National Seminar on Postgraduate Medical Education and Training
"Implementing Hanly: Top-Quality Training and Improved Working Hours"

Great Southern Hotel, Dublin Airport – 9th January 2004

Overview

Over 180 people attended the seminar[1], which focussed on the best way forward for postgraduate medical education and training in the context of wide-ranging health reforms, with particular reference to the Report of the National Task Force on Medical Staffing (Hanly Report) and the European Working Time Directive (EWTD).

Dr Jane Buttimer, Chairperson of the Postgraduate Medical Education and Training (MET) Group, chaired the seminar and introduced the contributors. She outlined the Group's vision of high-quality training schemes, attractive to graduates, resulting in sufficient numbers of fully-trained competent doctors to deliver a patient-centred health service in Ireland.

The Secretary General of the Department of Health and Children, Mr. Michael Kelly, gave the opening address, followed by presentations by Mr Andrew Condon (Department of Health and Children) on *"The European Working Time Directive: Key Issues";* Prof Gerry Loftus (Consultant Paediatrician, University College Hospital Galway) on *"Problems for every Solution: Solutions for every Problem?" and* Dr Jes Sandermann (Chief Vascular Surgeon, Viborg Hospital) on *"Quality Training within Reduced Hours: The Experience in Denmark since 1981".*

The presentations were followed by a wide-ranging discussion in open forum. The opportunity for all the relevant stakeholders to share their perspectives on the key issues and how to address them was welcomed by many participants. Concerns were raised regarding our level of preparation for the application of the European Working Time Directive to doctors in training from August 1, 2004. Other key issues raised included the definition of working time under the EWTD, the implications for training in a shorter week, the lessons for Ireland arising from the Danish experience, the need to avoid service deficits arising from reduced working hours and the imperative first and foremost to safeguard patient care.

The participants broke into six small group *"breakout"* sessions which focussed on:

- *Service/On-site Content of Training;*
- *Non-Service and Off-site Content of Training;*
- *Protected Training Time – Content and Quantity;*
- *Standards and Quality Assurance in Medical Education and Training;*

[1] Key documentation circulated at the seminar is also available on this website, including the text of the opening address, biographical notes on the contributors, presentation slides, a briefing note on the EWTD, the seminar agenda and relevant extracts from the Hanly Report.

- *Duration and Capacity of Training Programmes; and*
- *Managing Change.*

The main issues reported back from these sessions included the impact of the EWTD and Hanly Report on patient services and education and training, the need for a structured framework for education and training, the need to fully resource the proposed changes to the health system, the short time frame involved and the need for the relevant Government Departments to formally advise the specialist training bodies if it is deemed necessary to increase training numbers.

In general, the participants believed that training can be delivered within the 58 hour week. The Department of Health and Children representatives stated that the principles of the Hanly Report are now government policy and that commitment to the provision of the resources necessary to follow through on that commitment is implicit in the decision.

A number of solutions and opportunities were identified. These included:

- The need for Government to follow through on its commitments under Hanly including:
  - A structured framework for education and training with a wide range of integrated functions as outlined in the Hanly Report
  - All NCHD posts in future being training posts
  - Protected training time arrangements (should include rostered time for training, study and extended handovers)
- The more efficient use of training time during working hours
- Emphasis on teamwork, strengthening the links between the trainer and trainee
- Development of a better understanding of the roles of other health professionals
- Reallocation and clearer definition of the duties of doctors in training
- Centres of excellence providing more training opportunities
- Competency-based training
- Innovative methods of teaching
- Limited off site training (for some specialties)
- Mentoring system
- More structure and support for quality assurance and audit
- Structures to ensure continuum from undergraduate education, through internship to postgraduate and continuing professional development
- Retain Irish graduates by means of a high quality postgraduate education and training system, career opportunities and family friendly training and work practices.

Summing up, Prof Anthony Clare said that all stakeholders must decide to trust each other and work in partnership to help the process of reform that is underway – a reform package which provides an opportunity to improve education and training, to improve the working lives of doctors in training and most importantly, to deliver an efficient, high quality health service which benefits the patient and the public's health.

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Proceedings

A national seminar on postgraduate medical education and training, entitled *"Implementing Hanly: Top-Quality Training and Improved Working Hours"* was held in the Great Southern Hotel, Dublin Airport on the 9th January, 2004. Over 180 people attended[2] including representatives of the specialist training bodies, medical schools, non-consultant hospital doctors, consultants, nursing profession, medical manpower managers, Department of Health and Children, Department of Finance, Higher Education Authority, the Medical Council, Comhairle na nOspidéal, medical representative organisations, Health Service Employers Agency, Postgraduate Medical and Dental Board as well as senior management and human resource personnel representing a wide range of Health Boards and hospitals throughout the country.

Dr Jane Buttimer, Chairperson of the Postgraduate Medical Education and Training (MET) Group, who chaired the seminar, stated that the vision of the MET Group was that:

> *"the postgraduate education and training environment will be attractive to all medical graduates, and deliver high quality schemes that will result in a sufficient number of fully trained, competent doctors to deliver a patient-centred health service in this country."*

Dr Buttimer welcomed the participants and introduced the contributors. **Mr Michael Kelly**, Secretary General of the Department of Health and Children, gave the opening address, followed by presentations given by:

- **Mr Andrew Condon** (Department of Health and Children) on *"The European Working Time Directive: Key Issues"*;
- **Professor Gerry Loftus** (Consultant Paediatrician, University College Hospital Galway) on *"Problems for every Solution: Solutions for every Problem?"* and
- **Dr Jes Sandermann** (Chief Vascular Surgeon, Viborg Hospital, Denmark) on *"Quality Training within Reduced Hours: The Experience in Denmark since 1981"*.

[2] Key documentation circulated at the seminar is also available on this website, including the text of the opening address, biographical notes on the contributors, presentation slides, a briefing note on the EWTD, the seminar agenda and relevant extracts from the Hanly Report.

Panel Discussion (plenary)

Dr Buttimer chaired the session. The panel consisting of Mr Condon, Prof Loftus and Dr Sandermann addressed questions and comments from the seminar participants.

The discussion focussed primarily on the European Working Time Directive – how it would be applied and if there are exemptions:

Mr Condon explained that working time is

> "*when the doctor is required to be present at the place determined by the employer and to be available to the employer in order to be able to provide their services immediately in case of need*".

The EWTD is already incorporated into Irish law but key provisions relating to working hours and rest periods will not apply to doctors in training until 1st August 2004. Ireland cannot seek a derogation at this late stage. Ireland is legally obliged to transpose the Directive by August or there may be sanctions at EU level. Under Irish law, there are already individual penalties for breaches which are calculated per violation per individual per day. Mr Condon stressed that we must find ways to comply with the Directive, not to avoid it.

Research in the context of medical education and training was also discussed including whether Ireland could learn from the Danish experience.

Denmark has much the same structure as Ireland where university medical schools have no formal role in medical research in the hospitals. A challenge facing Ireland is ensuring adequate flexibility in future medical training programmes in order to accommodate and encourage research by our doctors in training (both in Ireland and internationally).

Breakout Sessions

The participants divided into 6 small group "breakout sessions" to discuss (1) service/on-site content of training; (2) non-service and off-site content of training; (3) protected training time – content and quantity; (4) standards and quality assurance in medical education and training; (5) duration and capacity of training programmes; and (6) managing change. The afternoon session commenced with the rapporteurs' presentations of the main points from each session.

Summary of Session 1: Service / On-site Content of Training[3]

The main recommendation of the National Task Force on Medical Staffing regarding medical education and training was for a central, statutory, independent training authority that would ensure that all NCHDs are in genuine training posts and promote high quality education and training. However, the government has decided not to implement this but structures must be put in place to protect these functions. The group considered that with the introduction of the EWTD in August 2004, there will be a 25% reduction in the hours worked by NCHDs. The challenge is to provide a level of training in a new structure with at least no diminution of standards.

Reduction in hours and shift work may impact on training time and quality in such areas as:

- reduced opportunities for involvement in the continuity of care/whole patient episodes
- reduction in the numbers of procedures performed
- increase in the intensity of work when fewer doctors on duty
- less opportunity for teamwork
- reduced interaction between trainer and trainee
- the effect of compensatory rest time after off-site on-call
- reduced opportunities to attend formal education

The possible responses include:

- more appropriate and clearly defined NCHD duties
- restructuring training received while in service
- rostered time for training, study and extended hand-over time
- different systems of training to include video conferencing, internet
- competency-based training versus number of years
- off-site training (only applicable to certain specialties)

[3] Session 1: *Professor T. J. McKenna (Chair), Mr Graham Roche-Nagle (Rapporteur)*.
Participants: Ms Eithne Breathnach , Dr Richard Brennan, Ms Teresa Bulfin, Dr Ian Callanan, Ms Lesley Costello, Dr Tom Crotty, Mr Michael Fitzgerald, Mr Gerard Gavin, Mr John Hennessy, Ms Jenny Hogan, Ms Trish Horgan, Dr Fenton Howell, Mr Michael Lyons, Ms Kathleen MacLellan, Dr Dave Madden, Mr Declan Magee, Mr Tommie Martin, Mr Pat McLoughlin , Mr Paraic Murray, Dr Risteárd Ó Laoide, Ms Tracy O'Beirne, Dr Michael O'Connor, Dr Brian Pickering, Ms Anita Regan, Mr Jim Ryan, Dr Margo Wrigley

There was much discussion on the service implications of reduced hours. It was stated that with the reduction of the numbers of doctors on site, service will suffer in the interim between the introduction of EWTD and the increase in the numbers of consultants. Risk management may be compromised. Smaller hospitals particularly will have difficulty in meeting the deadline. Waiting lists/times, outpatient's clinics and elective work may be sacrificed in favour of acute admissions.

Other options must be considered, e.g. providing the resources to develop primary care services to reduce chronic admissions, scheduling activities carefully, improving resources for nurse specialists (expanding the role of nurse specialists), infrastructure, information technology (IT), and ambulance services.

Teamwork and the trainer/trainee link must not be fragmented during the reforms. In general, there was concern that the resource necessary to deliver service and training had not been identified for implementation on the 1st August 2004.

Summary of Session 2: Non-Service and Off-site Content of Training[4]

The opening discussion was about what is considered "working time" for the purposes of the EU Directive and where does "off-site" fit in. It was also pointed out that the government's decision to incorporate the functions of the proposed central training authority into existing structures rather than have an independent agency, showed a lack of commitment to MET.

What quantity of training should be done off-site?

- this should be kept to a minimum
- depends on the specialty
- training time must be safeguarded and possible tailored to different stages of training and different specialties
- many specialties already have a percentage of their training off-site

What type of training can be done off-site?

- reading up on procedures carried out during the day
- attending lectures
- research
- skills labs
- acquiring skills of a non-clinical nature, e.g. management, communications, IT

What are the problems for training?

- compensatory rest periods after being on-call will be difficult to manage

[4] Session 2 *Professor Anthony Clare (Chair), Mr Asam Ishtiaq (Rapporteur).*
Participants: Ms Pauline Aherne, Dr Michael Boland, Mr Martin Caldwell, Dr Deborah Condell, Mr Martin Cowley, Dr Denise Curtin, Ms Deirdre Dineen, Dr Hugh Gallagher, Dr Detta Healy, Ms Arleen Heffernan, Ms Deirdre Horan, Mr James Keane, Pat Kiely, Ms Alice Kinsella, Dr Laura Mannion, Dr Ronan McDermott, Dr John McFarlane, Mr Joseph P McGrath, Ms Laverne McGuinness, Mr Tony McNamara, Dr Fionnuala Naughton, Ms Sorcha O'Quigley, Ms Denise O'Shea, Ms Anne Pardy, Peter Whitley

- shorter hours may mean that training may take more years
- no strong advocate for training, training may be in danger while this continues
- potential for longer actual working week for NCHDs with off-site training plus working hours as per EWTD
- may create an artificial distinction between service and training

What are the opportunities?

- training time more clearly defined in rosters
- restructure the activities of NCHDs on-site to be more productive
- grasp new methods of teaching, e.g. video-conferencing, e-learning, distance learning
- more structures mentoring/career guidance
- catalyst for all parties to talk to one another

What can be done in the short term?

- reorganisation of work and training is only possibility in the short term.
- start to implement Hanly recommendations :
  - proceed to increase the number of consultants
  - reorganisation of hospitals and reallocation of tasks as appropriate

Summary of Session 3: Protected Training Time – Content and Quantity[5]

Training time must be protected for both trainer and trainee. This should be incorporated into the contracts but may be different for each specialty at each level of training. The amount of time should be in the region of 10 – 15%. A definition of protected training time is required.

What should protected training time include?

- clinical skills training
- theoretic analysis
- research
- generic non-clinical skills, e.g. IT, management, evidence-based medicine, statistics

What are the problems?

- training did not receive sufficient emphasis in the morning session or in the Hanly Report
- employing authorities have not "bought into" education
- resources and facilities are limited

[5] Session 3: *Professor Paul Finucane (Chair), Dr. Michael O'Leary (Rapporteur).*
Participants: Dr Anthony Carney, Mr Terry Casey, Paul Connolly, Fiona Cunningham, Ms Antoinette Doocey, Dr John Fennell, Dr Siobhan Gormally, Dr Eric Heffernan, Mr David Hickey, Ms Aileen Killeen, Mr John Lamont, Dr Brian Marsh, Mr Ken Mealy, Mr Joe Mooney, JH O'Boyle, Darach Ó Ciardha, Ms Mary O'Keeffe, Mr Ciarán Ó Maoileoin, Ms Elaine Prendergast, Mr Martin Quigley, Ms Audrey Reinhart, Dr Martin Rouse, Ms Annemarie Ryan, Dr Paul Smith, Mr Shay Torsney

- three times more funding in the UK – training centres funded directly in Scotland
- the postgraduate dean is the single most powerful doctor in UK – should Irish deans be responsible for the postgraduate grant?
- funding should follow training
- postgraduate deans should define training in each specialty
- less working time – what suffers? answer - education and training

What structures should be in place?

- training requires active management with dedicated management structures, e.g. postgraduate deanery as in UK
- employers should be obliged to ensure training occurs
- training bodies should be responsible for quality of training
- continue grant for postgraduate training or give funds to one body for administration
- ring fence portion of training grant for structured training
- obligation on NCHD to prove training time used for training
- more formal links between universities, training bodies and employers
- time for research should be built into the contracts
- current trainer/trainee structure has many benefits

What are the short term issues?

- existing ratios will make protected training time difficult to implement
- each trainee to be assigned to a mentor/trainer
- regional centres for training
- protected training time and funding should be explicit
- recognition of half day release
- if we focus on the outcomes of training, we expect the appropriate process and structures will follow

Summary of Session 4: Standards and Quality Assurance in Medical Education and Training[6]

Currently each training programme has a curriculum outlining standards for each specialty and competencies required. Generic standards guidelines for all specialties do not exist in this country. There is a need for such a guide, similar to the World Federation of Medical Education standards document. Training bodies need to co-

[6] Session 4 : *Dr Ruth Barrington (Chair), Dr Margaret O'Riordan (Rapporteur)*
Participants: Dr Bridgette Byrne, Dr John Cosgrove, Mr Larry Dunne, Ms Rowena Dwyer, Professor Howard Fee, Dr Susan Fitzgerald, Ms Anja Flender, Dr John Gallagher, Mr Bernard Gloster, Dr Eoin Laffan, Mr Chris Lyons, Mr David Maguire, Mr Joe Martin, Dr Mick Molloy, Mr Joseph O'Beirne, Mr Paul O'Brien, Dr Emer O'Connell, Ms Maeve O'Connor, Dr John O'Connor, Eileen Poate, Dr Stanley Roberts, Professor Diarmuid Shanley, Fintan Shannon, Dr Ian Surgeon, Dr Cillian Twomey

operate with each other. There is currently no structured framework in which this can be developed.

There must be a continuum in medical education and training from undergraduate through internship to postgraduate. There should be a move toward competency based training. All NCHDs must be in genuine training posts as soon as possible. There is no set curriculum for the majority of NCHDs. It was suggested that 50% of NCHD posts are not training posts. An anomaly exists in the current situation where non-EU doctors can only apply for training posts and Irish/EU doctors can apply for both training and non-training posts.

The question was raised as to who should be responsible for quality assurance (QA) and standards?

- Postgraduate Medical and Dental Board?
- Medical Council?
- A central training authority that oversees all training?

If this role is to be taken on by the Health Service Executive as has been suggested then there is a danger that it will "get lost" among the many other functions of this body.

There is an urgent requirement to protect training time so that the quality of training is not affected during the implementation of the EWTD. There should be no distinction between education and training. Possible conflict between service and training must be recognised. Training costs include time and money.

There is a need to identify the numbers needed in each specialty in order to ascertain how many we need to train each year. It was suggested that the Health Service Executive could take on this role. In doing this, it must be borne in mind that Ireland currently has one of the lowest ratios of consultants to population in the OECD.

There should be QA at trainee and trainer level. The quality of training benefits if assessments are done by teams which include an element of external expertise, e.g. as per the RCSI surgical training programme.

Could the Medical Council play a more active role in QA for training?
If more resources are provided – staffing and protected time

The networking of hospitals provides an opportunity to improve systems. Clinical audit is considered desirable among all health professionals but needs more structure and support. Implementation must be supported by both employers and training bodies.

Summary of Session 5: Duration and Capacity of Training Programmes[7]

Implications of reduced working hours on training

- reduction in hands-on experience for NCHDs. This could have a negative effect on the competency of trainees and their potential as future trainers in some specialties, e.g. surgery and anaesthesia more likely to be affected and training programmes may have to adapt.
- shift work patterns may interfere with the training aspect of follow-on care – trainees may miss the final outcome of patient care
- trainees may not be present when important cases are presented although this may be offset by increased workload in regional hospitals
- more training may have to take place off-site
- some specialties may have difficulties in providing training within shorter week
- possible concentration of skills in training centres

Capacity of existing programmes

- it is encouraging that programmes can supply trained specialists but possibly over a longer period of time
- very important to maintain a level of competition for training and consultant posts.

Duration-based training vs competency-based training

- competency-based training already adopted by some specialties
- centres of excellence, as proposed, will assist competency-based training
- surgeons consider that they may not be able to provide adequate training in a 58 hour week over 6 years.

It was felt that some training should be carried out abroad, thus increasing sub-specialty training and making the doctor a better trainer in the future. It was accepted that if training/tutorials were to take place off-site, the 58 hour week would be easier to comply with.

The training bodies expressed concern that they have not yet been instructed to increase the numbers to be trained**.** They would welcome discussions with DOHC and employing authorities. It was suggested that maybe an additional medical school is required.

Comhairle na nOspidéal and National Hospitals Office need to co-ordinate their efforts in order to get the numbers of SpRs and SHOs in the correct proportion.

[7] Session 5: *Dr John Devlin(Chair), Dr Maeve Eogan (Rapporteur).*
Participants: Mr Robert Acheson, Ms Mary Brady, Declan Buckley, Dr Patricia Crowley, Ms Audrey Cunningham, Professor Anthony Cunningham, Dr Christopher Dick, Dr Rory Dwyer, Dr Maeve Eogan, Dr Helen Fenlon, Ms Alison Geraghty, Ms Karen Hubbard, Dr Imelda Lambert, Professor Gerry Loftus, Ms Ciara Mellett, Ms Eilis McAuliffe, Mr Eamonn McManus, Mr. Brendan Mulligan, Dr O'Neill, Mr William Quinlan, Ms Lorraine Rafter, Mr Joseph Richardson, Ms Margaret Sorohan, Mr David Sweeney, Professor W Arthur Tanner

Concern was raised that NCHDs may be asked to work more anti-social hours under the new system and that the timescale for implementation is unrealistic.

The quality of staff and patient care must not be compromised. Strong leadership is required to help phase the EWTD in.

Summary of Session 6: Managing Change[8]

Concerns

- there will be service gaps when the EWTD is implemented
- time frame left for the implementation of the EWTD means that it is unlikely to be met in full
- time for training must be protected
- where will the graduates come from to fill intern posts?
- service must remain patient-centred
- quality of training could be compromised
- training bodies may not have sufficient consultation mechanisms with trainees, or sought their views

Solutions

- changes to undergraduate system
  - possible expansion in numbers
  - graduate entry
  - consider demographics
- protect good practice that already exists in Ireland
- NCHD duties should be defined
- Hanly proposals on immediate steps to reduce hours should be implemented, e.g. skill mix initiatives, cross-cover, reduction of tiered on-call, etc.
- competency-based model should apply to all specialties
- end to non-training posts
- associate specialist may be required
- more communication between training bodies, employers, medical schools/trainees
- protected time critical to ensure excellence in training
- doctors are often leaders of teams and must understand the work, etc. of other disciplines

[8] Session 6: *Dr Mary Hynes (Chair), Dr Glen Doherty (Rapporteur).*
Participants: Mr John Bulfin, Dr Brídín Cannon, Ms Christina Carney, Mr Andrew Condon, Mr Rory Costello, Mr Fergal Costello, Ms Iris Cranley, Mr John Doyle, Mr Donal Duffy, Ms Gráinne Duffy, Dr Kate Ganter, Mr Fergal Goodman, Mr David Hanly, Dr Roisin Healy, Dr Seamus Healy, Ms Catherine Hogan, Mr Michael Horgan, Mr Fintan Hourihan, Dr Chris Luke, Mr Gavin Maguire, Dr John McAdoo, Mr Dan McCarthy, Ms Mary McCarthy, Mr Kevin Molloy, Ms Elaine Murphy, Ms Angie Noonan, Ms Marie O'Boyle, Mr Barry O'Brien, Mr Larry O'Reilly, Dr Siobhan O'Shea, Dr Roddy Quinn, Mr Pawan Rajpal, Mr John Russell, Professor Oscar Traynor

Retaining Irish graduates

- improve employment prospects
- flexible training
- perception that training abroad enhances advancement in Ireland
- incentives for returning trained graduates
- trainees in general, would prefer a consultant-provided service.

Summary of plenary open forum discussion

Mr Bernard Carey, Director, Personnel Management and Development, Department of Health and Children chaired a plenary open forum discussion in the afternoon. The chairperson form each of the "breakout" sessions together with the speakers from the morning session formed the panel. Many participants welcomed the opportunity for all sides to come together and share views. It was emphasised that managers, consultants, NCHDs and training bodies should consult more often.

How committed is the Department of Health and Children to the implementation of EWTD and Hanly, especially the training reforms?

- It is now government policy to implement the Hanly report
- There is no choice in implementing the EWTD – it is EU law
- At this stage, it is not possible to seek a derogation from the EWTD
- The commitment of all stakeholders working in partnership, not only the Department of Health and Children, is vital to successful implementation
- Resources for the whole package of the reform are implicit in the Hanly recommendations, which include bed capacity, ancillary professions, restructuring, primary care, ambulance services, continuing care
- The implementation of the EWTD and Hanly are linked
- There will be an announcement from the Minister shortly on the implementation teams

What is required for the number of consultants to be increased and when will this begin?

- The government is committed to implementing the recommendations of the Hanly Report which include increasing consultant numbers
- Resources are required
- Training bodies must start preparing to train sufficient NCHDs to meet the initial and longer term consultant staffing requirements
- Increasing the overall numbers of NCHDs, other than in structured training posts, is contrary to Hanly recommendations
- Approval for posts takes too long
- The long time lag between the commencement of training and being eligible for a consultant position dictates that urgent action is required to increase the number training posts
- May need more medical students

Training during transition to the Hanly model

- Protected time for training for the trainers and trainees is necessary
- Medical Council has a statutory responsibility for MET. The Council will be focussing more on postgraduate MET in the future

- Training bodies need to consult and share protocols, developments, etc. with each other
- Training bodies need to closely monitor training in the Hanly Phase 1 regions
- Changes in training can take place and be tested in other than in the Hanly Phase 1 regions
- Training need not suffer with shorter hours if efficiently reorganised[9]
- Focus on all NCHDs in genuine training posts
- Promote family-friendly policies
- Service pressure will affect undergraduate MET – clinical teaching, research
- The focus of this seminar on training should be principally on improving quality rather than on maintaining minimum standards
- Reduced working hours may compromise some of the current research opportunities

Will service deficits occur?

- Hanly does not envisage drop in services. There is a legal obligation to implement the EWTD but there is an overriding obligation to preserve safe clinical service
- Hanly recommend changes to work practices to help reduce hours for the August 2004 deadline, e.g. cross-cover arrangements, reduction in tiered on-call
- Smaller hospitals will have more difficulty meeting the target
- Elective care is in danger. Minister must be warned that there may be a service gap.

Other issues raised

- Does the patient have a right to a named physician and will this continue to be the case?
- All stakeholders must be willing to examine long time practices - a different way of working is possible

[9] For example, Danish vascular surgical trainees take part in as many training-indexed procedures as their UK counterparts whose average working hours are approximately double those in Denmark as per Dr Jes Sandermann's presentation (attached)

Concluding Remarks

Professor Anthony Clare, Consultant General Adult Psychiatrist at St Patrick's Hospital, Dublin, rounded off the day with some insightful and often wry observations on the preceding discussions.

He mused that the invitation to him to deliver the concluding reflections on the day's debate might owe more than a little to the fact that, if psychiatrists as a profession could lay claim to a particular clinical skill, it was their ability to recognise delusional thinking when presented with it (though he went on to acknowledge the widely-held view that, having made the diagnosis, psychiatrists can seldom offer any cure for the condition)!

He noted that the reality is that the EWTD *is* going to happen. We can't just ignore it and pretend it will go away, however desperately we might wish it would do so. There isn't going to be any 11th hour reprieve. Nobody made a mistake. It *is* coming in on the 1st August. *This* year.

We must trust each other, which in some cases will be a leap of faith as we have all had reasons in the past to doubt each other. Now is the time to stop blaming one another and to work together to find a solution that suits all parties.

We are presented with a marvellous opportunity for real reform. We can challenge traditional training and thinking and improve the service to the patients in the process. We all want to work in a service we can be proud of.