative area of the Eastern Health Board. Within southeast Dublin, there are three centres – St. Vincent’s Hospital, Hume Street Hospital and St. Anne’s Hospital. Hume Street Hospital, which is a 5-day institution devoted exclusively to dermatology, is the largest of the three and represents the single biggest concentration of dermatology services in the country. St. Anne’s Hospital is a cancer hospital which is orientated towards skin cancer and also provides a dermatology service – it is currently in the process of forming close ties with St. Luke’s Hospital which is the major radiotherapy centre in the country. St. Vincent’s Hospital is a regional general teaching hospital and it has the lowest volume of dermatology workload of the three. Between the three institutions, which are in relatively close proximity to each other, they cater for 43% of the total out-patient attendances in the country (36% of the new out-patients); they contain 35% of the 7-day beds and 56% of the 5-day beds for
dermatology and about 42% of all in-patients were admitted to these beds. They have 2.7 whole time equivalent consultants or 24% of the total consultant establishment of the country. The population within the south-eastern sector of Dublin is about 300,000 or 8.6% of the national population.

2.6 In contrast, the north Dublin service, with a population of 500,000 (14% of the national population) and also providing clinics in the north-east (300,000 population), caters for 18% of the total out-patient attendances in the country, 16% of the in-patients and it has an equivalent consultant manpower to south-east Dublin.

2.7 On the other side of the coin, the Mid-Western Health Board, with 315,000 population, has had no dermatology service since May 1987, due to the illness of the lone dermatologist in Munster who is based in Cork city – prior to that, Limerick had a clinic every three weeks which was attended by about 660 patients in a year.

2.8 A further serious imbalance in the existing services is that the two largest dermatology centres in the country i.e. Hume Street Hospital and St. Anne’s Hospital, are not only situated within a mile of each other but they are both physically isolated from St. Vincent’s General Hospital which is the base in the area for all the supporting specialties necessary to practice modern dermatology satisfactorily – in particular, pathology, plastic surgery and anaesthesia.

2.9 The approach of the committee to the dermatology services has, of necessity, to be from the national perspective. From that viewpoint, the deficiencies set out in the preceding paragraphs can be seen in stark form. However, the picture which emerges must be counter-balanced by the excellence of the services which have been developed in Dublin and at Hume Street Hospital in particular. The committee was impressed during its visit to the latter hospital by the way the services were organised and delivered in an obviously efficient manner
and in an environment which was conducive to achieving high standards of practice both from the medical/nursing viewpoint and from the patients' viewpoint.

2.10 The problems as seen by the committee do not lie in any lack of performance by individual institutions in the delivery of services – indeed, the evidence is to the contrary – but rather in the undue concentration of dermatological activity in Dublin and within one sector of Dublin. This situation has evolved over a lengthy period of time due to the dearth of dermatology services elsewhere and it can be attributed to a lack of planning of services at both national and local levels.

2.11 During the course of its discussions and visits outside the Dublin area, the committee formed the impression that most – but not all – health boards do not see the provision or the development of dermatology services as a matter of high priority. To some extent this is understandable given that dermatology is not usually viewed as a high profile specialty, probably because it is not involved in dramatic life or death situations. It is not a specialty which tends to excite the public imagination or to interest the media. On the other hand, patients with dermatological conditions can often be very debilitated, a minority can be extremely ill, most are socially embarrassed by their symptoms and some suffer from constant skin irritation which can be psychologically damaging. Then there is a sizeable number of patients in respect of whom the question of cancer arises and an early diagnosis is essential. In addition to all of this, treatment procedures involving topical applications followed by baths can, for many patients, be a further source of acute embarrassment and psychological upset. The lack of an adequate service – or any service at all in most parts of the country – leads to low expectancy on the part of the public, public representatives and indeed, health service managers.

2.12 An examination of the geographical distribution of outpatients based on the information supplied to the committee reveals an attendance rate of 21.5 per 1,000 population related to residents in the E.H.B. area compared to an attendance
rate of 6.7 per 1,000 population related to residents outside the E.H.B. area. The three-fold gap in demand is, in the opinion of the committee, a direct consequence of the dearth of consultant services.

2.13 The low expectancy, in turn, leads to the lack of training facilities for professional staff – medical, nursing and others – and the absence of pressure for the development of services which would normally emanate from such quarters. Indeed, at the national level, bodies such as the Department of Health and the Comhairle itself, are not immune from the lack of interest and low priority perspective which hitherto has seemed to prevail in relation to dermatology. The committee hopes that this report may contribute to the emergence of more progressive attitudes towards dermatology within the health services as a whole.
Section 3 – Principles for Future Development

3.1 Before attempting to draw up a “blueprint” for the future development of dermatology services, the committee considers it essential that the principles which should underlie the organisation of the services should be clarified. In this respect, the committee has been helped greatly by the guidelines produced by the Royal College of Physicians (Appendix C) and the consultation process described in Section 1.

Location

3.2 The College document begins with the statement that “these guidelines are based on the assumption that the district hospital concerned is the main centre for dermatology services where special diagnostic and treatment facilities would be located”. In the United Kingdom, the district hospital is a major general hospital providing a full range of specialties usually for populations of the scale of 250,000. The committee has no hesitation in supporting, as a matter of principle, the concept that dermatology services in this country should be located at and be an integral part of a major general hospital providing a comprehensive range of specialties including pathology and anaesthesia. Only in this way can the specialty develop properly in close association with other specialties such as paediatrics and plastic surgery and be adequately supported in the non-clinical area with laboratory back-up. Being an integral part of a major general hospital will facilitate interaction between the dermatologist and his/her consultant colleagues in a range of clinical departments.

3.3 Within the general hospital, the committee believes that there should be a designated area for dermatology with designated nurses. The relatively small in-patient component of the specialty should be exclusively based in the general hospital together with a significant day-care activity. From this base, consultant out-patient services should radiate out to
the periphery of the catchment area of the general hospital through the holding of regular clinics at the main population centres, where the workload would justify the holding of clinics. Based on this principle, the committee does not see a role in the future for dermatology services which are either based on special hospitals (e.g. cancer hospitals) or on physically isolated dermatology centres (e.g. Hume St. Hospital). The associations which are desirable between dermatologists and oncologists/radiotherapists are most appropriately developed within the context of the general hospital rather than in a cancer hospital. In this respect, it must be pointed out that St. Luke’s Hospital, which is the major radiotherapy/cancer hospital in the country, does not have nor does it see the necessity for having on-site consultant dermatologists.

Regionalisation

3.4 Faced with the extraordinary degree of centralisation which is a strong feature of the existing dermatology services, the committee has given very careful consideration to the approach which should be adopted in the future. While there are undoubted advantages, including economies of scale, in centralising specialist services, these are often outweighed by the inconvenience and lack of access for patients, particularly for those in the lower socio-economic groups. The committee holds to the general belief that, unless there are good reasons to the contrary, specialist services should be delivered as close as possible to the population being served. Good reasons for centralisation would be (a) to ensure minimum viability; (b) to avoid unnecessary duplication of expensive resources and (c) to facilitate necessary sub-specialisation. The relevance of these factors in relation to dermatology services is considered as follows:

(a) Minimum Viability: As a matter of policy, the Comhairle does not favour the concept of single-handed appointments across the spectrum of medical/surgical specialties. The College guidelines (Appendix C) indicate that “dermatologists should not be appointed in isolation”. The Irish Association of Dermatologists has indicated strong opposition to the concept of single-handed consultant
appointments in dermatology even though, at present, the services outside the E.H.B. area are mainly based on such appointments. The committee agrees that the ultimate objective should be that dermatologists would operate in minimum groups of two and that appointments should not be created where the potential for at least a two-consultant practice does not exist. However, it is inevitable in the build-up of services around the country and in the light of the economic restraints which currently apply and are likely to continue to apply to the health services in general, that, initially, dermatology services will have to be started up on the basis of single-handed appointments. Hopefully, the time-gap between the first and second appointments can be kept to a minimum.

(b) Avoidance of Duplication of Expensive Resources: The information and opinion available to the committee indicate that, compared to many other specialties, dermatology does not require unduly expensive resources. For example, one of the most expensive items of desirable equipment is a P.U.V.A. machine which, it is understood, costs in the region of £20,000. By modern standards, dermatology must be viewed as a low-technology and relatively inexpensive specialist service. Certainly, the arguments for centralisation from this viewpoint, are much weaker in relation to dermatology than in relation to other medical specialties. This is not to suggest that there are no advantages in centralisation but these must be weighed against the disadvantages to patients in terms of inconvenience; lack of access and costs arising therefrom; and to low demand/expectancy referred to in paragraph 2.11.

(c) Sub-specialisation: The Irish Association of Dermatologists has represented to the committee that there is little need for sub-specialisation within dermatology and, indeed, the dermatologists were of the view that sub-specialisation was to be discouraged in favour of continued generalisation. This view is reflected in the College guidelines (Appendix C) in relation to paediatrics – usually one of the first areas of sub-specialisation in most specialties – which state “dermatologists would be expected to treat children as well as adults”. Similarly, the children’s
hospitals in Dublin did not advocate the appointment of paediatric dermatologists who would be solely or mainly involved with children. Again, this feature of dermatology would point towards the service being delivered on a less centralised basis than most other specialties where subspecialisation is seen as a desirable objective to be facilitated in the organisation of services.

3.5 The joint submission on behalf of the eight dermatologists (Appendix B) strongly advocates the establishment of four regional dermatology centres at north Dublin, south Dublin, Cork and Galway. Each centre would be staffed by 3/5 consultants and they would serve very large catchment areas, some with a population in excess of one million. A network of peripheral clinics would be organised on a regular basis and held by the group of consultants from the regional centre. This concept undoubtedly has its attractions, particularly since it would facilitate the emergence of centres of excellence with specialised facilities as listed in the submission. For those patients who would attend the centres, there would probably be a very streamlined and cost-effective service available with specially trained nurses and good dermato-pathology back-up. There would be considerable advantages in such centres from the teaching aspect and, generally speaking, the level of skills would tend to be superior to that which might be achieved outside such centres.

3.6 However, on the other hand, centralisation to the extent indicated could only be supported if services are seriously curtailed outside these centres, otherwise unnecessary duplication occurs. Large areas of the country would be dependent on visiting consultants holding regular out-patient clinics. In this respect, the consultants would spend much of their time in an unproductive manner, travelling from clinic to clinic; the amount of consultant time available at the periphery compared to the centre would be less on a pro-rata to population basis; consultant staffing difficulties at the centre would tend to result in disproportionate cut-backs in services to the periphery; also, the tradition of providing and maintaining peripheral clinics particularly on the part of Dublin-based consultants is
not strong, not alone in dermatology but also in many other specialties.

3.7 Apart from the situation at the periphery, the proposed concept of four regional centres would also mean that, within the urban scene including Dublin, Cork, Limerick, Waterford and Sligo, major general teaching hospitals, some on a scale of up to 750 beds with a wide range of specialist activity, would not have locally-based consultants in dermatology and would be dependent on neighbouring hospitals to provide out-patient clinics and ward consultation services. The committee finds it difficult to accept that any major general teaching hospital (on the scale of 500 to 700 beds) should not have its own inhouse consultant dermatology services but should be dependent on consultants whose major commitments would be elsewhere.

3.8 The concept put forward in the joint submission (Appendix B) involves a physical centralisation of specialist facilities on to four sites. In considering this issue, the committee noted that the College guidelines (Appendix C – paragraph 2(a)) envisage dermatologists having “a formal link with one or a group of dermatologists in adjacent district(s), preferably including a medical school or postgraduate academic centre”. The committee is of the opinion that, in the future organisation of services, many of the advantages of a regional dermatology centre could be availed of and the disadvantages minimised, if the regional centre concept was of an organisational rather than a physical nature. This would involve some consultants being, for the most part, based outside a designated regional centre but having formal commitments including a right of access to the regional centre for more specialised facilities, for example, a consultant histopathologist with an interest in dermato-pathology.

3.9 There would be a commitment on the part of the designated regional centre to develop these specialised facilities and all of the consultant dermatologists within the region, (including those based at other general hospitals) would be members of the consultant staff of the regional centre and would share in the collective responsibility for the provision
of dermatology services to the region as a whole including, of course, peripheral out-patient clinics. The regional dermatology centre would thus be the focal point for the organisation of services within the region: it would arrange regular meetings of all the dermatologists and would be responsible for ensuring the proper planning and delivery of services to the periphery; to the other major general hospitals in the catchment area as well as to the regional centre itself. It would also be responsible for the training of medical and nursing staff; for undergraduate teaching and for postgraduate activities relating to dermatology. Having regard to all of the factors involved, the committee recommends that this concept of regionalisation is the most appropriate for the delivery of dermatology services in the geographic and demographic circumstances which apply to this country.

**Consultant Manpower**

3.10 As already indicated in paragraph 2.4, at present there is a consultant establishment of 11.1 whole-time equivalents (including three vacant posts) which is one consultant per 315,000 population. The College guidelines (Appendix C) recommend a norm of one consultant per 150,000 to 200,000 population. All of the advice given to the committee indicated that this is a reasonable norm which should be adopted as the target for this country. It would involve increasing, over a period of time as circumstances permit, the current number of consultants to between 17 and 23. The committee is satisfied that the dermatology services in this country are seriously undermanned at consultant level and that there is an urgent need to increase the number of consultants particularly outside the Dublin area. The manpower norm produced by the College is recommended as a reasonable guideline for this purpose.

**Out-Patient/Day Care Services**

3.11 The committee strongly recommends that the major emphasis in the future development of dermatology services should be on out-patient clinics and day care centres rather than in-patient activity. As already indicated, dermatology requires only a small in-patient component and this should be provided
in a designated area in a general hospital. The current availability of 7-day hospital beds has already been adverted to in paragraph 2.1. During the consultation process, the committee was not given to understand that, overall, there are any serious problems in bed availability for dermatology patients. In fact, the indications were that 7-day beds could, to even greater extent than has happened in recent times, be changed to 5-day beds. There is also scope for some current 5-day beds to be converted to day-care beds with an associated hostel facility. The committee believes that bed demand is influenced at present by the distance patients have to travel for services and, pending the availability of more locally-based services, the concept of hostel-type beds has considerable potential for reducing costs. This is particularly so in the case of Hume Street Hospital.

Peripheral Clinics

3.12 It is clear that in the future development of services, peripheral out-patient clinics will play a major role in reducing demand currently manifesting itself in the Dublin area and in meeting the suppressed demand which is a feature of the services outside Dublin (see paragraph 2.12). It is essential that these clinics should be properly planned and organised so that the correct balance is struck as between the frequency of clinics and the number of locations to be covered. In this respect, the view of the College (Appendix C) that “no new peripheral clinic should be established in a centre in which the number of patients seen does not justify a visit at least every two weeks” should be noted. While the committee has not arrived at a firm conclusion on this matter, it is important that the right balance be reached for the circumstances in each region in this country. The committee, however, does recommend that the responsibility for ensuring that adequate facilities (including secretarial support) are provided to enable the consultant dermatologist to run the clinic efficiently, should rest with the health board concerned. It is important that the peripheral clinic should provide, for the most part, a full service in dermatology rather than simply screen patients who would then be referred to the main centre for further diagnosis/treatment.
3.13 Finally, in order to ensure the development and maintenance of a network of peripheral clinics, the committee feels that financial incentives should be introduced. One way of achieving this would be that the health board receiving the service would recoup costs to the providing agency and that these monies would be an integral part of the funding of the regional service i.e. if the peripheral clinics are not maintained, for whatever reason, there would be funding implications felt at the regional centre. If the costs of the peripheral clinics are simply included in the overall financial allocations to the regional centres provided by the Department of Health, there will be no financial incentive to maintaining peripheral clinics.

Summary of Principles

3.14 The committee recommends that the following principles should form the basis for the future development of dermatology services:

(i) dermatology services should be based in and be an integral part of a major regional hospital providing a comprehensive range of specialist services,

(ii) for minimum viability, consultant appointments should only be created in centres where there is a potential for at least a two-consultant team,

(iii) as a low-technology and relatively inexpensive specialty, dermatology services, consistent with minimum viability, should be based as close as possible to the population being served,

(iv) sub-specialisation is not a requirement within dermatology in present circumstances,

(v) every major general hospital (of the scale of 500 to 700 beds) should have consultant dermatologists with major commitments to it,

(vi) a limited number of regional dermatology centres should be developed as the focal point(s) for the organisation of the specialty at regional level as described in paragraph 3.9,
(vii) A norm of one consultant per 150,000 to 200,000 population is recommended as a reasonable guideline for the future,

(viii) the major emphasis in the future development of dermatology services should be on out-patient clinics and day-care centres rather than in-patient activity,

(ix) A network of peripheral clinics should be developed and maintained within each region to provide a local diagnostic and therapeutic service.
Section 4 – Recommendations for Future Development

4.1 In accordance with the principles set out in section 3 of this report, the committee recommends that dermatology services be developed on the basis of four regional centres as described in paragraphs 3.8 and 3.9 of this report. The regions and the regional centres are set out in the following paragraphs.

North Dublin

4.2 The regional area would include north Dublin (including part of Kildare) with a population of 500,000 plus the North Eastern Health Board area (population 302,000) plus the Longford/Westmeath portion of the Midland Health Board area (population 98,000). The total population in the region would be 900,000. The Mater Hospital should be designated as the regional centre. There should be five consultant dermatologists to serve the total region. Three of these should be based at and have major commitments to the regional centre at the Mater Hospital. One of these should have a minor commitment (3/4 sessions per week) to the Children’s Hospital, Temple Street. Two consultants should be based at and have a major commitment to Beaumont Hospital and a minimum commitment to the regional centre at the Mater Hospital. All five consultants should be involved in the provision of a network of peripheral clinics at James Connolly Memorial Hospital, Cavan, Monaghan, Dundalk, Navan, Drogheda (International Missionary Training Hospital), Longford and Mullingar. As the designated regional centre, the Mater Hospital should negotiate with the North Eastern Health Board, the Midland Health Board, the Eastern Health Board (relating to James Connolly Memorial Hospital) and the Medical Missionaries of Mary with a view to planning, within the framework of this report, the development of dermatology services for the region as a whole including the priorities to be adopted in the implementation of the plan.
South Dublin

4.3 The regional area would include south Dublin (including Wicklow and part of Kildare) with a population of 700,000, and the Offaly/Laois portion of the Midland Health Board (population 113,000) – a total combined population of 813,000. St. Vincent’s Hospital should be the designated regional centre. It is recommended that the services at Hume Street Hospital should be physically transferred on to the St. Vincent’s Hospital site as soon as possible. Pending such transfer, there should be a joint management structure spanning St. Vincent’s Hospital and Hume Street Hospital.

4.4 With the development of the network of peripheral dermatology clinics, the use of radiotherapy clinics as a primary source of referral for dermatological problems would be phased out. However, there would always be a need for access to dermatological opinion by the radiotherapy services. The dermatology services at St. Anne’s Hospital should cease on the retirement of the existing permanent consultant – the temporary consultant appointment should also be discontinued.

4.5 The regional population for the south Dublin area would justify the appointment of five consultants – there are at present five posts including one vacancy. Outside of the recommended regional centre at St. Vincent’s/Hume Street Hospitals, the hospitals requiring dermatology services include St. James’s Hospital, the M.A.N.C.H. group and Our Lady’s Hospital for Sick Children. In addition, peripheral clinics would be required at Tullamore and Portlaoise.

4.6 It is recommended that the five posts in the south Dublin region should be deployed on the basis of two wholetime posts based at St. Vincent’s/Hume Street Hospitals plus a minimum part-time involvement at the regional centre by the other three south Dublin dermatologists to the extent of at least one or two sessions per week. Two of the latter posts
should be based primarily at St. James’s Hospital which is a major teaching hospital but the appointees should, between them, provide dermatology services of at least 3 sessions per week to Our Lady’s Hospital for Sick Children, Crumlin. The remaining post should continue to be primarily based in the M.A.N.C.H. group but with a minor commitment to the regional centre. St. Vincent’s/Hume St. Hospitals as the designated regional centre should negotiate with the Midland Health Board in relation to the provision of peripheral clinics at Tullamore and Portlaoise. Participation in the provision of peripheral clinics to the midlands should not be confined to the two dermatologists based at St. Vincent’s/Hume St. Hospitals. In line with the regional concept (see par. 3.9) all of the south Dublin dermatologists should share in the responsibility for providing a service to the defined region. The foregoing recommendations will involve the re-structuring of posts which are filled at present (subject to the agreement of all parties concerned including the incumbents) and also restructuring replacement posts as they arise.

4.7 The development of dermatology services elsewhere in the country as recommended in this report, should substantially reduce the heavy demand which is currently manifesting itself, particularly in south-east Dublin.

The South East

4.8 The south-eastern area (counties Waterford, Kilkenny, Carlow, Wexford and South Tipperary) has a population of 385,000. Its present dermatology service consists of six clinics per month undertaken by a Dublin-based consultant who is primarily engaged in private practice. Based on the consultant/population norm recommended in paragraph 3.10, this health board area has a potential for two consultants. The committee recommends that the South Eastern Health Board should establish its own locally-based dermatology service which should be centred at Waterford Regional Hospital, Ardkeen and involve a network of peripheral clinics at appropriate centres throughout the south-east.
4.9 The committee further recommends that the south-eastern service should have formal links with the south Dublin regional centre at St. Vincent's/Hume Street Hospitals. The exact nature of the formal links which should be orientated towards the academic/teaching role of the regional centre plus access to the specialised facilities to be developed there, will need to be worked out between the Health Board and the regional centre. It may be necessary to make provision for a sessional involvement in the regional centre by the appointees to Waterford-based posts. The above recommendations need not interfere with the long-standing arrangements for the part-time involvement in the south-east of the existing dermatologist.

Munster

4.10 The population of the Southern Health Board area (covering Cork and Kerry) is 536,000. There are strong traditional linkages between Cork and Limerick in relation to medical teaching. Limerick Regional Hospital is a recognised teaching hospital associated with University College, Cork. The population of the Mid-Western Health Board area (covering Limerick, Clare and North Tipperary) is 315,000. A regional dermatology centre based at Cork Regional Hospital would embrace a combined population of 851,000. Bearing in mind the distances involved, the region would justify five consultant dermatologists. It is currently serviced by two consultant posts, one of which is vacant due to the retirement of the incumbent who was based at Cork Regional Hospital and the post which is filled is based at the South Infirmary and the Mercy Hospital. The committee recommends that, for the Munster area, Cork Regional Hospital should be designated as the regional centre as described in paragraphs 3.8 and 3.9 of this report. In line with this recommendation, the base for the existing consultant post which is filled, should be transferred to the Cork Regional Hospital. At the same time, urgent steps should be taken to fill the vacant post, which was originally based at the Cork Regional Hospital.

4.11 The ultimate staffing for the regional centre at Cork should be three consultant dermatologists who should also
provide out-patient clinics and ward consultations at the Mercy Hospital and the South Infirmary/Victoria Hospital. The remaining two posts for the region should be based at Limerick Regional Hospital and each consultant should have a formal commitment, at the minimum, for teaching purposes and access to the specialised facilities to be developed at the regional centre. The region is a very large area and discussion will need to take place between the Southern and Mid-Western Health Boards, within the framework of this report, to agree on a plan for a regional dermatology service and the priorities to be reflected in its implementation. Clearly, the current establishment of two consultant posts when filled, will be inadequate for the needs of the region and priorities in terms of service delivery will need to be established locally. It is essential from the outset, that the two Cork-based consultants should function as a two-man team based at the one centre i.e. Cork Regional Hospital; that out-patient clinics and ward consultation services be provided at the Mercy, South Infirmary/Victoria and Tralee General Hospitals; and, pending a consultant appointment at Limerick, the previous out-patient services should be reinstated there. The former service provided at Clonmel should be incorporated into the locally-based service recommended for the south-east in paragraph 4.9.

The West

4.12 The Western Health Board area (covering counties Galway, Mayo and Roscommon) has a population of 347,000. Based on the recommended norms, this population would justify two consultant dermatologists. At present, the area is serviced by a single-handed consultant who also runs a peripheral clinic at Sligo in the area of the North Western Health Board. Some of the population of north Clare in the mid-western area have traditionally gone to Galway for specialist services. A dermatology clinic is not provided at Portiuncula Hospital, Ballinasloe. The committee has no doubt that a second consultant post is fully justified at Galway Regional Hospital and is of the opinion that there is an urgent necessity to relieve the single-handed consultant who has been providing, on his own, the services over a very big area geographically for a long number of years. The creation of a second post of
A dermatologist will allow for a peripheral clinic to be initiated at Portiuncula Hospital, Ballinasloe. It is also recommended that arrangements be made between the Western Health Board and the Midland Health Board for a regular dermatology clinic to be conducted at Athlone by the Galway-based consultants.

The North West

4.13 The north-western area (covering counties Sligo, Leitrim and Donegal) has a population of 212,000. Because of its geography, it is a very difficult area to service from an outside regional centre. At the same time, the population is not big enough to justify a dermatology centre based on a minimum of two consultants and a norm of one per 150,000 to 200,000 population. In fact, much of the north-west, particularly the northern half, is easier to service from Northern Ireland and the potential exists for such a solution, which would enable dermatology services to conform with the principles set out in Section 3 of this report. Bearing in mind this potential, the committee recommends that a post of consultant dermatologist would be appropriate to be based at Sligo General Hospital involving a network of peripheral clinics at appropriate centres throughout the north-west. It would be desirable, in order to improve the attractiveness of the post, that a formal link with the consultant dermatologists at Galway Regional Hospital and University College, Galway be established. The committee also envisages that the existing clinic at Sligo, run by the dermatologist based at Galway, should continue pending the emergence of a locally-based consultant service.

Summary of Recommendations

4.14 The recommendations of the committee involve the following numbers and distribution of consultant dermatologists:

1. North Dublin Region
   (including the North-Eastern Health Board area; half of the Midland Health Board area and part of Kildare)
### 2. South Dublin Region
(including half of the Midland Health Board area, Wicklow and part of Kildare) 5

### South-East
2

### 3. Cork Region
(including Cork City and County, and Kerry) 3

### Limerick
(including Limerick City and County, Clare and north Tipperary) 2

### 4. Galway Region
(including Galway, Roscommon, Mayo and the Athlone area) 2

### Sligo
1

**Total** 20

### Priorities

4.15 It will obviously take some considerable time to build up dermatology services as recommended in this report. In so far as consultant appointments are concerned, the committee sees the following as the major priorities:–

- the filling of the vacancy for a second consultant in Cork,
- the appointment of a second consultant at Galway,
- the appointment of a replacement third consultant in north Dublin,
- the appointment of a consultant to be based at Waterford,
- the appointment of a consultant to be based at Limerick.

### Teaching/Training

4.16 Finally, the committee would like to stress the importance of exploiting to the full, the enhanced potential for the teaching
of dermatology which is inherent in the re-organised service recommended in this report. A major defect at present is that there are so few consultants in dermatology that the capacity to teach and train is being undermined. With increased consultant manpower and within the concept of regional centres as advocated, the opportunity will arise to introduce better training and teaching arrangements for both medical and nursing personnel. The increased capacity in terms of undergraduate teaching which will arise for the medical schools associated with the proposed regional centres will be obvious and hopefully exploited to the full. Similarly, nurse training will be in a position to benefit. At the postgraduate training level, the committee recommends that each unit should be appropriately staffed at N.C.H.D. level and that S.H.O. posts in dermatology should be part of a rotation programme for doctors in training for both general medicine and general practice.

4.17 In relation to higher specialist training for dermatology itself, the committee is aware that difficulties have been experienced in advancing senior registrar training in all of the medical specialties. However, the emergence of regional centres in dermatology will increase the potential to train at higher specialist level whether as part of an organised senior registrar programme or independent of such a programme. Because of the overall size of the specialty in this country, the national requirement for the training of dermatologists is small. However, the committee believes that there should, at any given time, be one to two doctors in training at higher specialist level within dermatology and that their training should be organised to ensure that they rotate through several regional centres. Given the implementation of the recommendations in this report, it should be possible for each of the recommended regional centres to achieve the standards necessary to be recognised for training purposes by the Joint Committee on Higher Medical Training.

Concluding Comments

4.18 In formulating the foregoing specific recommendations for the development of dermatology services, the committee
has endeavoured to be pragmatic in recognising the services which are already there and using them as the basis for future development in accordance with principles which it has clarified. However, the level of under-provision of services from the national perspective and the serious disparities which have been identified in the existing services are such that radical change is inevitable in order to achieve equity in the availability of services throughout the country.

4.19 For some health agencies, the recommendations may represent disappointment having regard to earlier plans. In particular, the committee has not supported the hitherto plan for a regional dermatology unit at the proposed new Tallaght Hospital to which the M.A.N.C.H. group of hospitals are to transfer. However, in this respect, it must be pointed out that the Tallaght proposal emerged from the overall allocation of specialist units within the major Dublin hospitals and it was not based on the indepth study of dermatology incorporated in this report. Again, there may be disappointment within the South Infirmary/Victoria Hospital in Cork, that the hitherto planned regional dermatology unit is not now advocated. However, in this respect, the committee is firmly of the view that, if dermatology is to develop properly, it must be located within a regional teaching hospital along with the other regional specialties. All the evidence available points to this environment as being the most appropriate for a regional dermatology centre based in Cork. The recommended cessation of dermatology services at St. Anne's Hospital in south Dublin may also come as a disappointment to the authorities of that hospital. However, the committee is satisfied that not only must the over-centralisation of dermatology in south-east Dublin be remedied but the proper liaison between oncology and dermatology should take place within the environment of a major general hospital. Finally, the authorities of Hume Street Hospital who have contributed much to dermatology over the years and, in particular, have adapted well to the requirements of modern practice in more recent times, may not welcome the recommended physical transfer of its services to the St. Vincent's Hospital site. Again, the committee is convinced that this recommendation is in the best interests of patients who are entitled to see in the planning of services, attempts to achieve the best service that
modern hospital medicine has to offer, judged by international standards. Unfortunately, such standards cannot be achieved in the isolated circumstances of a special hospital, despite the best endeavours of all concerned.
APPENDIX A

Summary of Dermatology Workload Statistics

<table>
<thead>
<tr>
<th>Hospital</th>
<th>*In-patients</th>
<th>Average Duration of stay</th>
<th>No. of 5-day clinics per attendances</th>
<th>No. of 7-day beds</th>
<th>Out-patient Clinics per month</th>
<th>*Out-patient attendances</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Sessions per week</td>
<td>Duration</td>
<td></td>
<td></td>
<td></td>
<td>New</td>
</tr>
<tr>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cavan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>c.200</td>
</tr>
<tr>
<td>(1 session per month)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drogheda</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>89</td>
</tr>
<tr>
<td>(1 session per month)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>North Dublin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mater (14 sessions)</td>
<td>168</td>
<td>10.7</td>
<td>30</td>
<td>8</td>
<td>40</td>
<td>1,283</td>
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<td>Beaumont (8 sessions)</td>
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<td></td>
</tr>
<tr>
<td>J.C.M. (c. 3 sessions)</td>
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<td></td>
<td>8</td>
<td>607</td>
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<tr>
<td>Temple St. (4 sessions)</td>
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<td>5</td>
<td>as required</td>
<td>as required</td>
<td>8</td>
<td>592</td>
</tr>
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<td>South Dublin</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Vincent’s</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(9 sessions)</td>
<td>111</td>
<td>9.9</td>
<td>—</td>
<td>9</td>
<td>8</td>
<td>762</td>
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* Statistics relate to latest available year — mainly 1987 or 1986
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<tr>
<th>Hospital (Sessions per week)</th>
<th>In-patients</th>
<th>Average Duration of stay</th>
<th>No. of 5-day beds</th>
<th>No. of 7-day beds</th>
<th>Out-patient Clinics per month</th>
<th>Out-patient attendances New</th>
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</thead>
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<tr>
<td>Hume St. (15 sessions)</td>
<td>501</td>
<td>—</td>
<td>38</td>
<td>—</td>
<td>—</td>
<td>2,847</td>
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<tr>
<td></td>
<td>391 public</td>
<td>11.5</td>
<td>26 public</td>
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<td></td>
<td>110 private</td>
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<td>12 private</td>
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<td>Note: also Day-Care Unit</td>
<td></td>
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<tr>
<td>St. Anne’s (5/6 sessions)</td>
<td>132</td>
<td>—</td>
<td>as required</td>
<td>—</td>
<td>16</td>
<td>1,520</td>
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<td></td>
<td></td>
<td></td>
<td>usually 5-6</td>
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<td></td>
<td>4,545</td>
</tr>
<tr>
<td>St. James’s (8 sessions</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>2-4</td>
<td>12</td>
<td>401</td>
</tr>
<tr>
<td>incl. 2 from Dr. Steevens’)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(9 months)</td>
</tr>
<tr>
<td>Meath (1 session)</td>
<td>In-patients</td>
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<td>—</td>
<td>—</td>
<td>4</td>
<td>193</td>
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<tr>
<td></td>
<td>usually go</td>
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<td>455</td>
</tr>
<tr>
<td></td>
<td>to the Adelaide</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Adelaide (5 sessions)</td>
<td>61</td>
<td>10-11 days</td>
<td>—</td>
<td>—</td>
<td>24</td>
<td>867</td>
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<tr>
<td>Harcourt Street (3 sessions)</td>
<td>41</td>
<td>N/A</td>
<td>—</td>
<td>—</td>
<td>4 (8 per month from 1988)</td>
<td>382</td>
</tr>
<tr>
<td>Our Lady’s Crumlin (7 sessions)</td>
<td>367</td>
<td>4 days</td>
<td>as required</td>
<td>—</td>
<td>20</td>
<td>900</td>
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<td>St. Michael’s (1 session)</td>
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<td>—</td>
<td>none</td>
<td>none</td>
<td>—</td>
<td>197</td>
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Note: Also as required
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<th>In-patients</th>
<th>Average Duration of stay</th>
<th>No. of 5-day beds</th>
<th>No. of 7-day beds</th>
<th>Out-patient Clinics per month</th>
<th>Out-patient attendances</th>
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<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td>Total</td>
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<td>S.E.H.B.</td>
<td></td>
<td></td>
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<td>Kilkenny (2 sessions per month)</td>
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<td>—</td>
<td>—</td>
<td>2</td>
<td>N/A 370</td>
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<td>Waterford (2 sessions per month)</td>
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<td>—</td>
<td>—</td>
<td>2</td>
<td>180 403</td>
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<tr>
<td>Wexford (2 sessions per month)</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>2</td>
<td>231 619</td>
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<td>Clonmel (1 session per month)</td>
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<td>—</td>
<td>1</td>
<td>238 251</td>
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<td>M.H.B.</td>
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<td>Portlaoise (no service since 1984)</td>
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<td>—</td>
<td>—</td>
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<td>120/140 180 re</td>
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<td>Tullamore (no service since 1984)</td>
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<td>—</td>
<td>2</td>
<td>140 c.200</td>
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<td>W.H.B. (11 sessions)</td>
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<tr>
<td>Galway</td>
<td>39</td>
<td>32</td>
<td>—</td>
<td>—</td>
<td>8</td>
<td>670 1,604</td>
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<td>Castlebar</td>
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<td>166</td>
<td>333</td>
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<td>Ballina</td>
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<td>159</td>
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<td>Roscommon</td>
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<td>Out-patient Clinics per month</td>
<td>Out-patient attendances</td>
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<td>New</td>
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<tr>
<td>N.W.H.B.</td>
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<tr>
<td>Sligo</td>
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<td></td>
<td>1 on average</td>
<td>176</td>
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<tr>
<td>Letterkenny</td>
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<td>1 every 6 weeks on average</td>
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<td>M.W.H.B.</td>
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<td>Limerick Regional</td>
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<td></td>
<td></td>
<td>every 3 weeks - no service since May 1987</td>
<td>c.500</td>
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<td>S.H.B. (22 sessions)</td>
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APPENDIX B.

Dr. C. Twomey,
Chairman,
Dermatology Review Committee,
Comhairle na n-Ospidéal,
Fenian Street,
Dublin 2.

Dear Dr. Twomey,

At the Comhairle na n-Ospidéal Dermatology Review meeting on 25.2.88, you kindly suggested we could write to you with any further comments. After the meeting we contacted all of our consultant Dermatology colleagues named below. We unanimously agree on the following guidelines for the development of Dermatology in Ireland and wish to strongly recommend them to your Committee.

The establishment of 4 Regional Dermatology Centres i.e. Dublin North, Dublin South, Cork and Galway.

Consultant Dermatologists to be appointed to these Regional Centres and all Health Board Areas to be serviced from these Centres. The Regional Centre should be associated with a university Medical School and incorporate all of the necessary sub-speciality services and have an active Undergraduate and Postgraduate, General Practitioner and N.H.C.D. Teaching Programme.

Each Regional Centre to have specialised facilities as follows: In-patient ward units with specially trained nursing staff; Fully staffed and equipped Day Care centre; Specialised laboratory facilities including dermatopathology, immunology, immunohistochemistry, Electron Microscopy, Microbiology, Mycology, Virology; Extensive facilities for contact Dermatitis patch testing; close liaison with Plastic Surgeon.

While the initial development of 4 fully staffed and fully equipped Regional Centres incorporating all the necessary specialty facilities may appear expensive, it is essential for the provision of a satisfactory Dermatology Service in Ireland. If a decision
is made to appoint Dermatologists outside the designated Regional Centres, it would mean that the level of skill could not be maintained or advanced because of isolation. We are unanimous that the development of these 4 Centres is vital in order that a satisfactory and adequate service is available for our dermatology patients and feel that such a development will be cost effective.

When you have considered the contents of this letter, we would be grateful if you would contact us to arrange further discussion.

We thank you and your Committee for the courtesy, assistance and interest you have shown to us during our meetings with you.

Signed on behalf of ourselves and on behalf of our colleagues named below:

Sean O'Loughlin,
Frank Powell,
Louise Barnes,
Fergus Lyons,
Charles Meenan,
David O'Gorman,
Sarah Rogers,
Marjorie Young.
这些指南基于假设，区域医院是皮肤科服务的主要中心，其中包含特殊诊断和治疗设施。一个区域医院在一般情况下，可能有两名皮肤科医生，他们将每周访问其他区域医院不超过一到两次，具体取决于需求。皮肤科是一个门诊“病人流量”高而住院需求相对较少的专科。皮肤科门诊在大多数区域医院举行，而住院设施只适合那些医生有其主要职责的医院。皮肤科医生应负责治疗儿童和成人。

1. ACCOMMODATION

(a) Out-patients: Entrance, reception and waiting areas may be part of the main out-patient department, although a "secondary" waiting area is necessary in the dermatology out-patient area. The amount of accommodation will depend on the "case load" and population density.

At least two rooms per doctor per clinic session are required; most district hospitals have one consultation room and two examination cubicles per doctor. Since these will probably be combined consulting/examination/undressing rooms, adjacent communicating rooms should be allocated in order that one may be used for consultation and the other(s) for examination/undressing. As each clinic will have an assistant(s) working with the
dermatologist, similar room allocation will be required for each doctor. The demand for postgraduate teaching is likely to increase; in dermatology this is most efficiently done in the out-patient department; consequently one of the consulting/examination rooms must be larger than average to accommodate this need. Rooms should have natural light.

The above facilities may have to be shared but the following are essential for the exclusive use of the dermatologist(s).

A special treatment room(s) is necessary for daily dressings, leg ulcer treatments, etc; also a minor operations room is required. The availability of accommodation for daily treatment of psoriasis varies from centre to centre but each district will need some out-patient facilities for such therapy. This will mean the provision of a minimum of two baths (and changing rooms) and UVB treatment rooms, and the availability of nursing staff trained in these special techniques. Each district will also require a PUVA unit, suitably staffed. Such facilities for daily treatment of common dermatoses can materially diminish the demand for in-patient treatment by specialised supervision and management. Redesigned and newly planned units might better incorporate these treatment services with the in-patient unit to avoid unnecessary duplication of equipment and nursing skills. This arrangement also enables out-patients to attend outside "office hours".

(b) In-Patients: An adequate number of beds, specifically designated for dermatology will be required, the number varying with local circumstances; in addition, access to beds/cots in the paediatric unit is necessary. An average figure for beds required is 8-9 per consultant per 200,000 population.

Beds should be in a separate unit, preferably in close proximity to the acute general medical wards to assist in providing the general medical cover required. It is desirable for up to half the dermatology beds to be single rooms – a greater proportion if possible. If the out-patient and in-patients units are not adjacent, a treatment room will be required. An office for each consultant and secretary is essential.
(a) **Consultant Staff:** It is recognised that needs vary from district to district but at present it is considered a reasonable staffing structure to have one consultant per 150,000 to 200,000 population.

Dermatologists should not be appointed in isolation. Most districts will have at least two dermatologists and it will be possible to have a joint clinic at least once per two weeks. If, for geographical reasons, a dermatologist is in an isolated centre he/she should have a formal link with one or a group of dermatologists in adjacent district(s), preferably including a medical school or postgraduate academic centre. It is no longer considered ideal practice for a dermatologist to undertake many infrequent peripatetic sessions to deal with many peripheral sessions. No new peripheral clinic should be established in a centre in which the number of patients seen does not justify a visit at least every two weeks.

(b) **Junior Medical Staff:** Senior registrars and registrars will generally be trained in teaching districts but, depending on distances, can benefit from working with other district hospitals on a part-time basis. In some non-teaching districts, particularly where several dermatologists are based, a registrar appointment would be indicated. Irrespective of a number of trainees, clinical assistants are important and required on the basis of up to one per full out-patient clinic. Some resident medical staff help will be necessary to supervise in-patients. Either a shared house physician or senior house officer is necessary for this purpose; the exact staff at this grade will depend on whether a medical rota or general practice vocational training scheme exists in the district – both should ideally include dermatology in their rotation through the medical specialties.

(c) **Nursing Staff:** Appropriately trained nurses must be available for clinics, preferably on a long-term basis to enable them to be conversant with the various treatments and testing procedures; where the skin department
structure allows it, the same group of specialty nurses should supervise both the in-patient and out-patient care. In addition, these trained nurses could usefully also be employed in the community and in General Practice.

(d) Ancillary Staff: A medical social worker, not necessarily whole-time, should be attached to the dermatology department.

The help of physiotherapists will be required.

Adequate secretarial help is crucial in view of the large case load in dermatology departments. In general, one whole-time secretary is necessary per consultant, whole-time or maximum part-time, or per equivalent number of part-time sessions.

(e) Radiotherapy and Plastic Surgery: Close liaison with both the radiotherapy and plastic surgery departments is required. Ideally, this should include a regular joint clinic.

3. DIAGNOSTIC SERVICES

In addition to the usual radiological and laboratory services, it is essential to have histopathological, immunological and mycological services, probably on a district or regional basis depending on population density and the type of hospital service available in the district. Clinical photography should be readily available.

SEPTEMBER, 1986
APPENDIX D

[Extract from Journal of the Royal College of Physicians of London Vol. 20 No. 2 April 1986].

DERMATOLOGY

The specialty in Britain consists of 220 consultants, six professors and about 120 trainees – registrars, senior registrars and academic equivalents. Currently, every advertised dermatology registrar post attracts 15-20 well-qualified applicants, i.e. with at least three years' post-registration general professional training and MRCP. Teaching centres typically have two or three consultants, one or two senior registrars and one registrar; any senior house officers are usually part of general practice training or a general medical rotation scheme. There are now increasing numbers of married women training part-time in dermatology. In District General Hospitals there is one consultant per 250,000 population; with rare exceptions, staff below this level are either general practitioner assistants or rotating general practice or general medicine trainees. The specialty is expanding by an average of four new consultant posts a year.

Dermatology has adopted the same basic training as other medical specialties – a minimum of three years' post-registration general medical posts and the MRCP before entering dermatology at registrar level. It is recommended that a total of four years is spent in registrar and senior registrar posts before applying for accreditation. Further clinical training is likely to be needed before a consultant post is obtained.

Research in the specialty has made considerable progress in the last 20 years; much can be undertaken with very little technological back-up. Disease processes and their treatment can be followed from beginning to end, and tissue is easily obtained with little inconvenience to the patient. In addition, treatments known to be toxic when administered systemically can often be applied topically with impunity. Many important biological principles in fields such as cell kinetics, immunology and mediation of inflammatory reactions have been clarified by dermatology research workers.
There can be few specialties in medicine with as much variety in everyday practice as dermatology; in any clinic one may go from examining warts to investigating and treating systemic disease to removing a tumour. The majority of dermatologists still treat all the non-acute general medical problems diagnosed in their department. Most topical therapy is now based on antagonising known pathogenic mechanisms. In practice, much of the work involves the management of eczemas, psoriasis, leg ulcers and a wide variety of benign, pre-malignant and malignant diseases.

Dermatology is thus an interesting specialty for those who are physicians by inclination but who also wish to continue to exercise their surgical skills.

RODNEY DAWBER