AN BORD MIOCHAINE AGUS DEIDLIACHTA IARCHEIME
THE POSTGRADUATE MEDICAL AND DENTAL BOARD

REPORT OF SYMPOSIUM
ON
MONOSPECIALIST TRAINING
MULTIDISCIPLINARY NEEDS
THE POSTGRADUATE MEDICAL AND DENTAL BOARD

REPORT OF SYMPOSIUM

ON

MONOSPECIALIST TRAINING AND MULTIDISCIPLINARY NEEDS
Symposium on Monospecialist Training and Multidisciplinary Needs

A Symposium on Monospecialist Training and Multidisciplinary Needs was held under the auspices of the Postgraduate Medical and Dental Board, in the Royal College of Physicians of Ireland, on 28 October, 1983.

The Symposium had been prompted by views expressed by the health board chief executive officers in contacts with the Board that there is an urgent need to review the training of consultant staff of all disciplines in order to satisfy the service needs of the Irish health services and more especially in the hospital services as they are now evolving. The chief executive officers had expressed concern that current training schemes were geared to specialisation within disciplines as against overall general training.

The Chairman of the Board, Dr. BG Alton, presided and the principal speakers were as follows:

- Mr. PG McQuillan, Chief Executive Officer, South Eastern Health Board
- Professor MP Brady, Irish Surgical Postgraduate Training Committee
- Mr. DJ Doherty, Chief Executive Officer, Midland Health Board
- Dr. RP Towers, Faculty of Pathology
- Dr. P O'Regan, Senior Registrar (Medicine), Mater Hospital
- Dr. AR Morrison, Chief Administrative Medical Officer, Highland Health Board, Scotland.

The attendance included representatives of the health boards, voluntary hospitals outside Dublin, professional training bodies, Comhairle na nOspideal, Department of Health, Irish Medical Association, Medical Council and Medical Union. Several members of the Board were in attendance as were the Co-ordinators of Postgraduate Education. In all there was an attendance of about 70.

This report is a summary, not a verbatim account of the proceedings.
Introduction by Chairman of Board

In welcoming those present Dr. Alton said that the subject of the Symposium was both a major point in terms of postgraduate education and in terms of its impact on service needs. The aim of the Symposium would be to pin point the existing problems and to see a way forward. The achievement of these aims would be dependent upon the contributions and opinions of those present and he looked forward to a lively discussion in response to the formal papers. He would briefly put the matter in perspective by saying that each general hospital has a catchment area where problems can be treated in a routine way. In addition there is a small number of larger regional hospitals which in addition to serving a catchment area have the task of providing regional and in some cases national specialties and such hospitals are staffed accordingly and in most cases by monospecialists. In the smaller general hospitals the level of consultant staffing is much smaller and such hospitals must aim to provide a good and cost effective service. Clearly such smaller hospitals could not be staffed with large teams of monospecialists. Three approaches to the issue have been advanced in the past:

(a) the approach of rationalising hospital services along the lines advocated in the Fitzgerald Report. It was clear now that that particular approach had not been wholly accepted and the structure of general hospital services as now evolving was quite different.

(b) a second approach would be one based on an alteration of the training of doctors to produce a core of consultants who would specifically meet the needs of the smaller hospitals. It might be said that this was an easy and obvious solution but it can conflict with the type of training to which doctors aspire.

(c) the third approach might be one based on an alteration of the staffing structure of the smaller hospitals. Perhaps the substitution of some NCHD posts by an increased number of consultants would be a solution to the problem.

The Postgraduate Medical and Dental Board would hope that the Symposium would provide a forum for an airing of the topic in its many aspects, pin-pointing problems and perhaps suggesting possible ways forward.
Summary of Paper by Mr. P.G. McQuillan, Chief Executive Officer, South-Eastern Health Board

I would like to thank the Postgraduate Board for inviting the Health Board Chief Executive Officers to contribute to your debate on Monospecialist Training and Multidisciplinary Needs.

I have spoken before on this issue in another forum in relation to pathology and this aspect of the problem will be the subject today of a paper from my colleague Denis Doherty of the Midland Health Board.

My brief today is to say something about the problem in general and to relate it in particular to the specialty of orthopaedics.

In general the problem that presents to those responsible for developing the health services is that the systems of training which are based on practice outside this island and which are influenced by developments in technology and in medical and other sciences, do not appear to produce a practitioner whose training is best suited to the Irish situation in which he will practice.

This is not peculiar to surgery or pathology. It is a general issue and is part of a total trend and not peculiar to medicine. Neither is it peculiar to Ireland. The peripheral areas of the United Kingdom and the health services of the Scottish highlands and islands, the Welsh valleys and the moors of Devon and Cornwall suffer the same disabilities in this regard as Letterkenny, Tralee and Wexford.

The question which must be asked is - who determines the type of doctor which the system will produce? Is it the Government which has a planning responsibility? Is it the Health Agencies which have the statutory responsibility for delivering the service?

Is it the patients whose needs must be paramount? Is it the large training hospitals associated with the university centres? Is it the technology developers who are pushing the frontiers of invention? Is it the scientists, academics and researchers who are daily adding to the corpus of medical knowledge?

The problem is simple, but the solution is not. The problem is, that given a spread of population which is normal in Ireland (outside Dublin) and in many parts of the United Kingdom, can we produce a corps of specialists who will be capable of manning the hospitals of the future here; or will the increasing specialisation under the impetus of the current training system, create insuperable and unacceptable difficulties for the future organisation of consultant medical services in this country and create health service hospital costs which will result in the best driving out the good in hospital services for our citizens.
In relation to Orthopaedic Surgery the problem of the number, type and location of consultant appointments was considered in 1976 by a sub-committee of Comhairle na nOspideal and was the subject of a discussion paper published in May, 1977. The problem presenting to the hospital system was that the training programme of general surgeons no longer included orthopaedics as that branch of surgery began developing as a separate specialty.

Many hospitals which were hitherto staffed by general surgeons, who carried responsibility for all surgical cases presenting, found that as vacancies arose and new appointments were made the new appointees had little or no experience of or training in dealing with fractures etc. (apart from some experience at junior level) and were naturally reluctant to carry the same range of responsibility as their predecessors. A new need was therefore created, not primarily by the requirements of patients but by the system of training being followed.

Comhairle na nOspideal proposed a compromise system of appointments of groups of orthopaedic surgeons to regional elective surgery centres, each surgeon having an association with an acute general surgical hospital with a catchment responsibility. This practice has been followed with varying degrees of success in recent years. Its success has been tempered by the difficulties some orthopaedic surgeons have in getting access to beds and theatre facilities in their general hospital, in some cases by demands for special dedicated theatres for non-elective orthopaedic work in general hospitals and in other cases by logistical problems associated with the distance apart of locations of practice.

In other general consultant practices problems of a similar kind have arisen e.g. pathology (of which more anon in Mr. Doherty's paper) and radiology (especially in relation to ultra sound). Both of these are practised in all acute general hospitals. Developing Specialties in regional-type practices e.g., Ophthalology, ENT etc. do not create as many problems as there are clusters of practitioners in limited locations and sub-specialisation is an acceptable, valuable and practicable proposition. In paediatrics a tendency to separate into neo-natology and children's medicine is now likely to be a new problem for provincial general hospitals many of which have at present no paediatric consultants at all or possibly only one. Will the future appointees to these posts continue to carry the full range of responsibilities their predecessors did or will paediatrics follow the example of general medicine and fragment yet again into further sub-divisions?

It seems to this speaker that some consideration needs to be given to the kind of hospital services etc. the population of this country needs, and the profession should consider the means of promoting this rather than having the future organisation and provision of services dictated by other considerations which arise in the large highly specialised training centres of the United Kingdom and the United States of America.

Do we attempt to establish training systems suitable to our needs or do we change the organisation and location of services to suit the skills and aspirations of the doctors who are trained in an education system geared to other situations ....... and who decides these things?
Mr. Chairman in this brief paper which I have entitled "Monospecialist Training in General Surgery and Multidisciplinary Needs" I outline the current training scheme in general surgery following which I raise a number of issues which I hope will stimulate discussion in the afternoon.

After a six year undergraduate course and a one year internship, the general surgeon aspirant spends two years in prefellowship training (we call this prefellowship training in Surgery in General) as a senior house officer and one year as a registrar. Formal training is completed by 4 further years as a Senior Registrar in General Surgery.

Under the present regulations, two examinations have to be passed to allow continued progress. The primary fellowship is taken during the first year post internship or the first year of prefellowship training. The final fellowship is taken at the completion of prefellowship training in Surgery in General. Some candidates, especially those who aspire to an academic career, take a Masters Degree in Surgery in one of the Universities. This usually requires a year of full-time research which may be done before obtaining a post as a senior registrar, or as one of the four senior registrar years.

Supervision is by the Irish Surgical Postgraduate Training Committee (and its General Surgery Sub-Committee) which is based in the RCSI but which is not a Committee of the College. The Committee is representative of the RCSI, the Medical Schools, the Department of Health, Specialist Organisations, Health Board Consultants, Trainees and of the Representative Medical Organisations. It is a member of the Joint Committee on Higher Surgical Training and is recognised by the Medical Council and by the Postgraduate Medical and Dental Board.

It is obvious that the minimum period of training post internship is now seven years. It is not possible for a candidate to complete his/her training in the minimum time. Currently the minimum period between completion of prefellowship training and obtaining a senior registrar post is two years.

This two year period and the time spent after completion of training awaiting a consultant post is of importance. It is possible for the candidate to use this time in order to complete a curriculum vitae in accordance with ultimate career aspiration.

I would suggest that employing authorities, utilising appropriate professional advice should develop comprehensive job descriptions for posts in their respective institutions. The greater the difficulty in finding suitable candidates for such posts the more essential such an exercise becomes.
Using general surgery in a county hospital (district general hospital) as an example a candidate should be capable of in addition to his general skills, acting as the "surgeon of first contact" in the specialties of urology, orthopaedics and traumatology and thoracic surgery. This does not mean that he must be fully trained in these specialties but should be capable of dealing with what must be done immediately. Certain special technical procedures e.g. caesarian sections and dealing with a subdural haematoma may also be required.

The serious candidate for a county surgeons post should have no difficulty in preparing himself for such post under the present system particularly as there is a time lapse between completion of prefellowship training and appointment to senior registrar posts and a further period of time generally elapses between completion of higher-training and appointment to a consultant post.

This paper would be incomplete without mentioning another problem. For the last three county surgeon posts advertised in the State there were no applications received from members or graduates of the official training scheme. The reasons for this may be geographic or because of the intrinsic lack of attraction of such posts from the professional viewpoint or both.

The distribution of surgical facilities in this country has been decided. The need for some degree of centralisation is no longer a matter of debate. It may be that in the future economic considerations will compel more highly qualified people to apply for posts hitherto they would not consider.

But one problem may be solved and another created if this happens. It is necessary that a surgeon has an adequate workload both in numbers and variety of clinical material. "The under worked surgeon may present as much of a problem as the over worked one". This issue hasn't been discussed much up to now. It is a situation which is beginning to develop.

The Irish Surgical Postgraduate Training Committee is concerned with standards. Some consideration is being given to the type of training which should be provided here for overseas (from outside the EEC) candidates returning to work in under developed countries. Such training will differ somewhat from the long and specialised course undergone by our own nationals and the nationals of other EEC countries. The current thinking of the Committee would be opposed to a two tier system for this country.

The introduction of some mobility, at least in the earlier years, might be considered. The younger consultant surgeon, I would personally prefer the term specialist, could move to a larger centre after a period of say 5 years in a smaller hospital. The organisation of such a scheme would be difficult but it might be possible to enlist help from the Local Appointments Commission, for example, in the weighting given to particular types of experience.

In summary there are two main problems:

(a) the lack of comprehensive job descriptions, and

(b) how to face up to the fact that there may be lack of job satisfaction in the smaller hospital with inadequate back-up facilities and workload for two surgeons.
Summary of Paper by Mr. DJ Doherty, Chief Executive Officer, Midland Health Board

Fifteen years after the publication of the 'Fitzgerald Report' a clear picture of future general hospital provision has still not emerged. The recommended movement away from County Hospitals towards a smaller number of acute hospitals has proved to be unacceptable to communities faced with the downgrading of their local hospital and they have succeeded in persuading their public representatives to support their view.

Based on current trends it appears likely that, for the foreseeable future, at least half of the general hospitals in the State will be within the 150 to 350 beds range catering for acute general services namely surgery, medicine, paediatrics, obstetrics and gynaecology. The consultant medical staffing needs of these hospitals will be catered for by approximately 12 - 14 full time appointments supplemented by a number of visiting consultants providing mainly out-patient services.

Perhaps ten of the 12 - 14 full time posts will almost certainly be filled by dual appointments in surgery, medicine, obstetrics/gynaecology, paediatrics and anaesthetics. It is less clear how radiological and pathological services, at consultant level, will be provided. If geriatric medicine and rheumatology services are to be developed at the smaller general hospitals consideration will have to be given as to how best these specialties should be staffed.

As health services costs continue to escalate at an unacceptable rate much critical attention is being focused and is likely to continue to be focused on the costs of providing acute hospital services. It is likely acute hospitals, large and small, will be called upon to be more responsive to the genuine needs for acute hospital services within diminishing budgets, in real terms, for such services. More effective use of out-patient services, day beds and Monday - Friday wards are being advocated as responses likely to result in increased efficiency. These measures are likely to be effective only if the appropriate range of clinical and clinical support services are adequate and well co-ordinated.
I propose now to take Consultant Pathology staffing as an example of inadequacy of provision and difficulty of co-ordination. Pathology, as a medical specialty, has traditionally had strong academic links with training laboratories attached to training hospitals in Britain and North America. The response to the need to appoint Pathologists to provincial hospitals was to look to these traditional sources of supply to meet the expanding need.

The initial needs were indeed largely met by the recruitment of Irish graduates who had joined training programmes in North America and, to a lesser extent, in Britain in anticipation of an expansion of work opportunities in the specialty in Ireland. This initial success in increasing the number of Pathologists in provincial hospitals may have delayed consideration of the difficulties likely to arise in meeting the expanding needs of these hospitals. The addition of a full time Pathologist, typically with a major interest in Histopathology, represented a major improvement on the limited visiting service available previously but the inadequacy of post qualification continuing education facilities coupled with a progressive move towards mono-specialisation resulted in increased unmet needs within a short period.

Training programmes understandably evolve to meet the service and employment needs of the hospitals for which a majority of their trainees are being trained. In the United States, the term Pathologist is becoming restricted to include mainly Histopathologists and Morbid Anatomists. In Britain general hospitals tend to cater for catchment areas significantly larger than their counterparts in provincial Ireland and consequently can justify the employment of large numbers of Consultant Pathologists and a greater degree of specialisation.
As the trend towards mono-specialisation within pathology continues consideration is being given to how the Biochemistry, Haematology and Microbiology requirements of provincial hospitals should be catered for. Clearly only the larger laboratories can justify the appointment of a Pathologist in each of the five main divisions of the specialty.

Suggested solutions would involve the establishment of Regional Laboratories to serve the hospital at which the main laboratory is based plus a number of 'satellite' laboratories. Solutions of this type may involve visits by Pathologists to the 'satellite' laboratories depending on what is considered to suit an area best. The hospitals at which the satellite laboratories are located are unlikely to function or to be considered 'satellites' of the hospital at which main laboratory is based, for the clinical specialties. What may represent an efficient way of organising pathology services may not represent an efficient or an effective solution to the pathology requirements of the individual hospitals.

To what extent are clinical standards likely to be affected by the presence of an on the spot availability of appropriate advice on pathology to members of the clinical teams?

To what extent will the efficient use of diagnostic beds, day beds, five day week wards etc, be influenced by the availability or absence of appropriate pathological services advice at Consultant level?

These are questions which need to be addressed at the highest postgraduate medical education level with due regard to the size, type and distribution of our general hospital network and with regard also to the manpower resources which can be devoted to developing the pathology specialty and mainstream practice in the training and deployment of Pathologists.
I have used the pathology specialty to illustrate a difficulty being encountered by the smaller general hospitals. The difficulty in this specialty has been with us for some time and is reasonably well recognised. This problem is not, however, confined to pathology. The situation in relation to radiology is somewhat similar. Difficulties of a similar kind are emerging in the general medicine and general surgery specialties. Not very long ago certain orthopaedic and E.N.T. procedures were an accepted part of the work of a general surgeon. They are not so nowadays. General medicine appears to be moving in a similar direction. If the experience of the way specialisation in pathology has evolved is repeated in general surgery and general medicine the likelihood is that the present custom of seeking generalists with a special interest will progress in time to sub-specialisation.

The examples I have given demonstrate, I trust, the difficulty facing the Post Graduate Medical and Dental Board. Mainstream opinion leads towards sub-specialisation to a constantly increasing extent. However, something like half of the general hospitals in the State are likely to remain small. If only sub-specialists are available in the market-place the number of consultant posts may have to be increased to preserve the ability of the hospital to provide a service rather than because the workload involved justifies it. The result will be overstaffing and inadequate job satisfaction. The implications for patient care, which would result from such a development, require careful consideration.
The need for a meeting such as we are having to-day was recognised by the Faculty of Pathology when it organised a symposium with a similar title just a year ago. This was, of course, because the problem we are considering is particularly well exemplified in the case of laboratory medicine. Thirty years ago, a pathologist was expected to be reasonably competent in all branches of his specialty although most spent the larger part of their time in histopathology, performing autopsies and reporting upon surgically removed specimens. The explosion of knowledge and technique has made it virtually impossible for an individual to maintain an adequately high standard of performance in more than one area. The major disciplines are, in case anyone is in doubt, histopathology, microbiology, haematology, clinical chemistry and immunology. Further specialisation into neuropathology, forensic pathology, blood banking, paediatric and obstetrical/gynaecological pathology is commonplace and the trend nowadays is for further subspecialisation, to deal with topics such as renal, gastrointestinal or lymph node disease. In practice, many pathologists develop a special interest in diseases of an organ system or a specific disorder which means that, in a large department with a number of staff, broad coverage at an advanced level can be given.

The point is often made - and no doubt will be made again to-day - that smaller hospitals can make do with single general purpose pathologists who will refer problems on to more major institutions. This approach seems to me to gloss over two awkward facts: problems do not come labelled as such and the difficulty of obtaining adequate training in several disciplines, even if we accept that this is desirable. With regard to the first point, unless a person has been well trained, a problem may not be recognised as such at all. Nowadays, treatment of patients is increasingly specific and sometimes hazardous: diagnosis must be as exact as possible. Unfortunately, to take one example, in the field of lymphoma not only does categorisation of these not uncommon neoplasms present much difficulty but recognition that an enlarged lymph-node is cancerous, rather than representing a reaction to some inflammatory process or drug, can stretch the abilities of an expert. The increasing use of the endoscope, from which scarcely any cavity or orifice is exempt, percutaneous needle biopsy of the liver and kidney, punch biopsy of the skin and aspiration cytology, all of these not only increase the demand on the pathologists' skills but are expected by the well-trained clinical consultants who are not working in so many of our smaller country hospitals. Most of the procedures mentioned are technically within the range of a small hospital but interpretation of the sections and smears may place a considerable strain upon the diagnostic acumen of the pathologist.

If I have spoken at some length about histopathology, it is because I am one myself but similar problems arise in the other specialties within laboratory medicine. The modern haematologist is something of a hybrid, part clinician and part laboratory worker. It is probably true that a competent physician with the assistance of a laboratory giving basic data can deal with many routine haematological problems. No-one is going to propose that every small institution should attempt to treat leukaemia, do bone-marrow grafts or manage haemophilia. On the other hand, those who are familiar with the input of a good haematologist will appreciate the necessity of having consultant haematological expertise available in each Health Board area. As it is not practical to have a haematologist in each hospital, each small hospital should have clearly defined links with a major institution so that a haematologist - named and specifically appointed - should be available for
consultation and to superintend the local services, including such matters as quality control. Modern technical staff are very good indeed and a good senior technician on site with a consultant both available on the telephone and visiting regularly should enable a reasonable service to be given. Microbiology and clinical chemistry can be organised in similar fashion, the significant input of science graduates being recognised. In most cases, with this type of arrangement, there will be a consultant histopathologist on site in the smaller hospital so served.

Essentially, in this country, the problem we are discussing to-day arises because hospitals are frequently small and widely separated. Only limited staffing is practical and therefore individuals come under pressure to provide services over a range much wider than that for which they have been trained. This, of course, is not peculiar to Ireland. One solution, that put forward in the FitzGerald Report, would be to centralise hospital services so that a comparatively small number of large, fully-equipped and properly staffed hospitals would deal with the needs of the entire country. While this idea has obvious merits, it was not acceptable on political grounds, using that term in its broadest sense. Politics being the art of the possible, what alternatives are there? One such is to agree with the idea that we train doctors - and I quote from the letter which I received some months ago from the Chief Officer of the Postgraduate Board - "in order to satisfy the service needs of the Irish Health Services and more especially the hospital services as they have evolved here over the last number of years". I sense here a strong implication that, so far as laboratory medicine is concerned, we should train people as general pathologists, who single-handed or with perhaps a colleague, would provide overall services in our smaller peripheral hospitals.

At present, training in pathology in this country is largely based on preparation to take the Membership examination of the Royal College of Pathologists, which is monospecialist. The standard of this examination, which is an "exit" rather than an "entry" test, is high and possession of the MRCPath is internationally recognised. There is no question but that our major hospitals require this level of expertise. Are we then to introduce a two-tier system of training, the higher grade to MRCPath level, giving entry to a prestigious post, and the lower grade a multi-disciplinary training which would exclude its possessor from competing for a post in a major hospital? I cannot see such a system being acceptable and our Faculty would not countenance it. I have also heard it suggested that those persons who have had experience in pathology but who, for one reason or another, have not succeeded in obtaining the MRCPath, might be granted some form of diploma which might enable them to be appointed to a peripheral hospital. I would oppose such a suggestion vehemently; if there is a place for such individuals, then it is in a large department where they can work under adequate supervision. As an alternative, can one advise a Member of the Royal College of Pathologists to seek additional training in one or more disciplines other than that in which he qualified? If so, which and where? This has been suggested in correspondence relating to similar problems in Scotland but as far as I am aware, it has not got off the ground. In this case, it was suggested that a qualified histopathologist might have a year's training in haematology or microbiology, to fit him to hold a post with responsibility for two disciplines. As it was further mentioned that of course a haematologist or microbiologist could not qualify in histopathology in one year, I suspect that not much more will be heard of this suggestion.
Nevertheless, in spite of any suspicion of being unhelpful which may have been aroused by what I have just said, it is clear that something must be done to improve pathology services in our smaller hospitals. If "general" pathologists are not available (and in my opinion, undesirable) what can be done to provide a reasonable spectrum of laboratory diagnostic services? It seems to me that this might best be done by having a histopathologist in most hospitals where he can handle the routine surgical and biopsy material, provide a frozensection service, perform the autopsies give a general consultant service, taking part in hospital conferences and act as head of the pathology department. I envisage that most routine clinical pathology would be done locally by non-medical staff, more complicated work being sent to a major centre. Consultant services in haematology, microbiology and clinical chemistry should be available through specific arrangements with larger institutions. Where a local hospital merited two consultants, then one might be a specialist other than a histopathologist. Each Health Board area should have at least one microbiologist, one haematologist and one chemical pathologist. Geographical proximity or other matters of convenience might render it desirable to have individual consultants working in more than one Health Board area. A Comhairle working-party, of which I am a member, has been considering this problem for some months and I do not think I am breaking confidence if I say it is tending to take this point of view. I think it is impossible to lay down hard and fast rules and that each institution and area must seek its salvation on a largely ad-hoc basis. Of course this is not ideal but if compromise is necessary, as I think it is, then let us have compromise of this kind rather than by attempting to train a local form of multi-disciplinary feldsher who would be master of no trade. There is as little connection between my work as a histopathologist and, say, a microbiologist as there is between a physician and an obstetrician. No attempt is being made to require that newly-appointed consultant physicians in peripheral hospitals should also practise obstetrics as was the case twenty-five years ago and I do not accept that laboratory medicine differs in principle. We cannot put the clock back.
Summary of Paper by Dr. P. O'Regan, Senior Registrar (Medicine, Mater Hospital

As a State, Ireland occupies a unique position in Western Europe with at once, the lowest population density and the most rapid rate of population growth. The increasing centralisation of industrial and civil service jobs in a few large urban centres diminishes further the rural population density and produces a great imbalance in the numbers using the health services in different areas. This, then produces major problems for those involved in providing late twentieth century health care and demands an Irish solution to an Irish problem.

The Irish problem needs to be stated. It is the provision of acute specialist out-patient and in-patient services for the rapidly increasing, often socially deprived urban populous and the provision of a similar standard of service for the rural community scattered thinly in small towns and villages.

Figures published by Comhairle na nOspideal in relation to May, 1981 clearly show that there is an uneven distribution of the consultant establishment in ratio to population throughout the country. For example nationally there was 1 consultant post for each 3,000 of the population whereas in the East the ratio was 1 post per 2,100 persons and the ratio in the South East was 1 per 5,000. If one looks at the distribution of surgeon and physician posts one finds the following consultants/population ratios

<table>
<thead>
<tr>
<th></th>
<th>Surgeons</th>
<th>Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>1 per 21,600</td>
<td>1 per 17,300 persons</td>
</tr>
<tr>
<td>East</td>
<td>1 per 15,900</td>
<td>1 per 11,500 persons</td>
</tr>
<tr>
<td>South-East</td>
<td>1 per 41,600</td>
<td>1 per 46,800 persons</td>
</tr>
</tbody>
</table>

The appropriateness of the training of doctors appointed to consultant posts in the smaller city hospital and the country hospitals is often questioned. The difficulties that are mentioned most frequently are related to inadequate experience or training in some important branch of medicine or surgery, such as acute traumatic orthopaedics for the surgeon.

Two approaches may be taken to these problems. The existing hospital organisation may be changed or the training of the consultants may be made more appropriate.

As was suggested in the Fitzgerald Report, closure of the smaller country hospitals would allow the creation of larger hospitals with a larger complement of consultant staff and a wider spread of specialties, thus lessening the general expertise required by individual consultants and providing a working environment closer to that in which most consultants will have been trained. The same principles were to apply to the small hospitals in cities. In the 15 years since the report, this solution has not been socially or politically acceptable. If, therefore, no changes were to be made in the existing hospitals, consideration might be given to expanding the number of consultants in the country hospitals using as a model the British
District General Hospital which serve a similar geographical area, but a much larger population. The minimum consultant staffing would be 3 surgeons and 3 physicians each with a special interest in addition to a broad general background. This may seem impractical. However, to finance this, there would have to be a parallel reduction in the number of non consultant hospital doctors (N.C.H.Ds) which would be preceded by a reduction in the number of medical graduates, this latter, an event devoutly hoped for by most responsible medical bodies in the country including the organisers of today's symposium. It must be stressed that the N.C.H.D. reduction would be national and probably centred on the teaching hospitals, many of which are overstaffed to the detriment of the training and experience of the non consultants; the staffing of many county hospitals is already at an irreducible minimum. Additional savings would come from reduced inpatient stay and fewer admissions because of greater consultant attention, less payments for hours to cover the additional leave entitlements of consultants working 1:1 and 1:2 rotas under the common contract and reduced transport costs with the probable considerable fall in referrals to urban centres of excellence for specialist opinion.

The other approach is to change the training of doctors to make it more appropriate to the needs of the hospitals they will have to serve. The attitudes in postgraduate training to generalists, especially in Medicine, are not dissimilar to the attitudes held until recently to general practice in undergraduate training. This is more true of medicine than of surgery. No formal structure exists to assess the needs of the non teaching hospitals and to ensure that the doctors appointed are trained to meet these needs.

The average age of consultants at appointment is 38 years. This means they will have spent 14 to 16 years in non consultant training posts, located almost completely in the large urban hospitals. During this time they will have absorbed all the attitudes and ethos of big hospital practice. It is no wonder that they are often discontented and distressed when they find themselves in understaffed, underequipped and isolated peripheral hospitals. It is of equally little wonder that their performances are sometimes inadequate when the criteria on which their ability has been judged in the preceding decade and a half are of little relevance in their ultimate career post. The ability to produce original laboratory research, to write scientific papers and to always ask the right question at the end of learned lectures are highly desirable accomplishments in the teaching hospital N.C.H.D. but are of little value in the life of a busy county hospital consultant where decision making and appropriate action on a wide range of clinical problems is of prime importance and academic considerations are, at present, very much secondary.

Having defined the needs of the non teaching hospitals, how should the training programmes be changed to meet them? It must first be recognised that just as general practice is not a safety net for those who fail in the early stages of their hospital training, general medical and general surgical consultant posts are not reserved for those who fail to get the monospecialist jobs in the major hospitals. At the commencement of higher training, doctors should decide on "monospecialisation" or "generalisation". (This already happens to a large extent with surgical training). Usually mono-
specialists would ultimately be employable only in large hospitals where they would not have a general commitment and "generalists" would be employable in large or small hospitals but would be trained specifically to deal with the work of a country hospital. It would be important, therefore, that there be different weighting given to academic and practical work in the training programmes and that the research carried out by the generalist should have a clinical bearing and that it shall not be dependent on major teaching hospital facilities. Both groups shall be encouraged to work abroad for a period but only in settings appropriate to their ultimate career goals. In addition, some of the "generalists" higher training should be spent in the smaller city and county hospitals. For both groups and for physicians as well as surgeons, a logbook system of monitoring training would help to ensure that the training recommendations were fulfilled.

All this would come to nothing if appropriate appointments are not made. There is a need for full job descriptions as a contribution towards ensuring that the right person gets the right job.

The approaches to consultant training and hospital organisation modification discussed are not all practicable in the present state of the Irish economy, but as has been outlined, many of them could be introduced by a more equitable and rational use or resources already available.

One final thought. Just over 220 persons took up their first appointments as consultants in this country during the period April 1976 to March, 1981. 53.2% of them had not worked in Ireland in the previous four years, 30.5% spent some of the preceding four years working in this country. Just 16.3% spent the four years preceding their first consultant appointment working in Ireland. The training bodies should look further into this.
Summary of Paper by Dr. AR Morrison, Chief Administrative Medical Officer, Highland Health Board, Scotland

The Highland Health Board is responsible for the provision of medical services to the population of the Highland Region of Scotland i.e., the Counties of Caithness, Sutherland, Ross & Cromarty, Inverness-shire and Nairn-shire - a population of 192,000 and selected specialist services to the adjoining Western Isles Health Board with a population of 25,000. The area served is 10,000 square miles - about 1/3 of the land mass of Scotland, or 1/5 of the United Kingdom.

The population is concentrated along the Eastern Seaboard. Inverness at the head of the Moray Firth, being the only large burgh in the Region with a population of 40,000 - the old County Towns are also situated on the East Coast.

The medical services are based at Inverness where there are 810 general beds (689 acute - 121 long-stay), the only mental hospital in the Region 750 beds, and the only mental deficiency hospital 241 beds. There are specialist hospitals as follows: Thurso, 29 beds 1 Obstetrician; Wick, 131 beds, 2 Surgeons, 1 Physician; Golspie, 23 beds, 1 Surgeon; Fort William, 52 beds, 1 Surgeon, 1 Physician; Broadford, 28 beds, 1 Surgeon. When one of the surgeon posts in Wick was last vacant the Health Board sought and failed to recruit a general surgeon with experience in orthopaedics.

These hospitals all have Out-Patient Departments and are equipped with major X-ray sets - a full range of consultative out-patient clinics are provided on a monthly basis by visiting Consultants from Inverness, excepting those specialties where a locally based Consultant is in post. The only beds for Ophthalmology, Ear, Nose and Throat and Orthopaedic Surgery are at Inverness and only at Thurso are there Gynaecological beds in addition to the provision at Inverness.

LABORATORY SERVICES

The Regional Laboratories are at Inverness. The Board has accepted that medically qualified personnel are not available to staff small peripheral laboratories and most of the work arising outside Inverness, either from general practitioners or hospital services, is sent to the Inverness Laboratories.

There is a small technician staffed laboratory at Wick to undertake a limited range of tests in Clinical Chemistry, Microbiology, Blood Grouping and Haematology - this laboratory, with a Chief Medical Laboratory Scientific Officer in post, is under the general supervision of the Heads of Departments at Inverness. We consider that the current laboratory services provide an acceptable consultant based service to the Highland area hospitals and general practitioners and do not see a need to provide smaller peripheral laboratories in the charge of single-handed multi-specialist pathologists.
Surgical Specialties

Dr. Morrison then provided a series of statistics to give a guide to the type of surgical work being referred to Inverness from the peripheral hospitals. Those statistics showed that no ENT Surgery is undertaken by consultant general surgeons in the peripheral hospitals. The statistics also showed the disposal to Inverness or local treatment of patients diagnosed at the peripheral hospitals to be suffering from a fracture of the lower limb. Those figures showed, in percentage terms, the following picture for 1980 (with 1970 figures shown in brackets).

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Home</th>
<th>Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>28%(45%)</td>
<td>72%(48%)</td>
</tr>
<tr>
<td>Golspie</td>
<td>64(94)</td>
<td>25(6)</td>
</tr>
<tr>
<td>Broadford</td>
<td>59 (57)</td>
<td>41 (42)</td>
</tr>
<tr>
<td>Fort William</td>
<td>79 (83)</td>
<td>21 (17)</td>
</tr>
</tbody>
</table>

Dr. Morrison said that in his health board area there appeared to be a considerable volume of work in Ear Nose & Throat Surgery, Gynaecology and Orthopaedic Surgery which is not being undertaken locally by the Consultant General Surgeon. Yet by accepting this position we are subjecting patients to uncomfortable, possibly painful travel, relatives to costly and time-consuming journeys and denying the local surgeon the pleasure of a wider field of work.

What prevents this work being done locally? Dealing with each specialty in turn he asked:-

(a) **EAR NOSE AND THROAT SURGERY.** How difficult is it to train a Consultant General Surgeon to remove Tonsils and/or Adenoids with an acceptable degree of skill? Most of the patients concerned are children who need the support of a parent at the time of operation yet many parents are unable to leave the other children in the family to be with their child in hospital at Inverness.

(b) **GYNAECOLOGY.** How difficult is it for a Consultant General Surgeon to undertake operations on the uterus? Does he require additional training to do so, or is he so prevented by the knowledge that there is a specialist operator available at the base hospital?

(c) **ORTHOPAEDIC SURGERY.** Is it really outside the scope of a general surgeon to undertake a larger proportion of the case of fractures of the lower limb and especially fracture of the neck of the femur? What additional training is required?

The problems faced by the single-handed consultant surgeon are not confined to those working in Scotland or Ireland. Therefore it seemed to him that there is a sizeable group of general surgeons which has the same problems and which possibly may require the same solution.

He suggested additional training be offered to qualified general surgeons wishing to enter surgical practice in these situations.
Should only surgeons with this additional experience be appointed to posts in peripheral hospitals and finally should the additional experience be formally recognised by the provision of a post fellowship certificate of additional experience? The possession of such a certificate would be very important to the general surgeon extending his field of work - it would be readily recognised by the legal profession if any question arose about the area of competence of the individual surgeon and perhaps it will ensure that the specialist consultant colleague at the base hospital would accept that the local general surgeon had a proper interest in the specialist subject.
Discussion

Dr. Alton, opening the discussion listed the following options which had been put forward in the morning session and said that the Board would welcome the opinions of those present on them.

the training bodies could be asked to look at alternative modes of training

supplementary training could be provided so as to broaden the role of the specialist

a diploma might be awarded to give appropriate recognition for this supplementary training

an approach might be adopted involving two streams of training - one specialist and one generalist in content

the staffing structure in the hospitals might be altered, involving a reduction in the number of NCHDs, increasing the number of consultants and with some consequential change in the role of the consultant

a number of speakers had mentioned the production of job descriptions and this could lead to interview boards being briefed as to the precise nature of the work to be carried out and in certain circumstances it would follow that it would be appropriate to give preference to "generalists" rather than to "monospecialists".

Mr. McQuillan said that a number of interesting and worthwhile ideas had been put forward earlier in the day and if some of these were followed through some of the problems now faced by hospitals outside the university centres could be eased considerably. He felt that the suggestion put forward that job descriptions should be prepared was a welcome initiative and he was sure that his CEO colleagues would like further discussion on this; they would need general guidelines which then could be particularised for individual appointments. He was less happy with the suggestion that training programmes might continue to be structured as for monospecialists but providing supplementary training for "generalists". In his view the training programmes should be structured to take into account the needs of all hospitals. He welcomed the suggestions put forward that a change in the hospital staffing structure could be of considerable help. He would have to point out, however, that many of the hospitals outside of the university centres had very small numbers of NCHDs so that a national policy of reducing NCHD posts and increasing the number of consultants would have to be implemented in a manner which did not denude non university centres further of NCHD posts. He mentioned, also, that there has been a trend in recent years of involving general hospitals throughout the country in training programmes; this was a welcome trend but there was plenty of scope for expanding it. All provincial general hospitals should be involved in the training process. It was very important that future consultants obtained a certain amount of their training in smaller
Dr. O'Regan agreed that any proposed reduction in NCHD staffing would have to be national in character and would probably fall more heavily on teaching hospitals. He agreed that the NCHD establishment in many provincial hospitals is presently at an irreducible minimum. Referring to points made in relation to job descriptions he felt that these would be helpful for both candidates and interview boards.

Dr. D. Ward, Consultant Psychiatrist, Eastern Health Board who was attending the Symposium on the nomination of the Irish Psychiatric Training Committee said that he would wish to enter a caveat with regard to job descriptions. Job descriptions were very useful for relatively simple jobs but were much more difficult to prepare in respect of complex posts such as consultants and in fact could be too rigid for such posts. He felt that a better approach might be to inform candidates of the expected workload. Dr. Ward made another point to the effect that the public would increasingly enter the multidisciplinary versus monospecialist debate and there would be an increasing demand from the public to be treated by monospecialists.

Mr. D. Magee, Senior Registrar in general surgery said that it needed to be borne in mind that the training structures in medicine and surgery were somewhat different. General surgery is only one subsection of the surgical discipline and the training programme recognised this. It would be somewhat facile to think that it would be possible to recruit general surgeons who would also be able to deal with Orthopaedics. If it were decided to have a two tier system of training this would have major implications for the Irish training bodies and consultants and he doubted whether it would be generally acceptable. He mentioned that if two types of posts were to exist it should be borne in mind that it would be difficult for somebody who had trained as a monospecialist to change orientation. If there were to be such a system the training programmes would have to recognise this fact and provide for the two tiers at an early stage in training. He suggested that a possible approach to staffing problems would be for the health boards to select persons in training and provide them with the training needed to fill particular posts.

Mr. Magee mentioned that for any such system to be acceptable the two strands would have to be seen to be complementary with the clear aim of not creating one tier enjoying higher professional standing than the other.

Mr. McQuillan said to speak of a two tier structure implied some type of horizontal division in the training arrangements whereas he felt it would be more helpful to think in terms of vertical training schemes.
In a wide ranging contribution the principal points made by Mr. Baker, Surgeon, Bantry General Hospital, were (a) as indicated by Professor Brady a general surgeon in the Health Board General Hospitals should be capable of performing a caesarean section and uterus evacuation; experience in orthopaedics is also necessary, (b) he questioned the appropriateness of the Local Appointments Commission including Dublin based surgeons on interview boards for posts in provincial hospitals and went on to indicate that in his view there should be consultant representation on interview boards from the hospital where the appointee will work, (c) a common selection procedure is a necessity, (d) as a large percentage of surgical registrars will ultimately work in health board hospitals some of their training must be undertaken in those hospitals and (e) being a "generalist" did not make one any less a consultant.

Professor E O'Dwyer, said that while he agreed with the comments made by Professor Brady and Mr. Baker in relation to caesarean sections etc. there is, generally speaking, no place for a surgeon who has a peripheral interest in gynaecology. He went on to make the point that the trend in obstetrics/gynaecology is towards supra specialisation with three specialisations - gynaecological oncology, gynaecological endocrinology and perinatology. There would of course continue to be a role for a general obstetrician/gynaecologist and the training arrangements would have to take account of this. Referring to the comments which had already been made about a two tier structure Professor O'Dwyer said that while he recognised that this was a difficult area he felt there was a place for such tiers - some doctors may be attracted to positions where it would not be necessary to undertake the responsibilities of the consultant and this might apply particularly in the case of persons, seeking part-time appointments. In relation to previous speakers comments that the medical staffing structure might be altered he said that such an arrangement had been proposed in the Short Report in the UK and it was favoured by the DHSS there. It had met opposition from consultants particularly those who have been recently appointed who foresaw such a development as changing the working role of the consultant. He went on to mention that the Royal College of Obstetricians and Gynaecologists has recently published a Consultative Document in relation to Manpower and Training. This document recommends that in the UK there should be a gradual balanced increase in the number of consultant posts and while it did not anticipate that there should be any decrease in the overall numbers of junior staff the proportion of consultants to NCHDs would obviously be increased. The document also proposed the development of a "specialist" grade particularly for the part-time doctor practising medical gynaecology, ultrasonography etc.

Professor CF McCarthy made three brief comments. Firstly he said that he agreed with the reservations expressed by Dr. Ward in relation to job descriptions for consultant posts but, in his view, health boards should be able to say that experience in a particular branch of medicine would be an advantage when competing for posts. In relation to the points made in Professor Brady's paper that some hospitals did not provide sufficient work for two surgeons and two physicians etc. he felt that not enough attention had been paid to carrying out research in those hospitals. Operational research should be part of every consultants post and the common contract
recognised this. As regards the development of our general hospitals he would question the assumptions which seem to be gaining currency that it is not possible to change direction on rationalisation of the services.

Professor Brady spoke in agreement of the point just made in relation to hospitals being involved in research. He felt that in relation to hospital rationalisation it was necessary for medical staff to learn to live with the fact that the political will was not available to agree on a system like that advocated in the Fitzgerald Report.

Responding to a point made by Dr Patricia Fitzsimons, Radiology Registrar, that over 50% of the trainees in radiology, pathology and obstetrics are women and enquiring whether any consideration has been given towards the introduction of part-time job opportunities and job sharing positions Dr. S. Hewitt, Chairman, Institute of Obstetricians and Gynaecologists said that the Institute was in the process of organising such opportunities at the training level and it hoped that similar opportunities will be available for consultants.

Mr. G. Martin, Chief Officer, Comhairle na nOspidéal said that the problem posed to the Symposium was one that he had lived with for a considerable time and one for which it was difficult to find solutions. All of the emphasis to date has been on the problems of the smaller hospitals but a lack of general physicians and general surgeons also poses a problem for larger hospitals. There is a need to look at the structure of training involving, as it does, three years general work and four years of higher specialisation. This emphasis should be noted. Higher specialist training takes place in the larger hospitals with virtually no involvement of the small hospitals. The orientation in training is towards monospecialisation. Consultants are trained in a monodisciplinary ethos. Supplementary training is not a viable alternative since the requirement for additional training would have the effect of making it even more difficult for the smaller hospitals to attract high quality candidates. Regarding job descriptions, Comhairle has tried this approach without success. In a large city hospital a vacancy was advertised for a general physician but the consultant selected was a monospecialist. Four years later a request was received for a restructuring of the post with a "special interest". The approach of increasing consultant posts at the expense of NCHDs was not an answer to the problem under discussion but to the general manpower problem. There is a need to review the fundamentals of how we train doctors. Why not, for example, train obstetricians/neonatologists and general surgeons/gynaecologists? This type of approach at least ought to be examined. The problem presented has been growing since the 1960's. The Fitzgerald Report indicated a physical solution which has been found not to be acceptable. The challenge now is to train people to fit the existing hospital system.
Dr. Towers reported on a recent survey of pathologists in which 17 of the 70 respondents indicated that they were multidisciplinary. While the discussion at the symposium had centred on the modification of training he asked why greater effort could not be made to modify public opinion which opposes the closure of smaller hospitals. As regards methods of appointment he felt that proleptic appointments might be considered in certain circumstances. In pathology he felt that there was scope for a permanent NCHD grade, perhaps making it obligatory to hold an appointment in such a grade before being appointed as a consultant. He also felt that there was scope for part-time appointments.

Dr. N. Tierney, Department of Health said that he could not but feel that there was a certain amount of narcissism about the discussion. It was necessary to face the reality of the type of hospital structure which the public felt they needed and training would have to be structured to meet those needs. Referring to the point made about job descriptions and whether they were feasible or not he said that under the present Local Appointments Commission selection procedure health boards were entitled to nominate a person to the interview board and such persons could be fully briefed by the health board as to the workload and content. He felt that the Department of Health would welcome a change in the staffing structures, along the lines which been discussed by other speakers and he mentioned that student intake to medical schools will in any case be reduced in the future. Dr. Tierney also referred to a number of other points made by previous speakers and indicated that a recent survey by the Department had shown that 50% of fracture work was carried out by non orthopaedic specialists and that it was necessary for the profession to recognise that this was the case. He supported the views put forward by previous speakers that generally speaking NCHD posts in county hospitals should be available for training purposes. He also said that there was a need to look at administrative and organisational structures, for example, surely in certain circumstances two health boards could be paired to provide more rational systems of recruitment at consultant level.

Dr. D. Powell, Co-ordinator of Postgraduate Education, said that in a discussion on how to provide training for multidisciplinary needs there was a danger of losing sight of the need to provide for monospecialist training. It was necessary to provide a training structure which produced consultants who could treat persons presenting with the less common complaints. In his view "specialists" must also be good "generalists". In the UK most specialists will take some general work, and this was both beneficial for the consultants themselves and for the trainees. It was necessary for the monospecialists to keep in contact with general medicine. Dr. C. MacA/Bhaid, Radiologist, Letterkenny said that while nobody disputed the need for monospecialists the question to be posed was where should they be placed. The provincial hospital need to have "generalists" with adequate scope for referral to a monospecialist elsewhere. Commenting on the training arrangements in these islands he said that his understanding was that the training period in specialties such as surgery radiology, medicine were longer in these islands than in other EEC countries and in the USA. He
understood, that in the US general surgery training lasted for a period of 4 years, including internship, as compared with a minimum period of 7 years here. The need for longer training periods here needed to be seriously questioned. Referring to points made by other speakers Dr. MacA/Bhaird felt that the Local Appointments Commission selection system should be modified to provide for representation from the hospital to which the appointee is being selected and it was not sufficient merely for the employing health board to be represented on the selection board.

ON a point of information Professor Brady said that it would be dangerous to take an analogy from the US in relation to surgical training. The position there had arisen from a manpower problem but the length of training is not considered sufficiently long. In Europe training is for a minimum of 6 years this is a more realistic time scale from the Irish perspective. Elaborating on points made in his paper in relation to the serious problems which can arise in relation to underworked surgeons Professor Brady mentioned particular problems which had occurred in the US leading to unnecessary operations being performed. He took the point made by Professor McCarthy that there is considerable scope for research. He hoped that with the increase in the number of consultants being appointed to the smaller hospitals a vastly increased flow of results of research carried out in those hospitals would be prepared. He concluded his remarks by referring to the beneficial stimulating effects which can flow from having trainees on ones team and mentioned the moral responsibility on consultants to provide career guidance for their NCHDs.

Dr. C. Lucey, Physician, Castlebar commented that the average age of 38 for consultants on appointment had surprised him as also had the fact that nobody from the surgical training programme had applied for the 3 most recent vacancies for Surgeons in Health Board General Hospitals. The position in relation to those competitions contained a serious message for the training body and should of course be urgently reviewed by it. There seemed to be a system akin to apartheid operating between Dublin and the peripheral hospitals. Registrars should rotate between Dublin and the periphery. Senior registrar contracts should ensure that those in higher training spend a period of 3 to 4 months acting as locum consultants in peripheral hospitals. Dr. Lucey also mentioned that there is a need for a common selection procedure at consultant level.

Dr. O'Regan said that he agreed with the points made by Mr. Martin in relation to "generalists". A steady erosion of the role of the "generalist" had taken place. The generalist intake to hospitals should be dealt with by generalists. Some hospitals have replaced "generalists" with monospecialists and this had happened even in the case of some smaller hospitals. As regards selection procedures Dr. O'Regan pointed to the great differences which exist between the health board and voluntary hospitals sectors. In his view the individual voluntary hospitals have too great an input.
Dr. M. Smith, Radiologist, Mullingar pointed out that in his view there is a dichotomy between the needs of the large and the small hospitals. He mentioned that while he was training in the UK he had rotated between a teaching hospital and a general hospital. Unfortunately such rotations do not take place here and there was a very good case for its introduction in that (a) it serves to provide the trainee with an insight to the different work situations and the needs of different types of centres, (b) it helps to ensure that an effective diagnostic service can be made available in small hospitals and this is something which the public is quick to notice and (c) from the point of view of the consultant working in the small centre it provides him or her with regular contact with larger centres and thereby prevents the professional isolation which can occur if persons are working alone at small hospitals.

Dr. Kevin Moore, Faculty of Anaesthetists, said that the anaesthetists have attempted to keep their training as broadly based as possible. He mentioned, however, that a senior registrar in the training programme had recently been rejected for a consultant post in a smaller hospital on the grounds that he had been too highly trained. There was a need to take a firmer line in relation to the question of hospital rationalisation. There was also a need to quantify the workload in individual centres and that training had of course to be geared to meet the working requirements. He also mentioned that the perceived quality of life in some peripheral hospitals partly explains the shortage of applicants for posts in such centres.

Mr. O. Hogan, Department of Health said that he would like to comment on some of the points which had been made by previous speakers. Medical training is expensive and the training programmes should ensure that persons are trained for the work they will be expected to carry out. He mentioned that we have a very high number of hospital beds and gave as an illustration of this that while Dr. Morrison had indicated that there were in the region of 2,000 beds in the Highland Health Board area of Scotland the corresponding figure for a similar size population in this country would be in the region of 3,300. Reference had been made to the imbalance which existed between the consultant/population ratio between the Eastern Health Board and other parts of the country particularly the South-East. He would argue that it was not valid merely to point to stark figures in this matter as it was necessary to take account of the fact that there are three medical schools located in Dublin, the level of admissions to acute hospitals in the area and to the higher proportion of higher specialist activity functioning on a regional or national basis which is concentrated in the major Dublin Teaching Hospital. A number of speakers had referred to a lack of political will for hospital rationalisation but it must also be borne in mind that many consultants object to providing services from one centre to another. A number of speakers had referred to the possibility of altering the medical career structure to provide for more consultants and fewer NCHDs. When he looked at the experience over the previous decade he wondered whether such
a development would in fact be acceptable to the medical profession. In the period 1972 to 1981 the consultant establishment increased by over 40% and the number of NCHD posts increased by 80%. Existing consultants have not been agreeable to share their NCHD staffs with new appointees and there was no evidence to suggest that their attitude in relation to this would change.

Dr. D. Barry, Pathologist, Letterkenny commented that oncology had only been referred to once during the course of the Symposium and he wondered why this was so. Was it because the health services and the medical profession must pay attention to the expressed demands of the public and this was a field on which the public were perhaps not as well informed as other areas. Professor Brady remarked that oncology was not recognised as a separate specialty in this country, and went on to say that 65% of tumors are treated surgically. He was aware that application had been made to recognise oncology separately but he felt that such recognition would be a retrograde step.
Dr. Alton, thanked all present for their contributions and said that the discussion and the papers during the course of the day provided much material for consideration. He said that while he would not attempt to sum up all which had been said he would just draw attention to a number of points which had been raised frequently and which appeared to him to be of major importance and which would require further attention by the various responsible competent bodies:

- registrar training programmes should provide for rotations to hospitals outside the main teaching centres
- the creation of opportunities for part-time training/jobs and work sharing arrangements needs further attention
- while varying opinions were sought on how best to proceed there was fairly general agreement that it would be desirable for employing authorities to be able to specify the work content of posts which they have or will have available
- selection boards should be fully aware of the service needs of the position they are filling and should be aware of the need to appoint suitably qualified candidates.

He concluded his remarks by saying that perhaps the most fundamental question of all was whether it was appropriate that training arrangements for this country should be so closely associated with those in the United Kingdom. Perhaps it might be more appropriate for our training programmes to place much greater emphasis on the training of "generalists" while also making provision for the training of monospecialists. He was sure that this could be negotiated while staying within the framework of reciprocity. The Postgraduate Medical and Dental Board would prepare a report of the Symposium which would be circulated to all present and to the training and employing bodies as well as to other interested parties. The Board would hope that the Report would provide the stimulus for further consideration of the topic and particularly in relation to the various suggestions which had been made today. It would be the Board's task to co-ordinate and promote such further consideration.
Addendum by Postgraduate Medical and Dental Board

This Symposium on "Monospecialist Training and Multidisciplinary Needs" was one in a series of annual symposia being held under the auspices of the Postgraduate Medical and Dental Board on topics of major importance to Irish Medical Manpower policies as well as of direct relevance to the Board's terms of reference in relation to the promotion and co-ordination of postgraduate medical and dental education and the provision of career guidance. This particular symposium was prompted by concerns expressed by the health board chief executive officers that Irish higher medical training does not, perhaps, take sufficient account of the organisation of the Irish hospital services as now being developed.

It will be clear from the preceding pages that the many aspects of the topic were aired during the course of the symposium. There is in this report much material for consideration by

- those charged with the delivery of health services,
- the training bodies,
- those charged with the selection of hospital consultants, and
- the various statutory bodies involved in medical manpower and training.

In urging the various interested bodies to study the report and to use it as an aid to an appraisal of existing policies and practices the Postgraduate Medical and Dental Board would like to draw particular attention to a number of points and themes which recur throughout the report and to comment briefly on some of them

- although the future direction of acute medical services from the institutional viewpoint seems to be decided consideration could be given as to how further rationalisation of acute hospital services might be achieved in a way that would be acceptable to the general public e.g. health boards might examine how greater co-ordination of services, including the provision of specialist facilities at peripheral hospitals, could be achieved as between their various hospitals

- the Board commends for further consideration the suggestions made during the course of the symposium that employing authorities should be able to specify, with appropriate professional assistance, the work content of the posts which they will have available in the future
it is clear that the Irish hospital services will require, in addition to monospecialists, consultants with general training and perhaps it should be made clear to prospective candidates that job specifications in respect of posts in smaller hospitals would indicate that preference would be given to consultants whose general training and special interests were particularly suitable for such posts. Another point made or touched on in the symposium in relation to this general aspect and which merits further consideration was to the need for employing authorities to ensure that adequate facilities (including facilities for postgraduate education) are made available in smaller hospitals so as to ensure that consultants working in those centres can have professional job satisfaction.

many speakers mentioned that selection boards for consultant posts in smaller hospitals should include representation from the hospital in which the vacancy exists; the Board feels that this suggestion should be considered by the appropriate bodies.

there is much in the report for consideration by the training bodies e.g. should much greater emphasis be placed on the training of "generalists" while also making provision for the training of monospecialists to international standards? Could training bodies play a greater role in the provision of consultants for the smaller hospitals by increased career guidance and better utilisation of the in-between years which now occur in the middle of training programmes and at their completion while awaiting a consultant post? The Postgraduate Medical and Dental Board particularly asks the professional training bodies to consider the contents of this report and is sure that any changes which are deemed desirable or necessary in the content or orientation of training programmes to gear them more specifically for the Irish Health Services can be brought about without putting in question the reciprocal arrangements which these training programmes already enjoy.

Postgraduate Medical and Dental Board
February, 1984