An Bord Míochaine agus Déidliachta Iarchéime
The Postgraduate Medical and Dental Board

FIRST REPORT

MARCH 1980 - 1985

Corrigan House, Fenian Street, Dublin 2. Telephone (01) 760875/760456

An Bord Míochaine agus Déidliachta Iarchéime
The Postgraduate Medical and Dental Board

FIRST REPORT

MARCH 1980 - 1985

Corrigan House, Fenian Street, Dublin 2. Telephone (01) 763875/602452

An Bord Míochaine agus Déidliachta Iarchéime
The Postgraduate Medical and Dental Board

FIRST REPORT

March 1980 - 1985

CONTENTS

List of Appendices

PREFACE

In presenting the First Report of the Postgraduate Medical and Dental Board to the Minister for Health, Mr. Barry Desmond, it must be borne in mind that the statutory duty of the Board is the fostering of postgraduate education, both in the career training years and also as a continuing process thereafter for doctors and dentists. In addition, there is the obligation to provide career guidance to the best possible advantage of the postgraduate student and to the Irish Health Service.

Unlike other statutory bodies, the Board has no real power of diktat. It has therefore been dependent on its powers of persuasion and on the goodwill, co-operation and hard work of many bodies and people.

Tribute must be paid to the Board members whose enthusiasm and interest in the remit was very obvious and was equally well balanced by their common sense appraisal of the various ideas and projects put forward for consideration; to the Department of Health which demonstrated its goodwill and belief in postgraduate education by its help and support in these difficult times; to the CEOs, the Health Boards, the Voluntary Hospitals, Dental Hospitals, the Medical Council, Comhairle na nOspidéal, Dental Board, the various training bodies and the other medical and dental organisations for their co-operation and interest; and to our predecessor, the Council for Postgraduate Medical and Dental Education on whose solid foundation the Board was enabled to build.

Special mention must be made of our Chief Officer, Mr. John Gloster, whose dedication, unremitting efforts and tact — and those of his staff, Mrs. Ann O'Cuinnegáin and Ms. Assumpta Linnane — surmounted many obstacles and ensured the translation of concepts into positive reality; of our Co-ordinators who succeeded, under considerable difficulty, in getting General Practitioner Postgraduate Centres off the ground while actively encouraging training lectures and courses in hospitals and other centres; of those doctors and dentists who undertook the management of our Pilot Schemes with great zeal, a sense of vocation and with total disregard of the inroads these made into their own personal and professional time.

In reviewing the Board's activities over the past five years, the highlight has, perhaps, been the establishment of the Pilot Schemes for the continuing education of General Practitioners, both medical and dental, — new approaches which, to the gratification of the Board have been looked at with great interest and favour by corresponding bodies overseas.

In a series of symposia, the Board has been a forerunner in drawing attention to the Medical Manpower problem (which yearly grows more acute), the effect of monospecialism and the concept of part-time training (including job-sharing).

In the realm of Career Guidance, the process of documentation, including the manpower position, has been completed. A panel of professional advisers to whom the postgraduate student may turn for help has been organised and published. A series of Career Guidance information meetings have been held at intervals in Dublin, Cork and Galway. Different methods of presentation have been attempted and the process is still an evolving one.

This preface must end with a plea. It is to those decision makers in the Department of Health, the Health Boards and the Voluntary Hospitals to ask them to remember that the provision of future and up-dated expertise is as much a part of sound economic planning as is the provision of a current efficient service.

This can only be achieved by the encouragement of active postgraduate education in this country, constantly refreshed and stimulated by the return of highly trained personnel from abroad, who will bring with them — and teach — the more advanced knowledge and techniques.

Without such an approach the standard of Medicine and Dentistry in Ireland would gradually decline to a second-class level. No one expects that the most esoteric procedures should be carried out in this country but it is surely the right of the Irish people to expect — through the provision of educational facilities — a highly qualified cost-effective Medical and Dental Service.

Bryan G. Alton
March 1985.

CHAPTER 1

Functions and Membership of Board

Introduction

1.1 Section 39 of the Medical Practitioners Act, 1978 provided for the establishment of a body known as the Postgraduate Medical and Dental Board. The Board was established with effect from 7 March, 1980 and replaced a former non-statutory Council for Postgraduate Medical and Dental Education.

Functions

1.2 The Board's statutory functions are defined in section 40 of the Medical Practitioners Act, 1978 as follows:-

(a) to promote the development of postgraduate medical and dental education and training and to co-ordinate such developments;

(b) to advise the Minister, after consultation with the bodies specified in sections 9(1) (a), 9(1) (b), 9(1) (c), 9(1) (d) and 9(1) (e) of this Act, and with such other bodies as the Board may consider appropriate, on all matters, including financial matters, relating to the development and co-ordination of post-graduate medical and dental education and training;

(c) to provide career guidance for registered medical practitioners and registered dentists.

Membership

1.3 The Medical Practitioners Act, 1978 provides that the Board shall consist of twenty-five members, appointed by the Minister for Health, of whom each shall be a person having practical experience or special knowledge of the matters relating to the functions of the Board and not less than twenty shall either be registered medical practitioners or registered dentists.

The Act also provides that the Minister for Health shall, before making appointments to the Board, consult with the Medical Council, the Dental Board, University College, Cork, University College, Dublin, University College, Galway, University of Dublin, the Royal College of Surgeons in Ireland, the Royal College of Physicians of Ireland, a body or bodies, as in his opinion represent psychiatry, a body or bodies, as in his opinion represent general medical practice, any body recognised by the Medical Council pursuant to section 38(3) of the Act (i.e. any body recognised by the Medical Council for the purpose of granting evidence of satisfactory completion of specialist training), and with any organisation which in the Minister's opinion represents, in the State, registered medical practitioners or registered dentists.

1.4 The following were appointed by the Minister for Health to be members of the Board for the five year period ending on 6 March, 1985:-

Dr. B. G. Alton, Mater Hospital, Dublin.
Dr. J. P. Alvey, National Maternity Hospital, Holles Street, Dublin.
Professor B. E. Barrett, University College, Cork.
Dr. M. M. Berber, 69 Upper Churchtown Road, Dublin.
Professor G. Bourke, University College, Dublin.
Professor M. P. Brady, Regional Hospital, Cork and University College, Cork.
Professor A. D. H. Browne, Rotunda Hospital, Dublin.
Professor R. J. Daly, Regional Hospital, Cork and University College, Cork.

Mr. D. Q. Dudley, Chief Executive Officer, Southern Health Board.
Professor D. O'B. Hourihane, Trinity College, Dublin.
Mr. B. Joyce, B.D.S., Arklow, Co. Wicklow.
Mr. V. Morris, President, Dental Board.
Professor C. F. McCarthy, Regional Hospital, Galway.
Mr. G. MacGabhann, Secretary/Manager, Mater Hospital, Dublin.
Dr. C. S. Macnamara, Newtown, Waterford.
Dr. G. O'Byrne, Regional Hospital, Cork.
Dr. J. O'Callaghan, 82 Delwood Drive, Castleknock, Co. Dublin.
Professor N. O'Higgins, St. Vincent's Hospital, Dublin and University College, Dublin.
Professor E. O'Malley, Mater Hospital, Dublin.
Dr. D. O'Mullane, Chief Dental Officer, Department of Health (present appointment is in University College, Cork).
Dr. M. Ryan, St. Laurence's/Jervis Street Hospitals, Dublin.
Dr. W. Shannon, Hawkes Road, Bishopstown, Cork.
Dr. E. Tempany, Our Lady's Hospital for Sick Children, Dublin.
Dr. N. Tierney, Senior Medical Officer, Department of Health.
Dr. W. Wren, Our Lady's Hospital for Sick Children, Dublin.

1.5 There have been three changes in the membership of the Board during the period under review. **Dr. G. O'Byrne** resigned in September, 1981 and was replaced by **Dr. G. Kerr,** Merlin Park Regional Hospital. **Professor D. O'B. Hourihane** resigned in September, 1983 and was replaced by **Dr. R. D. O'Moore,** St. James's Hospital, Dublin. **Dr. W. Shannon** resigned in September, 1984 — the consultation process was not completed in time to enable a replacement appointment to be made.

Chairman and Vice-Chairman

1.6 At the Board's first meeting in March, 1980 **Dr. B. G. Alton** and **Professor A. D. H. Browne** were appointed Chairman and Vice-Chairman respectively for the period to September, 1982.

At the meeting of the Board held in September, 1982 **Dr. B. G. Alton** and **Professor B. E. Barrett** were appointed Chairman and Vice-Chairman respectively for the period to March, 1985.

Staffing

1.7 Chief Officer: **Mr. J. Gloster**
Staff Officer: **Mrs. A. O'Cuinneagáin.**
Clerical Officer: **Ms. A. Linnane.**

Pending the making of permanent appointments in 1981 at chief officer and clerical officer levels interim staffing arrangements were made in 1980 whereby Mr. J. Darby who had been Chief Officer to the former Council for Postgraduate Medical and Dental Education was appointed as Acting Chief Officer to the Board and Miss M. Marrinan, Clerk-typist was seconded to the Board from the Department of Health. These interim staffing arrangements provided a valuable continuity between the work of the former Council and the Board. The Board is appreciative of the contribution Mr. Darby and Miss Marrinan made to its work during its first eighteen months.

Meetings

1.8 During the period covered by this report the Board held 44 meetings. In addition there were many committee meetings — mainly concerned with finance and with dentistry but also dealing with manpower, structures and educational science. Representatives of the Board also met with representatives of Comhairle na nOspidéal, Department of Health, Health Board Chief Executive Officers, Medical Council and the Training Bodies.

The Board organised 4 day-long Symposia dealing with (i) manpower, (ii) career guidance, (iii) monospecialist training and multidisciplinary needs and (iv) part-time training and job-sharing in medicine. These symposia are referred to later in this report.

Board's representatives or nominees to other Bodies

1.9 The Board is represented by or has nominated the following persons to the Bodies listed:

Health Services Export Co-ordinating Committee: Dr. B. G. Alton;
National Health Council: Professors B. E. Barrett and G. Bourke;
RCPI Sub-Committee on General Professional Training: Professor C. F. McCarthy and Dr. J. O'Callaghan.

CHAPTER 2

Promotion and Co-ordination of Postgraduate Medical Education

PROGRAMMED TRAINING

Recognition of Professional Bodies

2.1 For the purpose of its functions under the Medical Practitioners Act, 1978 the Postgraduate Medical and Dental Board has recognised the following nine main Irish professional bodies as filling major roles in programmed training for doctors:-

(i) The Faculty of Anaesthetists of the Royal College of Surgeons in Ireland;

(ii) The Irish College of General Practitioners (The Irish Institute of General Practice was the recognised body until 1 March, 1985 when its functions relating to postgraduate training for general practice were assumed by the Irish College of General Practitioners. The Institute was dissolved with effect from 1 March, 1985);

(iii) The Irish Committee on Higher Medical Training;

(iv) The Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland;

(v) The Faculty of Pathology of the Royal College of Physicians of Ireland;

(vi) The Irish Psychiatric Training Committee;

(vii) The Faculty of Radiologists of the Royal College of Surgeons in Ireland;

(viii) The Irish Surgical Postgraduate Training Committee;

(ix) A Committee of the Royal College of Physicians of Ireland, which deals with general professional training in Medicine.

GENERAL APPROACH OF THE BOARD

2.2 The general approach adopted by the Postgraduate Medical and Dental Board could be summarised as follows:-

(a) Programmed training is under the immediate guidance of the recognised professional bodies;

(b) The laying down of criteria and standards for training is the responsibility of the professional bodies (subject to the powers of the Medical Council as defined in section 35 of the Medical Practitioners Act, 1978);

(c) The professional bodies are responsible for the general organisation and monitoring of training;

(d) While responsibilities as at (a), (b) and (c) are regarded as lying primarily with the professional bodies their authority cannot be absolute. The Board to fulfil its functions, has to exercise a general supervision of the development and co-ordination of postgraduate education and, with its overall view of the situation, it has the right to question and make suggestions regarding the existence of adequate programmes and their implementation;

(e) While the Board has responsibilities as at (d) it desires to interfere as little as possible with the professional bodies and its aim is to help and encourage them to carry out the functions set out at (a), (b) and (c) and in co-operation with them to seek ways and means of bringing about changes and improvements considered desirable;

(f) The Board deals only with the main professional bodies — it does not deal directly with regional training committees or with committees concerned with sub-divisions of specialties.

GENERAL PATTERN OF POSTGRADUATE TRAINING

2.3 The broad pattern of postgraduate training as it has evolved or is evolving in this country is set out in summary form in the following paragraphs.

(a) **Intern Posts**

Irish graduates are required to obtain provisional registration and to serve for twelve months as interns in approved intern posts before they are eligible to apply for full registration as medical practitioners. The Medical Council has recently issued the following statement in relation to the intern year:

> "The Medical Council reaffirms that the period of provisional registration should last twelve months, consisting of six months general experience in medicine and six months general experience in surgery. Experience of medical and surgical emergencies must be included. The Council affirms that this year is a continuing educational experience and it has the statutory responsibility of reviewing the duration and content at regular intervals. Interns should live in residential accommodation provided by the hospital. The Council emphasises that great care should be taken that interns are not allowed to undertake duties and responsibilities for which, by reason of their inexperience, they are unsuited. Experience in specialised units must be gained in a general hospital. Experience in obstetrics should not be part of the Intern Year".

All intern posts must be in hospitals and posts approved by the Medical Council. The Medical School which awarded the primary qualification will on satisfactory completion of the intern year, grant a Certificate of Experience. This enables an application to be made for full registration.

Appointments to intern posts usually start in July each year with further appointments e.g. rotation, in January. Most posts are filled through matching schemes operated jointly by the medical schools and their associated teaching hospitals. Some posts are filled following advertisement in the national newspapers.

(b) **Training in Specialties other than General Practice**

Following the intern year training is divided into two periods — a preliminary period and an advanced period, usually referred to as general professional training and higher specialist training. The general pattern is a three year period of general professional training, followed by three to five years of higher specialist training.

The aim of all programmes of training is to bring the trainee to the stage of accreditation — that is the stage where the appropriate professional body certifies that the trainee has satisfactorily completed a full and approved course of training. If a specialist register is established the trainee will be entitled at this stage to have his/her name entered on the register.

There are seven divisions of the specialities — Anaesthetics, Medicine, Obstetrics and Gynaecology, Pathology, Psychiatry, Radiology and Surgery. There are several sub-divisions in some of these specialties — (26 in medicine, 4 in obstetrics and gynaecology, 5 in psychiatry, 2 in radiology and 9 in surgery) so that there are in the region of 50 specialties or sub-specialties in all.

There are Joint Committees representing Ireland, England and Wales, Scotland and Northern Ireland in all specialties except Obstetrics and

Gynaecology, Pathology and Radiology. In the case of the last three named specialties while there are no Joint Committees between Ireland and the UK there is a considerable degree of co-operation between the training bodies in each country.

For general professional training the programme is laid down by the appropriate Royal College or other appropriate Irish training body. In the case of higher specialist training the programme is laid down by the appropriate Irish training body and by the Joint Committee where such exists. Similar arrangements apply in relation to the recognition of posts for training purposes and information in this regard is given in Appendix 1 and the principal career structures are shown in Appendix 2.

(c) **Training in General Practice**

Criteria for training in general practice are determined by the Irish College of General Practitioners. The College recommends that vocational training for general practice is undertaken for at least three years, after completion of the intern year, in hospital and general practice posts approved for the purpose.

GENERAL PROFESSIONAL TRAINING

2.4 Non-consultant hospital doctor posts are recognised by the appropriate College or Faculty as suitable training posts both for those intending to make a career in a particular specialty and for those aiming at a different branch of medicine for which the experience is valuable. One such post may thus be suitable for training for a number of branches of medicine. For example a house officer post in paediatrics might be accepted towards accreditation in general medicine, in psychiatry and in paediatrics and could also form part of a rotation in a vocational training scheme in general practice. This means that a doctor need not necessarily decide on his or her future career as soon as he or she is on the medical register. However, if this decision is delayed for too long, it may well mean that in the end it may take longer than the minimum time to be accredited in a particular specialty.

The three year post-registration training period includes, in the main, experience in such posts, or in posts recognised specifically for the appropriate higher qualification where this is required before higher professional training can begin.

SUGGESTED GENERAL PROFESSIONAL TRAINING REQUIREMENTS LEADING TO HIGHER TRAINING PROGRAMMES

2.5 In the medical specialties general professional training ordinarily occupies a period of three years after registration. **The Royal College of Physicians of Ireland** requires that the training should be obtained in posts approved for the purpose, but does not lay down rigid regulations for the training of medical specialists. For example a proportion of the time may be spent in general practice, research etc. It recognises that the non-consultant doctors may spend all or much of their time in their chosen branch of medicine, or alternatively may explore several branches, but that in any case physicians should not specialise in one of the special areas of medicine until they have demonstrated their competence in medicine by obtaining the Membership of the Royal College of Physicians of Ireland (MRCPI). In Paediatrics general professional training should be primarily a training in the general medicine of children and adults and should normally occupy two or three years after completion of the intern year. This training should largely be in approved posts giving broad experience of hospital medicine including emergency work. It must include a post of at least six months duration in a children's hospital or children's department of a general hospital.

The Royal College of Surgeons in Ireland requires for its Fellowship Examination a total of four years experience after graduation (e.g. M.B.) This includes the intern year. A substantial part of this experience must be spent in posts approved

specifically for this purpose by the College. A list of approved hospitals is available. Fellowship requirements as regards training must be completed before Higher Surgical Training can commence. It is not necessary to have passed the Final Fellowship Examination before starting Higher Surgical Training. To be accredited, however, at the end of Higher Surgical Training the Fellowship of one of the Royal College of Surgeons is required. Of the training period (3-5 years) required for Higher Surgical Training in the specialties of surgery, six to twelve months, depending on the specialty may be spent in a University Department or in another approved centre working in one of the Basic Sciences or in research relevant to the specialty.

The Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland requires that one of the three years should be devoted to a branch of clinical medicine other than obstetrics and gynaecology, or to supervised experience or research in disciplines such as anatomy, bio-chemistry, pathology or physiology.

The Faculty of Radiologists requires that candidates should have at least one year's clinical experience after full registration before entering training in radiology.

The Faculty of Anaesthetists requires three years in Anaesthesia post-registration, before being eligible to sit the Fellowship examination. Of this, a period of six months can be spent in a related medical position.

The Royal College of Pathologists strongly recommends that aspiring pathologists be encouraged to spend six months to a year in hospital appointments in an appropriate clinical specialty, such as metabolic diseases, before starting their training in pathology. This must be undertaken in recognised laboratories. Additional experience in clinical work or in related basic sciences may also be accepted for part of this training period. Trainees intending to specialise in haematology, however, should spend one of the three years in an appointment in general medicine. **The Faculty of Pathology of the Royal College of Physicians of Ireland** is the Irish body recognised by the Postgraduate Medical and Dental Board and it works closely with the **Royal College of Pathologists.**

General professional training in psychiatry lasts three years and comprises two components, namely in-service training in hospitals or units approved by the **Irish Psychiatric Training Committee** and a didactic three year day-release programme organised on a regional basis by the three regional committees of the Training Committee. Much of the general professional training period should involve the supervised experience of the assessment and management of patients of all ages suffering from disorders representative of the whole range of psychiatric practice. The in-service programme involves rotation through the various modules of general psychiatry and the specialties of child and adolescent psychiatry, mental handicap and forensic psychiatry. Provision must also be made for training in psychotherapy. Provision is made for trainees, who have sought prior approval, to spend part of their general professional training in other fields of medicine including research.

The Faculty of Community Medicine requires that clinical training should continue for at least one year after registration, and may include experience in general practice. The subsequent two years of general professional training will normally contain at least one year in approved clinical, administrative, academic, or combined/rotating posts and one year in an approved post in community medicine.

TRAINING IN GENERAL PRACTICE

2.6 As already mentioned the **Irish College of General Practitioners** recommends that vocational training for general practice is undertaken for at least three years, after completion of the intern year, in hospital and general practice posts approved for the purpose. An important part of the approved vocational training schemes is the regular day-release programme organised throughout the period of training.

Apart from the three year vocational training schemes in general practice in which suitable appointments (both in hospitals and in general practice) are linked in a planned rotation, many young doctors, aspiring to a career in general practice, follow self-structured training arrangements. At the moment about 28 doctors are recruited annually to the vocational training schemes.

The minimum experience for entry to the General Medical Service ('Choice of Doctor Scheme') for doctors who commenced full-time general practice after 1 July, 1982 is two years experience subsequent to full registration in the Medical Register. It is specified that the required experience shall comprise:-

(i) **Six months experience in full-time General Practice.** While it would be expected that this would be in an established practice it is recognised that this may not in all cases be possible. The six months experience need not be continuous but must be in full-time general practice. Experience gained in short term locums, in a locum bureau or in employment otherwise than as a full-time general practitioner will not be reckonable towards the aggregate of the six months.

(ii) Periods of **six months** hospital experience **in each of any three** of the following specialties (or three months in the case of participants in a recognised Vocational Training Scheme): Accident and Emergency Medicine or General Surgery, General Medicine, Geriatric Medicine, Obstetrics and/or Gynaecology, Paediatrics, Psychiatry.

All entrants to the General Medical Service should have at least six months hospital experience in either General Medicine or Paediatrics.

Whilst fully supporting the concept of vocational training schemes in general practice the Postgraduate Medical and Dental Board has in the past given support to the view that the introduction of a second or alternative mode of training (that whereby doctors who have worked in suitable hospital posts would be placed in suitable trainee general practice appointments) for general practice should be developed. In coming to this view the Postgraduate Medical and Dental Board bore in mind that the output from the existing vocational training schemes corresponded to about half of national requirements and the Board also wished to avoid the development of a very rigid inflexible single training pathway or system. The report of the Working Party on the General Medical Service recommends that full integrated training programmes should be the norm for entry to general practice but that special arrangements might be made for those who may begin hospital appointments without opting to join a training programme. The Postgraduate Medical and Dental Board welcomes and endorses this recommendation. The Board is of the view that the recognised training programmes in general practice should be funded in the same general manner as applies in the case of training programmes for hospital specialties.

SELECTION PROCEDURES FOR GENERAL PROFESSIONAL TRAINING POSTS

2.7 The selection procedures for entry into general professional training vary between the specialties. In some cases there is a strong input in the procedure from the training body concerned whereas in some other specialties the training body is not involved in the selection of trainees for general professional training. In the following paragraphs there is a summary of the position.

Medicine, Obstetrics/Gynaecology, Pathology

In the case of these specialties the training bodies are not involved in the selection of trainees at general professional level — such selection is carried out by the hospital authorities in whose hospitals the training posts exist.

Anaesthetics

There are three regional training committees. These Committees set up the selection boards (representative of the Committee, medical schools and hospital authorities) to select and recommend trainees for appointment to the hospital authorities in whose hospitals the training posts exist.

Psychiatry

There are three regional training committees. Doctors are recruited at house officer/or registrar level by the hospital authorities as vacancies arise in the normal course. Sometime after their appointment (about 3-6 months) these doctors are assessed by the appropriate regional training committee as to whether they are suitable/ready to be admitted to the general professional training programme.

Radiology

About eight trainees are selected every two years. The trainees are selected by the training body on which the training hospitals concerned are represented.

Surgery

About 33 doctors are recruited annually into the Pre-Fellowship Clinical Training Schemes in General Surgery and Specialties. The trainees are recruited by the Regional Committees of the Training Committee in the case of the Eastern and Western schemes and by the Department of Surgery, UCC in co-operation with the Southern Health Board and voluntary hospital authorities in the case of the Southern scheme.

There is also a Pre-Fellowship Training Scheme in Otorhinolaryngology. Selection to this scheme is made by the Training Committee concerned.

TRAINING SCHEME IN GENERAL PRACTICE

2.8 There are at present 5 Regional Vocational Training Schemes in General Practice — Cork, Dublin, Galway, Letterkenny and Sligo. The annual intake to the schemes is about 28 and the trainees are selected by the Training Committees following advertisement and competition.

SELECTION PROCEDURES FOR SENIOR REGISTRAR POSTS

2.9 As in the case of general professional training the selection procedures for appointment to senior registrar posts vary as between specialties. In the case of anaesthetics, surgery and medical specialties the posts are advertised by the training bodies whereas in the case of obstetrics/gynaecology and psychiatry the hospitals in which the vacancies occur issue the advertisements.

HIGHER SPECIALIST TRAINING

2.10 Higher Training in anaesthetics, the surgical specialties, obstetrics/gynaecology, psychiatry and medicine is usually obtained in the grade of Senior Registrar. The length of higher training varies as between specialties e.g. a minimum of three years in anaesthetics, three to five in the surgical specialties and four years in medicine and psychiatry. In the medical specialties higher training may begin in an approved post as a registrar but will normally be completed at the level of senior registrar. The creation of posts of senior registrar in pathology and radiology is under consideration.

The number of senior registrar posts is regulated by Comhairle na nOspidéal. However, while the Comhairle approves the number of posts at this level which may be filled the provision of finance to fund the posts is ultimately a matter for the Department of Health and in some disciplines, notably medicine, only a small

proportion of the approved posts have been funded to date. This means that, currently, higher training in the medical specialties is effectively taking place at registrar level in approved posts. Further details are given in Appendix 3.

The stated object of the Comhairle is to align in a flexible manner the intake of trainees to the Senior Registrar grade with the anticipated need for consultants. The intention is to avoid the over-production of highly-trained personnel for whom there might not be outlets either in this country or abroad.

Every post occupied by a senior registrar must be approved by the appropriate Higher Training Committee, College or Faculty as suitable for leading to accreditation of the holder.

The organisation of higher specialist training programmes is still evolving and whereas in some disciplines all approved senior registrar posts are funded and filled, in other specialties only a small proportion of the posts have been funded or filled, and in some specialties senior registrar training programmes have yet to be developed. Persons seeking more information in this area are advised to contact the appropriate training body.

ACCREDITATION

2.11 Some Higher Training Committees and their equivalent bodies in other colleges issue certificates of accreditation to those doctors who have satisfactorily completed a programme of training.

It is important to realise that higher professional training can be flexible and accreditation can be granted to doctors who choose an alternative but suitable pathway e.g. training in the USA; in research medicine etc. If accreditation is the goal it would be wise for the doctor in training to check with the appropriate Higher Training Body before embarking upon such a programme. In Ireland and in Great Britain accieditation is not mandatory for appointment to a consultant post. For example appointment boards have appointed doctors who have trained in America or Canada and taken his/her "Boards" or specialty Fellowship.

OUTLINE OF BOARD'S ACTIVITIES IN RELATION TO PROGRAMMED TRAINING

2.12 In this paragraph the activities undertaken by and the issues raised by the Post-graduate Medical and Dental Board in relation to programmed training are outlined and summarised:-

- provides financial assistance to the professional bodies in their exercise, as national bodies, of a general control over programmed training (see chapter 6),
- provided advice to the professional bodies as to the criteria they should adopt in structuring their higher training committees so as to ensure their competence, autonomy and representativeness,
- recommended that additional schemes of vocational training in general practice be established in Letterkenny and Sligo and supported proposals to expand the annual intake to the Cork and Dublin schemes to 10 each,
- recommended that trainers in vocational training schemes in general practice be remunerated (the Working Party on the General Medical Service concurs in that view),
- welcomed and funded the initiative taken by the Irish Institute of General Practice towards the establishment of a single representative body concerned with training and academic matters in general practice and which led to the foundation of the Irish College of General Practitioners,
- recommended in May, 1981 that favourable consideration be given to expanding the intake to the radiology training programme,

- recommended that funding be provided for a post of Course Organiser to co-ordinate and develop the academic component of the higher specialist training programme in community medicine,
- expressed support for the Pilot European Training Programme of the Standing Committee of the Doctors of the EEC which provides for transnational post-graduate medical specialist training periods amongst most countries of the EEC and the Board has provided the administrative support for the project insofar as this country is involved,
- returned time and again to the issues related to the non-funding and non-filling of senior registrar posts (see paragraph 2.13),
- asked the Department of Health to consider the possibility of introducing a scheme of disturbance allowances for doctors undergoing higher specialist training who obtain suitable posts abroad and subsequently asked the Scholarship Exchange Board and the Department of Foreign Affairs to consider any way in which they could be of assistance to higher medical specialist trainees who are seeking, or are successful in finding suitable training opportunities abroad,
- asked the Training Bodies to consider what steps they might take to make part-time training more readily available and subsequently organised a Symposium dealing with Part-time Training and Job-Sharing in Medicine (see paragraph 2.15),
- encouraged the Training Bodies to seek to organise planned rotations with posts in the Developing World,
- organised in October, 1983 a symposium on the theme of "Monospecialist Training and Multidisciplinary Needs" (see paragraph 2.14),
- provides an administrative service to the Irish Psychiatric Training Committee and in addition provides secretarial services to the Dublin Regional Vocational Training Scheme for General Practice; provided an administrative service to the Irish Institute of General Practice until the Institute ceased to exist in March, 1985.

SENIOR REGISTRARS

2.13 As at 1 September, 1984 there was an approved establishment (i.e. approved by Comhairle na nOspidéal) of 95 senior registrars of which 66 were filled. Details are given in Appendix 3. 30.5% of the total number of posts are vacant.

While practically all the posts in General Surgery, Orthopaedic Surgery, Anaesthetics and many of the posts in the Psychiatry specialties were filled just 6 of the 21 posts in the medical specialties were filled.

Whereas some of the 29 unfilled posts were not filled because they had only recently become vacant, or were recently created or were not being utilised because of manpower considerations well over half of them were vacant because they have not been funded.

The Postgraduate Medical and Dental Board has on many occasions drawn attention to the most unsatisfactory situation which has arisen in relation to the funding of senior registrar posts, particularly in the medical specialties. The non-funding and non-filling of senior registrar posts has meant that there is no proper recognised limiting outflow from the ranks of general professional training to higher specialist training. This has implications for manpower planning and makes career guidance difficult. It can also be said that it can place an onus on consultant selection boards of de facto accrediting specialist training and this function was never intended for them nor were they geared for it. Furthermore there is the possibility that doctors in training in this country may be placed at a disadvantage

when competing with other doctors who have trained abroad, particularly in the UK, where senior registrar posts (or their equivalent) are much more numerous and funded. The Board has drawn the attention of the Local Appointments Commission to this possibility.

It is difficult to escape the conclusion that sufficient attention is not being paid to the search for a solution to the present unsatisfactory situation. From the perspective of the Board it seems that an impasse has been arrived at, with funding authorities indicating that no additional moneys will be available and some training authorities unwilling to consider the conversion of existing NCHD posts to senior registrar positions.

If the programmes for higher specialist training in Ireland are to survive and be effective, it is necessary that the following steps be undertaken:-

— Training Bodies and centres which are concerned with medical education must realise that some of the current NCHD complement will have to be replaced by senior registrars.

— Selection boards for consultant appointments must, normally, only consider applicants who have been accredited by Training Bodies, or who have reached standards which have been acceptable to these bodies. To do otherwise is to undermine the training programmes.

— Selection boards must recommend for appointment personnel whose training is appropriate to the advertised position — this is particularly important as far as "generalist" posts are concerned.

— It is extremely important that the training authorities seek to facilitate in every possible way the introduction of our senior registrars into suitable finishing programmes overseas.

Even accepting that there is severe financial stringency, the Department of Health may have to concern itself with the expenses of assisting in the training of a small number of senior registrars overseas. The Board has previously asked the Department to consider the possibility of introducing a scheme of disturbance allowances for doctors undergoing higher specialist training abroad and wishes now to repeat the request. It is essential that the training bodies take an active role in seeking out suitable training opportunities abroad — in order to ensure satisfactory standards and to clear the way for the appointment of Irish trainees. While the Board is pleased that one Irish senior registrar was offered a position abroad under the Pilot European Training Programme that programme is very much in its infancy. Without substantial expansion both in scope and in funding it does not, as presently constituted, offer any real prospect of meeting other than a small portion of the foreign training needs of Irish doctors. In any event Irish doctors will almost inevitably seek their international training in the English speaking world. It would perhaps be valuable if the Department of Foreign Affairs were to consider ways in which it could be of assistance.

SYMPOSIUM ON MONOSPECIALIST TRAINING AND MULTIDISCIPLINARY NEEDS

2.14 The Board held a Symposium on the theme of Monospecialist Training and Multi-disciplinary Needs in 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. Current trends indicated that for the foreseeable future at least half of the general hospitals will be within the 150 to 350 beds range which the health boards had

the responsibility of staffing appropriately and cost effectively with staff suitably trained and competent for the service needs. The service needs in these hospitals were for generalists and the scope for monospecialists being severely restricted or non-existent. Viewed from the health board perspective training in many specialties, surgery and pathology being the most frequently quoted examples, did not adequately take into account the typical workload and mix of the general hospital.

Papers were presented at the symposium by two health board chief executive officers, by two training bodies, by a senior registrar and by a chief administrative medical officer from Scotland. The attendance included representatives of the health boards, voluntary hospitals outside Dublin, professional training bodies, Comhairle na nOspidéal, Department of Health, Irish Medical Association, Medical Council and Medical Union, as well as members of the Board and the Co-ordinators of Postgraduate Education. In all there was an attendance of about 70.

The aim of the Symposium was to provide a forum for airing the topic in its many aspects, pinpointing problem areas, suggesting possible ways forward and highlighting issues for further consideration.

The principal issues and options raised as worthy of further consideration could be listed as follows:-

- the training bodies could be asked to look at alternative modes of training, perhaps placing much greater emphasis on the training of "generalists" while also making provision for the training of monospecialists
- supplementary training could be provided so as to broaden the role of the specialist
- a diploma might be awarded to give appropriate recognition for such 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
- 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 voiced 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.

The topics raised during the course of the Symposium covered the whole spectrum of the debate of monospecialist training versus multidisciplinary needs, and how best to cater for those latter needs. These issues merit further consideration by those charged with the delivery of health services, the training bodies, those charged with the selection of hospital consultants, and by the various statutory bodies involved in medical manpower and training.

The Board has urged the various interested bodies to study the report of the Symposium and to use it as an aid to an appraisal of existing policies and practices. When circulating the report the Board drew particular attention to a number of

points and themes which recur throughout the report and commented briefly on some of them as follows:-

— 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-operation of services, including the provision of specialist facilities at peripheral hospitals, could be achieved as between their various hospitals,

— further consideration should be given to 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 mono-specialists, 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,

— employing authorities should ensure that adequate facilities (including facilities for postgraduate education) are made available in smaller hospitals so as to ensure professional job satisfaction for consultants working in such centres,

— 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 has particularly asked the professional training bodies to consider the contents of the 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.

PART-TIME TRAINING AND JOB SHARING

2.15 The Board held a Symposium on the topic of part-time (including job-sharing) training in medicine in October, 1984.

While part-time training would not be confined to women doctors, but could also be availed of by any doctor whose domestic commitments or personal circumstances were such as to make training on a whole-time basis very difficult or impossible, the symposium was prompted by the Board's consideration of issues arising from the increasing number of women medical graduates. For example, at 1 January, 1984 45% of all Irish medical students were women, as were 39% of all Irish non-consultant hospital doctors.

A survey published in 1982 (Kelly D. A., Nolan M., Shelley E., Rudd J. Medical Graduates of the Seventies: Plans, Problems and Prospects. Irish J Med Sci 1982;

151: Supp 1) reported that women doctors with children had particular career problems associated with the difficulties in maintaining a medical post with their domestic commitments and identified a need for both part-time training posts and for part-time career posts. The survey population were all medical graduates of Dublin University, National University of Ireland and the Irish medical graduates of the Royal College of Surgeons in Ireland for the years 1971, 1973 and 1975. Women doctors comprised one third of the study population. 43% of the women doctors, with children, living in Ireland were in part-time employment, many in sessional posts, not recognised for postgraduate training; 30% were not medically employed although all but two of these wished to continue in medicine. 97% of the women doctors surveyed indicated that they wished to continue actively in medicine and identified the need for part-time training and career posts and also the provision of child-care facilities.

2.16 The main purposes of the Symposium were to highlight issues which:-

(a) might demonstrate the demand/need for the development of a mode of post-graduate medical and dental education on a part-time or job-shared basis, and

(b) should be taken into account in the development of such a system of post-graduate education.

2.17 The five main papers were designed to give:-

(i) the perspective of women doctors,

(ii) the views of an English Health Region with over fifteen years of involvement in part-time training,

(iii) the views of a trainee,

(iv) the experience of a public sector agency, outside the health services, in organising job-sharing schemes, and

(v) the views of a Scottish Health Board acknowledged to be a leader in the sphere of job-sharing in the health services.

2.18 The report of the proceedings of the Symposium has been circulated to the professional training bodies, employing authorities and other agencies concerned with medical personnel issues. The report should serve as a valuable stimulus in the development of policy towards making part-time (including job-sharing) post-graduate training available.

2.19 It was clear from the papers delivered at the Symposium that it is possible to successfully train on a part-time basis. It was also clear that there is a demand for such training arrangements although this demand has not been quantified. It was very evident that such training can best be provided in an organised framework where some person (or persons) has clear responsibility for its organisation and where that person is sufficiently senior in status and knowledgeable to help resolve any difficulties which may arise. The training bodies have set out the criteria which they will accept as regards part-time training. The Minister for Health has indicated that he will be prepared to consider proposals from employing authorities for shared appointments to non-consultant hospital doctor posts. Individual doctors, however, find it very difficult to obtain part-time (or shared) training opportunities. Perhaps there are many reasons for this but basically it is because there is no organised framework and the various steps which a young doctor has to take are first of all not wekk-known and are in any event time-consuming. As an Initial step towards rectifying this position the Board would recommend that the following measures should be adopted:-

2.19.1 the organised profession should establish and maintain an up to date register of doctors who are interested in training on a job-shared basis,

2.19.2 the professional training bodies should nominate a person (or persons) to liaise with and advise young doctors interested in training on a part-time basis with a view to helping such doctors with the processing of their applications,

2.19.3 the employing authorities should jointly develop a protocol or procedure for dealing with applications for part-time or shared training arrangements and individually nominate persons to deal with such applications and to continue to be available to liaise with successful applicants.

The adoption of the measures set out above would be an invaluable aid to young doctors seeking part-time or shared training arrangements. At the present time doctors seeking to train on such a basis are often faced with what must be seen as a multitude of difficulties and it can be scarcely surprising if and when they become disheartened before processing the application to a conclusion.

2.20 PILOT STUDIES

As already mentioned the adoption of the measures set out in the preceding paragraph would be an invaluable aid to young doctors seeking part-time or shared training arrangements. It has to be said, however, that there is not, as of yet, widespread and universal acceptance either among the profession or employing authorities that such training is feasible. It is organised effectively in parts of the UK but it does not exist in other EEC countries. Training on a part-time (or shared) basis is a topic on which there is no shortage of opinion. It can be shown to work successfully when carefully organised and monitored. Without such monitoring and organisation serious questions and doubts can be raised about its effectiveness. Some specialties seem more suited to it than others. It has to be said, as indeed was raised at the Symposium, that doubts exist in some quarters whether it is compatible with continuing medical care while others are confident that no such conflict or incompatibility arises. To pursue one's entire postgraduate training on a part-time basis would indeed be a truly formidable and daunting undertaking that few would recommend. Whether or not part-time training represents a compromise or an ideal way of combining dual functions of domestic commitments with a desire to continue to pursue a career in medicine must perhaps remain an open question. It does, however, represent a significant departure from the established pattern and practice in this country. When circulating the report of the symposium the Board indicated that it was prepared to lend its support to the concept being tried provided its introduction was carefully planned and continuously assessed and evaluated. In the Board's view it might be helpful if a number of pilot projects were established to test the concept in Irish conditions and to this end the Board has invited the training bodies to consider the report and to bring forward proposals. The Board has also asked the training bodies to report to it in due course on the actions they have taken or propose to taken.

2.21 PART-TIME CAREER POSTS

Inevitably some who will train on a part-time basis will seek part-time career posts. The absence of such posts is outside the remit of the Board, but nevertheless attention is drawn to it here so that the appropriate agencies be alerted to the need to consider the issue.

CHAPTER 3

The Board and Continuing Education in Medicine

3.1 The Board's remit includes the promotion of the development of continuing medical education and the co-ordination of such developments. Continuing medical education is, broadly, postgraduate education following programmed training and has been defined by an Expert Committee of W.H.O. "as the training that an individual physician undertakes after the end of his basic medical education and, where applicable, after the end of any additional education for a career as a generalist or a specialist — training to improve his competence as a practitioner (not with a view to gaining a new qualifying diploma or licence)". (Continuing Education for Physicians, Technical Report Series No. 534).

3.2 The former Council for Postgraduate Medical and Dental Education in its second report published in December, 1977 dealt at some length with Continuing Education in Medicine. That report contained sections dealing with, inter alia, the aims of continuing education, motivation therefor, methods thereof, the position as it then was in this country and a series of conclusions and recommendations including financial considerations. That report is still relevant today and the Board strongly commends professional bodies, clinical societies and employing authorities to study its contents once more and to take action and/or redouble their efforts to implement the recommendations contained therein. In re-reading that report it will of course be borne in mind that the introduction of the consultants common contract has standardised the contractual position of health board and voluntary hospital consultants and thus providing, inter alia, that voluntary hospital consultants are eligible for help towards their continuing education from public funds.

ACTIVITIES BY THE BOARD

Budgetary Considerations

3.3 In the period covered by this report (1980-1985) health boards and hospital authorities have been faced with financial difficulties. Unfortunately in such circumstances some authorities seek to solve some of their financial problems by drastically reducing or practically eliminating their allocation for postgraduate education in general and for continuing education in particular. While sympathetic to the financial difficulties faced by employing authorities the Board has on a number of occasions during the past five years drawn the attention of health boards and voluntary hospitals to the need to make adequate financial provision for post-graduate education and wishes to avail of this opportunity to do so again.

3.4 The Board believes that continuing education for doctors is essential. The WHO Expert Committee referred to earlier, stated that the "need for appropriate funding is inescapable". In the Board's view each employing authority should have a specific budget for postgraduate education. It considers that it should be a matter for each employing authority, in consultation with the medical staff involved to decide on the allocation of the budget within certain guidelines. There should be a structure within each authority that recognises that there are limited funds available, that it is known that the funds are there and the extent of them and that the medical staff have a voice in the allocation of the funds.

3.5 The following guidelines and conditions might be applied to the operation of the specific budget for continuing education:-

(a) preference should be given to courses within the country, unless there is

knowledge or techniques to be learned abroad which are not available in this country.

(b) In considering applications for help for visits abroad preference should be given to:-

(i) Persons who wish to attend meetings with a major educational content — particularly scientific meetings of the major specialised societies — or who wish to study new and important techniques which are not available in this country.

(ii) Persons who are engaged in providing continuing education. (Consultants going abroad should be expected to report on their visits to their own departments).

(iii) Persons who are asked to read papers at conferences etc.

(c) In the case of applications from doctors in training to attend courses abroad, the views of the professional body dealing with the training should be obtained as to the need for attendance at the couse and its suitability for the applicant.

(d) In considering applications to go abroad health boards and voluntary hospitals should ask themselves:-

(i) is the primary purpose of the course the continuing education of those attending?

(ii) is all or a substantial part of what the applicant can learn at the course likely to be of benefit to him/her in the carrying out of his/her duties?

(iii) will the cost represent an undue proportion of the funds available or could they be distributed to greater advantage?

(iv) is the course of a type to which the applicant would normally elect to go even at his/her own expense?

(e) For the purpose of acquiring new skills and techniques associated with the introduction of new services, a hospital may consider it necessary to allow some of its staff to attend special courses. The Board considers that time devoted to such work should not be counted as normal study leave.

Grants Paid by Board

3.6 While the primary responsibility for the provision of adequate finance for the continuing education of their staff rests with the health boards and various voluntary hospital authorities the Board would hope to be in a position on occasion to provide some assistance. Inevitably such assistance is likely to be the exception rather than available on an annual basis and when available will usually take the form of a grant to help towards the purchase of some teaching equipment or other resource. Such equipment or resources would of course be also available for programmed training as well as for continuing education and it has already been indicated to health boards that where they are grant-aided by the Board to purchase equipment facilities should be made available to allow private practitioners avail of the equipment concerned.

3.7 As will be seen in Chapter 6 during the period 1980 to 1984 the Board paid grants to health boards, hospitals and to postgraduate centres amounting to £83,550. These grants, the payment of which was concentrated in the period 1982-4, were designed to help towards the purchase of teaching equipment and also in a small number of cases helped to upgrade library facilities.

CO-ORDINATORS OF POSTGRADUATE EDUCATION

3.8 Chapter 4 deals with the appointment and functions of the Co-ordinators of Postgraduate Education engaged by the Board. It will be seen that their involvement with the organisation and provision of continuing education includes:-

- organisation of seminars on topics relevant to general practice and assisting local groups of general practitioners with the organisation of continuing education programmes;
- organisation of continuing education programmes in various hospitals;
- participation in the management and administration of postgraduate centres and in the organisation of the programmes of activities in such centres;
- participation in the monitoring of the pilot studies on general practitioner continuing education programmes (see paragraph 3.9);
- organisation of postgraduate lecture programmes.

General Practice Continuing Education: Pilot Studies

3.9 Commenting on continuing education for general practitioners the Consultative Council on General Medical Practice said in 1973

> "At present professional bodies, such as the Royal Colleges, hospitals, the organised profession, and voluntary bodies run courses, lectures, etc., for general practitioners. Medical societies make a particularly valuable contribution. While all these activities are commendable in themselves, the overall position is unsatisfactory because there is no single organisation vested with overall responsibility to provide continuing education for general practitioners and many of the courses being provided are not directed specifically towards the needs of general practitioners.
>
> The courses which are being provided are not being attended by general practitioners in sufficient numbers. This is probably due to a variety of reasons. Some general practitioners are not convinced that they need continuing education. The courses tend to be too centrally located and are not so arranged as to fit into the normal work pattern of the general practitioner. General practitioners find it difficult to obtain locums to enable them to attend.
>
> What is required is an organised programme of continuing education which would have as its aims:-
>
> (a) filling the gaps left by undergraduate training;
>
> (b) keeping the general practitioner up to date on advances and developments in his own field and reasonably well acquainted with developments in others; and
>
> (c) the provision of the sort of stimulus that sharpens the intellect, excites the curiosity and makes general practice a challenge".

3.10 The position as described by the Consultative Council had essentially remained unchanged when the second report of the Council for Postgraduate Medical and Dental Education was published in 1977. That report drew attention to the fact that most general practitioners were not eligible at that time for any help towards their continuing education from public funds, although it went on to mention that the Department of Health did indicate in March 1975 in correspondence with the Irish Medical Association and the Medical Union that it "would be willing to discuss arrangements for special grants towards study leave as long as it is provided in respect of agreed recognised courses and within agreed recognised limits". In 1980 the Board recommended that the same arrangements in regard to study leave should apply to all doctors (and dentists) providing services for public patients.

3.11 No essential changes occurred in the period immediately after 1977 and it was against this background that the Irish Institute of General Practice in 1980 prepared proposals for a national structure of continuing education for general practitioners. In summary these were based on the appointment of a national network of 20-25 general practitioners as part-time tutors to organise, promote and conduct continuing medical education amongst their 1,800 plus general practitioner colleagues.

Aims of Institute's Proposals

3.12 The aims of the proposals produced by the Irish Institute of General Practice were to overcome the deficiencies common to continuing education by:-

(i) Providing the co-ordinating and organisational framework for existing and new educational activities.

(ii) Motivating general practitioners by actively promoting continuing education rather than by compulsion or inducement.

(iii) Providing a comprehensive system to reach all general practitioners and not just "the enthusiasts".

(iv) Establishing an ever-increasing pool of educational skill.

(v) Accepting the discipline of the essentials of planning a programme of continuing education as outlined above.

(vi) Adding to the existing didactic lecture programmes by establishing small groups of general practitioners (6-8 in each) and approaching individual general practitioners to participate in active learning programmes.

(vii) Evaluating the acceptability of the proposals among the profession and their educational effectiveness in terms of success and outcome.

Establishment of a Pilot Study in South-West Cork

3.13 In submitting its proposals to the Postgraduate Medical and Dental Board for consideration, the Irish Institute of General Practice proposed that the Board fund a pilot study or studies to test their effectiveness. The Board agreed to this suggestion and subsequently agreed to a proposal from the Institute that it fund a pilot study for a period of two years based on an area in South-West Cork — this period was later extended by a further six months to permit the completion of a full second year of educational activity and allow sufficient time for completion of a report and assessment of same.

The area chosen for the pilot study was south and west of Blarney. It is largely a rural area with a number of small towns. It is served by 65 general practitioners and their centres of practice are separated by a maximum distance of 80 miles.

Dr. Michael Boland, a general practitioner in Skibbereen, was appointed as part-time tutor and this pilot study effectively commenced at the beginning of April, 1981.

It had been agreed that in the initial months, the tutor would have the tasks of devising specific objectives for the study and of establishing as many small groups of general practitioners (6-8 in each) as possible which would meet on 8 or 9 occasions per year. The tutor would also have the task of co-ordinating the activities of the small groups to complement the lecture programme of the clinical society in the area.

In the following paragraphs, an extended summary is given of the pilot study's progress over its first 30 months followed by a summary of the recommendations adopted by the Board following a review of this progress.

3.14 South-West Cork Pilot Study - The first 30 months

3.14.1 Motivation and Response

Using individual practice visits by the tutor, followed by personal telephone calls, 56(86%) of the general practitioners in the area agreed to join in small group learning activity. Each doctor in the area had been promised that the learning material would be relevant and each participant would be matched to a group which suited him/her best. The overall monthly average attendance at the group meetings was 35, i.e. over 63% of those who had jointed or 54% of all doctors in the area. Nearly 60% of the doctors in the area attended more than half of their scheduled 13 monthly meetings held during the period to summer 1983. Each participant was reminded by personal phone-call three to four days before a meeting and asked whether or not he/she would be attending.

3.14.2 Number of small groups established

Seven groups of eight doctors in each were established, meeting monthly, eight times per year. Initially the tutor acted as leader of each group, with this task being taken over by a member of each group after the first series of four monthly meetings. The group leaders also jointly form a group.

Experience has shown that perhaps a group of eight is somewhat too small when account is taken of the unavoidable absences of some members from some meetings. Following a review based on the experience of the first 30 months the group size has now been increased to 12.

3.14.3 Determining Learning Needs

Formal attempts to establish learning needs through a curriculum planning committee and through a questionnaire to non-general practitioner colleagues proved less successful than the informal emergence of needs in the discussion groups.

In order to establish the educational paradigm, (aims, methods and assessment) some method of determining learning needs, preferably normative needs, had first to be found. Yet no data was available from within general practice or elsewhere on the outcome of medical care in West Cork. To start the new programme with an assessment of each participant's knowledge was to risk discouragement and to ignore the other important aspects of doctor performance — attitudes and skills. A third difficulty in establishing normative needs was that no universally accepted norms existed against which to measure the educational gap. The study's attempts therefore concentrated at first on expressed needs.

Methods

(a) A curriculum committee of eight general practitioners was formed and using the description of the work of the General Practitioner, (Leeuwenhorst), and the educational aims derived from it, tried to establish a list of priorities.

(b) A questionnaire was sent to those with whom the general practitioners in the area worked, (i.e. hospital specialists, diagnostic services, public health nurses, and social workers) seeking their views on the use of their services.

(c) Content and methods used in the group meetings themselves were made deliberately varied and wide ranging to allow individual learning needs to emerge.

Results

(i) No clear consensus was reached by the curriculum planning committee. They felt the task was too enormous and they concluded that the plan would take as long to complete as the learning itself.

More importantly, while there was some overlap, many of the learning priorities listed reflected only the needs of the individuals on the committee. It was decided to abandon the attempt.

(ii) Questionnaire respondents all stressed the importance of better communication with General Practice. Just 17 of 30 colleagues contacted replied. In doing so they were perhaps unduly reticent in their criticisms of that part of general practitioner work for which they encounter. Such reticence may be a partial explanation for the lack of response from the other 13. Not surprisingly many of the shortcomings listed were not due to a lack of knowledge among general practitioners but the poor organisation, lack of time, or an inappropriate level of confidence in their own decisions.

The results of the questionnaire were later discussed by the groups. The comments were generally well received and the exercise was felt to be worthwhile.

(iii) The tutor has reported that in the course of the meetings, discussion varied, in duration, in detail and in the participants involved, in ways that he could not have predicted. The pattern of these exchanges, of the questions, either simply seeking information or challenging an opinion expressed, or seeking support for a point of view, strongly suggested that individuals were identifying their own learning needs.

The emergence of individual learning needs in group discussion of problems seemed to be the best and most flexible method. Its disadvantages are that it may be limited by consensus error, that the consensus itself may be unduly influenced by strong personalities, and that the learning gap which emerges is the difference between the norm and what is believed to be done rather than what is actually done.

3.14.4 Methods and Content

A variety of methods, — simulated problem cases, patient management problems, video consultations, practice activity analysis, and topic discussions, — were tried. Simultaneously, a systematic attempt to cover the content of General Practice was made. No single method was best, but variety, balance, absence of threat, a minimum of advance preparation and informed follow-up were important.

In the period under review twenty-one of the participants allowed their consultations to be video-recorded and the recordings to be discussed subsequently by their groups.

Using a system of practice activity analysis it was possible to gather information in one year on psychotropic prescribing, use of the investigations, antibiotic prescribing, consultation rates and hospital referrals. The results of two of these analyses viz psychotropic drug prescribing and secondly consultation rates have recently been published in the Irish Medical Journal (May, 1984, Vol. 77, No. 5 and September, 1984, Vol. 77, No. 9 respectively).

3.14.5 Peer Review

A system of discussion evolved which formed the basis of peer review.

3.14.6 Assessment and Feedback

At the end of each group meeting, it's content and process was assessed by the group members. Their reactions were conveyed to the tutor by the leaders. The programme for the year was discussed by the groups at

the beginning and end of each year with the tutor present. A confidential postal questionnaire was completed twice. Group leaders devoted a full study-day each year to a review of their performance with expert advice.

3.14.7 **Funding and Monitoring**

The Postgraduate Medical and Dental Board funds the salary of the tutor (2 sessions per week), together with meeting the cost of his travelling expenses and secretarial services. It also funds his membership of the New Leeuwenhorst Group (i.e. A European party of promote General Practice as a discipline by learning and teaching). The Board has also funded the tutor's attendance at a number of educational courses. In addition to the funds provided by the Board, the Pilot Study has received some sponsorship from a number of outside sources, including the pharmaceutical industry. During the two year period, October '81-September '83, this sponsorship amounted to £2,675 and has been used to defray the cost of rental of meeting rooms, purchase of books and teaching aids as well as providing the funding for the end of year meetings of the group leaders.

The progress of this study has been assessed and monitored by a small committee chaired by the Cork based Co-ordinator of Postgraduate Education and including noninees of the Board, Irish Institute of General Practice, South of Ireland Faculty of the Royal College of General Practitioners and the clinical society active in the Pilot Study area. This monitoring committee reported periodically to the Irish Institute of General Practice and to the Board.

Continuation of Study

3.15 At the end of the first thirty months of the pilot study the Board reviewed very fully the progress made. This review included a visit by representatives of the Board to the Pilot Study area. The Board was very satisfied at what had been achieved and felt that the study should be allowed to continue and further develop as a model for other areas. The Board has agreed to continue to provide funding for the study for a further period to October, 1985.

Other General Practitioner Continuing Education projects funded by the Board

Waterford City and County

3.16 The Board agreed to fund for a period of two years, commencing in July, 1983 a continuing education programme for general practitioners in Waterford City and County. The main participants in this pilot programme are the 50 general practitioners in whole-time active general practice in the area and the programme is modelled on and draws on the experience of the West Cork pilot study, although it does not precisely mirror that study. The participating doctors have been divided into five groups and meet both as small and large groups on alternate months. The tutor for the programme is **Dr. E. L. Grant,** a general practitioner in Waterford City. As in the case of the West Cork study the programme is monitored by a small committee chaired by the Co-ordinator of Postgraduate Education and consisting of representatives of the Board, the Irish Institute of General Practice and the South-Eastern Health Board. The funding provided by the Board is on exactly the same basis as applies in West Cork.

The First Year of the Waterford Programme

3.17 More than 80% of the doctors in the catchment area have attended on one or more occasions while the attendance at individual meetings has exceeded 70%. Overall then the attendance has been extremely gratifying with many doctors who hitherto have not participated in any form of continuing education seemingly anxious to become involved in this type of activity. Some 20 meetings have taken place and 40 or so simulated presentations have been considered. At 4 meetings audio visual

material was reviewed. The overall objective of the tutor has been to involve each participant fully in the project and discussions are so structured as to effectively require all who attend to do so. After the initial round of meetings this process has been very successful.

The overall impression of the participants following the first year has been very positive as evidenced by the high level of attendance. It is the tutor's view that a vital factor in securing and maintaining that level of attendance has been the intensive efforts made to involve each and every doctor in the catchment area in the design of and the ongoing work of the project. In a nutshell the sense of belonging to and fully participating in the activity on an equal footing with one's colleagues appears to be a crucial factor in achieving and maintaining interest in the project.

West Midlands

3.18 The Board is funding for two years with effect from October, 1984 a programme closely modelled on the West Cork study in the West Midland Region, the centre of the catchment area being Ballinasloe/Athlone with a general practitioner population of about 55. The tutor appointed is **Dr. Henry Finnegan,** a general practitioner in Ballinasloe. The funding and monitoring of the scheme is on the same basis as already described for the programmes in West Cork and Waterford.

Sligo General Practice Library Information Scheme

3.19 The scheme began in March, 1983 when all general practitioners in the Sligo General Practitioners' Society were circulated, and offered the services of a fortnightly 46 page newsheet including a listing of current journals' contents from which they could choose articles they wished to acquire. Out of a total of fifty five doctors in Counties Sligo, Leitrim and Donegal, twenty responded requesting regular circularisation of the newsheet. Initially, an average of 20 reprint requests followed each circulation, but the number of requests was to grow each month the scheme operated. The aims of the scheme are two-fold — (i) to publicise in a general sense the literature available specifically for general practitioners and its availability within the local library and (ii) to allow all general practitioners to scan the contents of current general practice literature and request articles as needed.

In June, 1983, the Postgraduate Medical and Dental Board contributed £500 to the Scheme, thus enabling its continuation, as funds had at that stage run out. On the recommendation of the Irish Institute of General Practice, the entire catchment area of Sligo General Hospital was once again to be circularised after the summer recess. The result of this second notification was a huge increase in numbers requesting circulation.

The first fortnightly issue in September, 1983 was sent to all General Practitioners in the North West with a greatly increased response. The second September issue was sent to a new membership of 48 doctors, and reprint requests grew to four times the original number. The number of doctors wishing to be circulated continued to grow and at the end of 1983 was 54. The Board agreed to provide some funding towards the continuation of the project in 1984. The number of requests made by doctors for reprints varies enormously, with on average 13 doctors requesting 1 to 10 articles per fortnight, 10 requesting 10-30 articles and 3 requesting more than 30 per fortnight.

Proposed National Network of General Practice Continuing Education Programmes

3.20 The Leeuwenhorst European Working Party in its 1980 statement 'Continuing Education and General Practitioners' said "We see the small group as the most appropriate method for most of the established practitioner's learning needs". In its report published in August, 1984 the Working Party on the General Medical Service said that the "most effective form of continuing education for general practitioners is medical audit" and in a later paragraph referring to the Pilot Studies in West Cork, Waterford and the West Midlands the Working Party recommends "that this mode of provision of continuing education be developed and expanded to the point where all doctors who are able and willing to participate have the opportunity to do so".

3.21 The Postgraduate Medical and Dental Board welcomes and supports this recommendation. In April, 1984 the Board had already indicated to the Department of Health and the Irish Institute of General Practice that it wishes to encourage the expansion of continuing education programmes along the lines already described and supporting the concept that there should be a national network of such studies. The Board looks forward to taking part in discussions with the other interested parties to make progress towards this.

3.22 In making the recommendation at paragraph 3.21 the Board indicated that there should be discussions between the Irish Institute of General Practice, the Irish College of General Practitioners and the Department of Health on how such a national network of continuing education programmes should be funded. At mid-1984 prices the estimated annual cost of a programme, along the lines of West Cork, is £10,000. Thus the cost of a national network of 25 such programmes would be a quarter of a million pounds and would therefore be very much outside the capacity of the Board to provide the funds even if the principle were to be adopted that the Board should fund the network.

3.23 When the Board adopted the recommendations that the development of a national network of these continuing education programmes be encouraged, it also adopted the following recommendations:-

— part-time General Practitioner Tutors continue to be paid on the basis of 2 sessions per week,

— that all tutors should be supplied at the outset with the following equipment or ready access to same: typewriter, photocopier, flip charts or overhead projector, portable video-recorder and camera, portable T.V. set, library allowance,

— half-time secretarial assistance, mileage allowance and telephone and postal expenses of the tutors should be met,

— the cost of training tutors in small group methods, curriculum planning etc. should continue to be met,

— that the new programmes to be established should as far as possible be co-ordinated and integrated with existing traditional continuing medical education activities,

— the growing resources of vocational training schemes, Medical School General Practice Departments and general practice researchers should be tapped in the development of continuing medical education.

The Board had also received proposals from the Irish Institute of General Practice that a system of accreditation for completed performance review, as part of these programmes, should be introduced. While the Board recognised that some system of providing incentives (not necessarily financial) to satisfactorily participate in approved exercises may be necessary, it took the view that decisions in relation to this would have to wait until the system of continuing education provided in the pilot studies is much more widely available.

Appointment of General Practitioner Tutors: Guidelines

3.24 The Board agreed that the following guidelines, which the Irish Institute of General Practice recommended, should be adopted in assessing applications for part-time general practitioner tutors:-

— the applicant should be an established general practitioner in the area,

— it should be demonstrated that he/she can devote 2 sessions per week to the task,

— responsibility should be accepted for a defined geographical area,

- responsibility will be accepted for **all** the general practitioners in that area, whose names should be listed in the application,
- a concerted effort will be made to motivate all general practitioners in the area through active promotion by personal contact, especially during the first 6 months,
- an accurate record of attendance of activities will be kept to enable response to be gauged,
- in addition to existing continuing medical education, new programmes involving at least 15 hours organised educational activity per participant per annum will be provided and that a starting up period of six months will be allowed,
- that whatever methods are chosen, the principles of assessing learning needs, stating objectives, active problem based learning, and performance review will apply,
- some form of assessment to determine whether objectives are being achieved, should be provided,
- definite arrangements for part-time secretarial services will be outlined,
- that progress will be reported at least twice yearly to a monitoring committee appointed by the Postgraduate Medical and Dental Board,
- appointments should be reviewed every two years.

Conclusion

3.25 The Board is satisfied that the experience gained to date in its pilot studies demonstrates the effectiveness of this system of providing continuing education for general practitioners. It supports the view that a national network of such programmes be developed and looks forward to taking part with the other interests in progressing this aim and hopes that a satisfactory system of funding can be agreed upon.

CHAPTER 4

Co-ordinators of Postgraduate Education

4.1 The former Council for Postgraduate Medical and Dental Education appointed, in 1977, six part-time Co-ordinators of Postgraduate Education. These appointments were initially made on an experimental basis. Following a review in 1980, the Board agreed to continue the appointments, subject to further annual or biennial reviews.

4.2 The initial six appointments were made on the basis of one each for the Cork and Galway Regional Hospital Board areas and four for the Dublin Regional Hospital Board area.

During the course of reviews in 1982, it became increasingly apparent that as the Co-ordinators were employed on a sessional basis and because of the concentration of non-consultant hospital doctors in Cork, Dublin and Galway, it was becoming more and more difficult for the Co-ordinators to have any real lasting impact outside of those three centres.

The Board decided to increase, on a phased basis, the number of Co-ordinators as soon as finances allowed — the aim being to make three further appointments as quickly as possible. It was possible to provide finances to enable two additional appointments to be made in 1983 — one each in the North-Western and South-Eastern Health Board areas and a further third appointment was made in 1984 in the Mid-Western Health Board area.

4.3 **Co-ordinators in post at 1st October, 1984**

EASTERN, MIDLAND AND NORTH-EASTERN HEALTH BOARD AREAS:

Dr. D. Coakley, Postgraduate Medical Education Centre, St. James's Hospital, James's Street, Dublin 8.

Professor D. Powell, Mater Hospital, Eccles Street, Dublin 7.

Dr. S. Murphy, St. Laurence's Hospital, North Brunswick Street, Dublin 7.

Professor R. Mulcahy, St. Vincent's Hospital, Elm Park, Dublin 4.

MID-WESTERN HEALTH BOARD AREA:

Mr. P. V. Delaney, Regional Hospital, Dooradoyle, Limerick.

NORTH-WESTERN HEALTH BOARD AREA:

Dr. L. Bannan, General Hospital, Letterkenny, Co. Donegal.

SOUTH-EASTERN HEALTH BOARD AREA:

Dr. R. Tait, Ardkeen Regional Hospital, Waterford.

SOUTHERN HEALTH BOARD AREA:

Dr. R. Godfrey, Aldworth, Donovan's Road, Cork.

WESTERN HEALTH BOARD AREA:

Professor J. F. Greally, Regional Pathology Laboratories, Regional Hospital, Galway.

4.4 The Board wishes to express its appreciation to the following who have also held appointments as Co-ordinators of Postgraduate Education for various periods since 1980: **Dr. R. Draper,** Dublin; **Professor J. J. Fennelly,** Dublin; **Professor J. Flynn,** Galway; **Dr. N. Gibney,** Dublin and **Dr. D. O'Leary,** Dublin.

4.5 **Co-ordinators' Duties, Responsibilities and Conditions of Service**

Duties and Responsibilities

(a) To co-ordinate and encourage the development of postgraduate medical education, both at the level of programmed training and continuing education,

(b) To stimulate learning by all trainees,

(c) To co-operate with the Board, the professional training bodies and the teaching hospital authorities in the promotion of postgraduate education.

Reporting Relationships

The Co-ordinators report directly to the Postgraduate Medical and Dental Board and have a close working relationship with the professional training bodies, the health boards and voluntary hospital authorities and work closely and co-operate with one another. All Co-ordinators meet together nationally twice yearly to exchange views and to report generally on their activities and plans. The Co-ordinators in the Eastern Region meet together and with the Chief Officer of the Board frequently (about every three weeks). The principal purpose of these meetings is to plan, organise and review their joint activities e.g. clinical science courses, basic science courses etc. It is customary for one Co-ordinator to attend each Board meeting.

Conditions of Service

The appointments are temporary and are reviewed periodically. The current appointments are for the period to 31st March, 1986. Remuneration is at the rate of two sessions per week and in addition travelling and subsistence expenses are payable.

Secretarial Services for the Co-ordinators

The Board has made arrangements with the various hospitals, health boards and/or universities where the Co-ordinators are based to provide secretarial services for them.

4.6 **Illustrative listing of Specific Tasks undertaken by Co-ordinators**

The main tasks undertaken by the Co-ordinators are set out in this paragraph. It will be appreciated that the emphasis differs from area to area but the listing will illustrate the position generally:-

(a) Organisation of Basic Science Courses in Dublin and Galway consisting of a series of lectures, up to 70, in a year. In the South-Eastern area the Co-ordinator has organised tutorials aimed at NCHDs sitting primary examinations. In the Dublin area since February, 1983 the Basic Science Course has evolved to a new format consisting of a Friday night/Saturday morning symposium on a specialty topic, involving a speaker from abroad and five or six local experts. Topics covered in these Symposia in the period February, 1983 to December, 1984 have included: Recent Advances in Haematology; Recent Advances in Pituitary Diseases; Recent Advances in Respiratory Diseases; Peripheral Nervous System; Intensive Care; Infectious Diseases; Renal Diseases; Rheumatology; Oncology; Coronary Heart Disease; Emergencies in Medicine; Medical problems in Obstetrics.

(b) Clinical Science Courses — usually organised twice yearly in the Eastern Region, given by up to 70 consultants in their own hospitals with average NCHD attendance in the 30-35 range.

(c) Symposia and lectures organised by the Co-ordinators outside Dublin have included: courses of lectures in medicine suitable for NCHDs specialising in medical subjects; course in specialised pathology and radiology for final fellowship candidates in surgery; symposium on coronary heart disease; UCC/Wellcome Postgraduate lecture programme; regional medical monthly conference in Waterford.

(d) In the period 1979-80 four inter-hospital trans-city clinico-pathological conferences were held in Dublin. These were held in the Mater, St. James's, St. Laurence's and St. Vincent's Hospitals. The proceedings were recorded and published. The Co-ordinators have now revived these conferences and the first in the revived series was held in the Mater Hospital in May, 1984 and followed by another in St. Vincent's Hospital in Autumn 1984. Two others are currently planned for Spring and Summer 1985 in Jervis Street and St. James's Hospitals respectively.

(e) A whole-time week-long basic clinical pathophysiology course was organised in October, 1984 in conjunction with the Faculty of Pathology, aimed primarily for NCHDs in pathology training but also open to others — so that it has tested the "market" needs of other trainees for a full-time basic science type course.

(f) Initiation, development and, in some instances, organisation of continuing education programmes in various hospitals — the programmes referred to here cover the full range of continuing education activities including regular specialty conferences, journal clubs, research seminars, mortality conferences, occasional symposia, annual meetings (e.g. study days), etc.

(g) Organisation of seminars and meetings on topics relevant to general practice, co-ordinating these with the activities of clinical societies, and assisting local groups of general practitioners with the organisation of continuing education programmes.

(h) Participation in the development, management and administration of post-graduate centres and in the organisation of the programmes of activities in such centres.

(i) Participation in the monitoring of the pilot studies on general practitioner continuing education programmes (see paragraph 3.9).

(j) Maintaining liaison with hospitals outside their main bases and advising on the development of facilities in such hospitals for libraries, continuing education etc.

(k) Providing career guidance to individual NCHDs and organising in Cork, Dublin and Galway the career guidance symposia held under the aegis of the Board (see paragraph 7.13).

(l) Prepared, on behalf of the Board two lists of books as the suggested basic minimum requirements for (i) all hospitals where NCHDs are employed (issued December, 1981) and (ii) libraries in general hospitals recognised for General Professional Training in Medicine (issued May, 1984).

Concluding Remarks

4.7 The Co-ordinators of Postgraduate Education perform a range of important functions on behalf of the Board. They have helped the Board in the initiation of many worthwhile undertakings such as the Basic Science Courses referred to and the Career Guidance Symposia. The Co-ordinators themselves are only too aware of the many tasks which remain to be tackled, time constraint has been an inhibiting factor and will continue to be so as will a shortage of finance. However, with the increased number of Co-ordinators it will in the future be possible to provide a more national, albeit regionalised, service than heretofore. The Co-ordinators are only too pleased to hear from hospitals or groups which might like some advice or assistance.

CHAPTER 5

Dentistry

5.1 The Board has the same functions and responsibilities in regard to postgraduate training in dentistry as in medicine. Just as in medicine there is no doubt that there is a need for postgraduate training in dentistry.

5.2 To advise it in its task of promoting the development of postgraduate dental education and training and co-ordinating such developments the Board has appointed two special committees as follows:-

(i) **Dental Affairs Committee** which has the task of advising the Board on all aspects of postgraduate training in dentistry, other than continuing education. The membership of this committee, which is drawn from within the membership of the Board, is: **Professor B. E. Barrett, (Chairman), Professor G. Bourke, Mr. D. Q. Dudley, Mr. B. Joyce, Mr. V. Morris and Dr. D. O'Mullane.**

(ii) **Dental Committee:** The remit of this Committee is to advise the Board in relation to the promotion and co-ordination of continuing education in dentistry, to suggest to the Board the criteria and standards for continuing education in dentistry where this is not already a function of other bodies and thirdly to suggest national policy as to the establishment of regional committees (the broad function of regional committees would be the promotion of continuing dental education within their areas) and finally to examine on behalf of the Board special problems or issues affecting or related to continuing education for dentists. The membership of this Committee consists of all members of the Dental Affairs Committee together with **Dr. F. Brady, Messrs. W. Davis, M. Galvin, D. Keane, J. F. Lemasney, B. O'Loughlin and S. McMahon.** Mr. J. F. Lemasney was nominated to the Committee by the Society of Chief and Principal Dental Surgeons of Ireland and the other six members named in this paragraph were nominated by the Irish Dental Association.

The Board is indebted to the members of both committees for the manner in which they have undertaken the tasks assigned to them and wishes to particularly express its appreciation of the contribution made by those members nominated by the Irish Dental Association and the Society of Chief and Principal Dental Surgeons of Ireland.

Joint Committees and SACs

5.3 There is a Joint Committee for Higher Training in Dentistry. It has four Specialist Advisory Committees as follows:-

- Oral Surgery and Oral Medicine
- Orthodontics and Paediatric Dentistry
- Restorative Dentistry (comprising Conservative Dentistry, Periodontology and Prosthetic Dentistry)
- Community Dental Health.

This country is represented on the Joint Committee and on the Specialist Advisory Committees.

Irish Organisations

5.4 There is an Irish professional body — the Faculty of Dentistry of the Royal College of Surgeons in Ireland. It is concerned with general professional training and higher specialist training. For its purposes under the Medical Practitioners Act, 1978 the Board has recognised the Faculty of Dentistry. Agreement has been reached in discussions with the Faculty regarding the establishment of a special committee concerned with higher specialist training, and with membership drawn from the various interested parties (viz the Faculty, the Dental Schools, the practising profession, Department of Health and trainees). The functions of the Committee are as follows:

"To be responsible, subject to the appropriate legislation, for higher training in dentistry in the Republic of Ireland and including in particular:-

(i) overseeing the conduct of the higher training programme in dentistry

(ii) to advise the appropriate bodies on the needs for consultants in all aspects of dentistry and to keep such needs under review

(iii) to liaise with the Joint Committee for Higher Training in Dentistry and its Specialist Advisory Committees

(iv) to consider, if required, proposals for creating new consultant posts and the required number and location of training posts at senior registrar level".

The Board looks forward to the early establishment of the Committee.

5.5 The professional organisation — the Irish Dental Association — takes a keen interest in continuing education. The staff of the two dental schools as well as providing undergraduate education, also contribute extensively to continuing education.

5.6 **Hospitals Approved for Training**

Hospitals approved for full period of General Professional Training:-

Cork Dental Hospital
Dublin Dental Hospital

Higher Specialist Training

Programmes in Higher Specialist Training in Orthodontics have been previously approved in Cork and Dublin. It is hoped to have formal approval of the higher training programme in Oral Surgery and Oral Medicine in Dublin in the near future.

Special Considerations in regard to Dentistry

5.7 In many ways the position in regard to postgraduate education in dentistry is similar to that in medicine, but in addition there are several factors which make continuing education in dentistry, if anything, more necessary than in medicine e.g.

(i) Most dentists work in their own surgeries, many in relatively isolated areas, the number of dentists is relatively small and they are not brought into regular contact with colleagues as are many medical practitioners. At 1 October, 1984 there were 1,115 dentists on the Dental Register of Ireland. Less than 300 of these are employed in the health boards and dental schools/hospitals, leaving the vast majority in private practice. Most of those in private practice provide services under the scheme administered by the Department of Social Welfare for certain insured persons. These dentists are regarded as being in a similar position to general medical practitioners paid on a fee-for-service basis. Health Boards contribute towards courses etc. for dentists employed by them but, otherwise, there is no State aid for postgraduate education in dentistry, with the exception of the help provided directly by the Board to professional bodies and more recently the help provided by the Board and the health boards to the regional committees in the North-West and South/Mid-West.

(ii) There is not in Dentistry, as in Medicine, a pre-registration year during which a graduate can gain increased practical experience.

(iii) There is only a very small number of hospital posts where graduates can obtain practical postgraduate experience.

(iv) Continuing Education for dentists must include a large proportion of participatory courses as new techniques and the use of new materials and equipment can frequently be learned only by work with patients.

(v) The report on the Dental Services by the Joint Working Party (Department of Health, Health Boards, Irish Dental Association) in 1979 stated that "Priority must be given to the development of preventive services and the adoption of a philosophy of prevention". If dentists are to practise a philosophy of prevention there is agreement that training in that philosophy is essential for many dentists.

5.8 **Outline of Board's activities in relation to Dentistry**

5.8.1 One of the first reports to be considered by the Board on its assumption of office was the report prepared in January, 1980 by the Dental Committee to the former Council of Postgraduate Medical and Dental Education. That report dealt with all aspects of postgraduate education and training in Dentistry, but was particularly concerned with continuing education.

5.8.2 The main recommendations in the report concerned the establishment and funding of regional committees to promote continuing education in dentistry. These proposals and the actions taken in relation to them are discussed in paragraph 5.11 and subsequent paragraphs.

5.8.3 The report referred to in paragraph 5.8.1 recommended that "Subject to the development of suitable programmes of training and an agreed need for more dental consultants, we consider it desirable that there should be increased provision for Programmed Training in this country. We consider schemes of training desirable not only to enable dentists to obtain training in this country, but also because of the beneficial effects schemes of training can have on the general practice of Dentistry. We recommend that the Irish Committee on Higher Training in Dentistry should enter into discussions on the matter with the Department of Health and the new Postgraduate Medical and Dental Board. One of the matters which should be considered is the possible need to spend a period abroad during Higher Specialist Training".

There are some 28 whole-time consultant posts in dentistry (Conservative Dentistry 4; Oral Medicine and Surgery 7; Orthodontics 9; Paediatric Dentistry 1; Periodontology 2; Prosthetics 3; Preventative Dentistry 2). Not all of these posts are filled, this is particularly so in the case of Orthodontics. In addition to the whole-time posts a small number of Orthodontists and Oral Surgeons are employed on a part-time basis by health boards and voluntary hospitals. The Board endorses the views expressed that there should be increased provision for programmed training. This was the principal motivating factor in it entering into discussions with the Faculty of Dentistry regarding the establishment of a special committee concerned with higher specialist training which would replace the former Irish Committee on Higher Training in Dentistry which had existed in the latter half of the 1970's but which was dissolved, it having achieved its primary objectives of considering and reporting on the implications in the Irish context of the November, 1972 Report of the Joint Committee for Higher Training in Dentistry. As indicated in paragraph 5.4 agreement has been reached with the Faculty of Dentistry on the establishment of a new committee to oversee higher training and it should be set up shortly.

5.8.4 The 1980 report referred to earlier recommended that the costs of programmed training should be met in the same way as in Medicine. The Board agreed with this recommendation and it contributes to the financing of the Faculty of Dentistry in exactly the same manner as applies to the other bodies recognised by the Board. The system of financing involved is dealt with in Chapter 6. Similar arrangements will also apply when the new committee dealing with higher specialist training in dentistry referred to in paragraph 5.4 is established.

5.8.5 During the past five years the Board has helped towards the funding of a number of specific projects relating to dentistry viz:-

- contributed towards the funding of a 3 day postgraduate/undergraduate course in Oral Medicine held in UCC in October, 1982;
- helped defray some of the deficit incurred by the Irish Society of Dentistry for Children in the running of its 1981/82 Scientific Programme;
- contributed towards the costs of a report on Irish Dental Manpower 1941-2001 commissioned by the Dental Board and published in August, 1984. This report will provide valuable information in the development of a career guidance programme for dentists;
- contributed towards the updating/restocking of the Irish Dental Library collection;
- provided a grant in 1983 to the Cork Dental School and Hospital towards the purchase of teaching equipment for its continuing education programme;
- heped to meet some of the deficit incurred by the Irish Dental Association in the running of its 1984 Annual Scientific Programme;
- as already mentioned in paragraphs 3.6 and 3.7 the Board paid grants to health boards, hospitals and centres to help towards the purchase of teaching equipment. Much of this equipment was for both medical and dental education, with funds being specifically earmarked for dentistry in the case of the Eastern, Midland, Mid-Western, South-Eastern and Southern Health Boards.

5.8.6 Reference is made in Chapter 3 to the need for all health boards and hospitals to make adequate financial provision for continuing medical education. These comments apply with at least equal force to continuing education in dentistry, and all correspondence with employing and funding authorities has made this clear.

Continuing Education, Dentistry

5.9 The main thrust of the Board's activities in relation to dentistry has concentrated on the development of continuing education. In the preceding paragraph an outline is given of the help provided by the Board to particular activities. Important and welcome as this help was, it was only a help and was intended as a spur to greater efforts or as a recognition for a particularly important activity. It was not intended as a substitute for more fundamental appraisal as to how to promote continuing education. This appraisal arose from consideration of the 1980 report of the Dental Committee of the former Postgraduate Council for Medical and Dental Education.

5.10 **Summary of Conclusions and Recommendations of 1980 Report**

In this paragraph a summary is given of the conclusions and recommendations of the 1980 Report in respect of providing a national framework for the co-ordination, promotion and provision of continuing education in dentistry. The report said:-

"Dentists who do not receive Continuing Education must suffer a decrease in professional competence. This has grave implications for the community from

the health, social and financial aspects. It is in the interest of dentists, of their patients, of their employing authorities and of the community generally that dentists should receive Continuing Education. A large part of Continuing Education is self-education through reading and discussions with colleagues. Even in self-education some help and guidance from others may be necessary and organised continuing education is essential for most. Those who rely solely on their own reading may suffer from a false sense of security.

An appreciable, but far from adequate, amount of Continuing Education is already organised by a number of bodies. The chief one is the Irish Dental Association. It has a Scientific Committee which organises an Annual Scientific Meeting. It has a Sub-Committee dealing specially with Continuing Education. The Sub-Committee has Branch Liaison Officers who co-operate with the Branch Secretaries and other dentists in organising Continuing Education at local level. While the activities of the Irish Dental Association are most praiseworthy and represent the greatest single effort in the interest of Continuing Education, they are of necessity limited and, while they are reasonably successful in some areas, the results in most must be regarded as far from adequate. The Dental Hospitals/Universities make a significant contribution as they supply speakers to several meetings and organise some Scientific Meetings each year. A number of dedicated individuals put a considerable amount of work into Continuing Education.

While all the activities mentioned are beneficial, they provide no more than a fraction of the Continuing Education which is desirable. The difficulties in having an adequate and co-ordinated system of postgraduate education in Dentistry were appreciated but when regard is had to the obvious needs a serious effort must be made to meet these needs".

The report went on to recommend that some national body be given responsibility to try and promote an adequate and co-ordinated system of Continuing Education. It recommended that this body should be the Board subject to the establishment of a special Dental Committee, to which persons who are not members of the Board could be co-opted and the arrangement proposed be regarded as an interim and experimental measure until a new Dental Council is in operation. The Report did not recommend that the Dental Committee should itself provide continuing education but should operate through regional committees.

It is important to recognise that under statute the Board has the responsibility of promoting the development of postgraduate dental education and training and co-ordinating such developments. Subject to this the Board accepted the recommendations made in the 1980 report and quoted above. It held discussions with the Irish Dental Association and a Dental Committee was formed in 1981 — its membership and terms of a reference are set out in paragraph 5.2 (ii).

Regional Committees

5.11 The Board and its Dental Committee has adopted proposals which envisage the establishment of five or six regional committees. Stated in general terms the functions of a regional committee would be the promotion of continuing education within its area. Particular functions would be:-

(a) Co-operation with other bodies involved in postgraduate education. It should co-operate with the Dental Committee in trying to have implemented criteria or standards suggested by the Dental Committee, with local Dental Associations and, where appropriate, with Dental Hospitals/Universities. **It is important that the Regional Committees should not be seen as in any way supplanting existing bodies within their areas. The aim of the Regional Committees should be not only to assist and encourage existing bodies, but to help in co-ordinating their activities and in promoting additional activities;**

(b) The general guidance of the activities of a Course Organiser and co-operation with the Course Organiser in the advancement of postgraduate education within its area;

(c) The making of recommendations to the Dental Committee as to the developments necessary in its area;

(d) A consideration of the educational needs of dental practice and of the relevance and effectiveness of particular activities in meeting these needs;

(e) An examination of the steps necessary to assure that the whole field of primary care is covered over a period.

Appointment of Course Organisers

5.12 To assist them in their work the proposals adopted envisaged that each regional committee would appoint a course organiser on a sessional basis. The course organiser would have the task of promoting and encouraging continuing education at individual, group and regional level. He or she would be required to make recommendations to the regional committee on local needs and on the best way to meet these needs and would be involved in the assessment of the relevance and effectiveness of different courses and activities organised within the area covered by the regional committee. The course organiser would also be required to liaise with all groups interested in continuing education and would be expected to encourage the co-ordination of the activities of different groups. Another function of a course organiser would be the provision of continuing education in his/her area — mainly, indirectly, through the organisation of suitable activities, but also directly by talks on particular subjects within his/her competence (these could be scientific, or on matters such as self assessment, the formation of small group activities, desirable reading and on how additional information or knowledge may be obtained).

Number and Location of Regional Committees

5.13 The proposals adopted envisage the establishment of 5 regional committees, based on Dublin, Cork, Galway, the North West and the South East.

The regional committee based on Dublin would serve the Eastern, Midland and North Eastern Health Board areas; the committee based on Cork would serve the Southern and Mid Western Health Board areas; the committee based on Galway, North-West and South-East would serve the Western, North-Western and South Eastern Health Board areas respectively. It was not intended however that there would be a rigid division by areas and dentists would be free to attend courses or activities outside their own areas where they found it more convenient to do so and this has happened already in the case of the first committee established.

Some consideration was given as to whether there should be a separate regional committee based on Limerick serving the Mid-Western Health Board area. A final decision on this has been left in abeyance and will no doubt be considered again when the work of the pilot study based on the South/Mid-West is being evaluated (paragraph 5.20 refers).

Membership of Regional Committees

5.14 It is intended that the regional committees should be as representative as possible of the dentists in the area they are serving. In general it is envisaged that there should be about 5 private dental practitioners and 3 public dental officers together with one member of the Dental Committee of the Postgraduate Medical and Dental Board and one health board representative on each regional committee. It may be necessary in the case of some committees, because of local circumstances, to vary these numbers. It is also envisaged that the dental schools will be represented on the Dublin and Cork based committees and it is hoped to appoint a dental consultant to the other committees.

Response to Proposals

5.15 The proposals relating to the establishment of regional committees were put to the dental profession and to the health boards late in 1981. All registered dentists were also notified. There was a very good response to these proposals from the dental profession and from individual dentists throughout the country with over 100 indicating that if appointed they would be prepared to serve on the regional committees. When the proposals were prepared it was envisaged that the funding of the regional committees would come from the health boards. However, while the Health Board Chief Executive Officers indicated that the regional committee arrangements should be actively pursued the health boards have not been able to provide funding for them.

The Board reviewed the position in the latter half of 1982 and decided to seek funds to enable it to appoint one or two regional committees on a pilot study basis. The Board was able to provide sufficient funds to establish one regional committee in 1983 and to establish a second in 1984. Details in this regard are given in paragraph 5.17 and subsequent paragraphs.

Policy Document "Continuing Education in Dentistry"

5.16 In conjunction with its consideration of the establishment of regional committees the Board and its Dental Committee had under consideration the policy aims which should be adopted in relation to continuing education in dentistry. These aims were embodied in a policy document adopted in June, 1983 and circulated to all interested parties. Some extracts from this document are given beneath:-

> "Professional education is a continuing process. It begins when the student first enters a dental school and should end only when the dentist retires from practice. Undergraduate education and postgraduate education should thus be seen as two distinct phases of the same process. "The young graduate, upon leaving the dental school, should be imbued with the ideal of making continuing education a way of life. It is the task of those responsible for professional education to provide him with the opportunities to live and practice in accordance with this ideal". (W.H.O. 1970 Postgraduate Dental Education, W.H.O. Regional Office for Europe, EURO 0431).
>
> The need for continuing education in dentistry is perhaps best illustrated by the fact that in the past 20 years, for example, the content of the undergraduate programme in our Dental Schools has changed dramatically. In 1960 the principles and techniques of Preventative and Childrens Dentistry and of Periodontology occupied a negligible part of the undergraduate curriculum and yet at the present time extensive knowledge and skill in these subjects is an essential part of primary dental care. Since 1960 the content and range of knowledge and skills in the primary care aspects in Conservative Dentistry, Prosthetics, Orthodontics, Oral Surgery and Oral Medicine have extended considerably. For example, the first clinical studies of the resin that would bond to etched enamel were not reported until the late 60's and yet the technique is now commonplace in many aspects of primary care dentistry No doubt many of the dentists currently practising in this country either in general practice or in the public dental service and who qualified prior to 1960 (40%) have acquired the necessary knowledge of new developments through the many excellent courses provided by various bodies over the years. Nevertheless it is reasonable to suggest that many have acquired the necessary knowledge only through informal reading and discussion with colleagues and commercial interests. Few participatory courses (i.e. courses in which patients are treated) have been held, hence familiarisation with new techniques and with the use of new materials and equipment has probably occurred mostly by trial and error. A proportion of these dentists may indeed be depending solely on knowledge and skills acquired when they were undergraduates.

Policy Aim

In the context of Continuing Education in Dentistry therefore a reasonable policy aim at this stage would be:-

(a) That all dentists who qualified say prior to 1976 and currently providing primary dental care in this country (both in general practice and in the public dental service) will have the opportunity to acquire at least the knowledge and skills expected of undergraduates taking the current final dental examinations in our two Dental Schools and Hospitals.

(b) That all dentists providing primary dental care in this country will have the opportunity every five years to up-date their knowledge and skills to at least the level of that expected of undergraduates sitting the current final dental examinations in our two Dental Schools and Hospitals.

(c) In addition to updating knowledge and skills to the level expected of undergraduates sitting the final dental examinations continuing education will also be arranged to ensure that skills and knowledge already acquired will be complemented and increased.

It might well be argued (and probably will) that such policies are over-ambitious and unrealistic when the availability of teachers, clinical facilities and finance are taken into account. However, up-dating of long-term plans for dental teaching and the consequent clinical facilities and financial implications are constantly taking place, hence it is important that overall policy aims for continuing education in dentistry are clearly stated and periodically reviewed. Current short-falls in suitable manpower, clinical facilities and finance should not be a major factor in formulating policy.

Strategies to Achieve Policy

In choosing strategies to carry out the above policy, close co-operation between the planned Regional Committees, the local branches of the Irish Dental Association and other bodies is envisaged. Such co-operation will ensure that overall programmes rather than isolated topics are included in continuing education curricula. The setting up of study groups to include case presentations and journal clubs for example will be encouraged. In order to document progress it will be important that all activities be reported to the Regional Committees and to the Postgraduate Medical and Dental Board through its Dental Committee. It is essential that the two Dental Schools play a leading role in carrying out the policy on continuing education. Allocation of staff and facilities to the Schools must take account of this essential role. Clinical attachments, whereby practitioners spend a period of time participating in the functions of a Dental School and Hospital are an efficient method of providing continuing education and also when regional consultants are appointed clinical attachments to their units should also be organised".

Regional Committees: Pilot Projects

5.17 As indicated in paragraph 5.15 financial constraints have dictated that a phased approach must be adopted in establishing regional committees to provide, promote and co-ordinate dental continuing education. The Board is pleased that it has been able, in conjunction and partnership with the relevant health boards, to provide funds to establish two regional committees. The first was established in the North-West in 1983 and the second in the South/Mid-West in 1984.

North-West Regional Dental Committee

5.18 The first regional committee established as a pilot study covers the North-Western Health Board area i.e. Donegal, Leitrim and Sligo. The Committee which was

established in partnership with the North-Western Health Board, held its first meeting in June, 1983. Its members are **Messrs. D. Bonar,** Dungloe; **B. Byrne,** Sligo; **J. P. D. Cribben,** Ballinamore; **P. Dockry,** Ballymote; **P. MacNamara,** Sligo; **M. McGinley,** North-Western Health Board; **S. McMahon,** Sligo **(Chairman); Mrs. B. C. Montgomery,** Dungloe; **Mr. J. Murray,** Letterkenny and **Miss A..P. O'Donoghue,** Derrybeg.

There are some 50 dentists in the committee's catchment area, spread over a wide area geographically. The area was chosen for the first pilot study principally because it is geographically distant from the Dental Schools and would therefore have been seen as being at some disadvantage in organising continuing education.

At its first meeting held in Ballyshannon on 10 June, 1983 the committee agreed to proceed with the appointment of a course organiser. The position was advertised among all dentists practising in the area and **Mr. Brendan Flanagan,** a private dentist in general practice in Sligo was appointed with effect from 19 September, 1983. The course organiser wrote to all dentists in the area seeking their views on continuing education needs. Based on the responses received (over 90% replied) and having regard to the Board's policy document, already referred to, the regional dental committee has compiled a comprehensive list of possible course contents.

5.19 **Courses organised by North-West Regional Dental Committee**

The first course was held on 19 November, 1983, in the General Hospital, Letterkenny. Four lectures were given on this day-long course; Preventive Dentistry, Minor Oral Surgery, Systemic Diseases and their Oral Manifestations, and fourthly Emergencies in Dentistry. 52 dentists attended.

The second course was held on 25 February, 1984, in a health board centre in Sligo. The programme started with a lecture on Endodontics followed by a clinical demonstration. There was then a lecture on Acid Etch Technique followed by a clinical demonstration. 20 dentists attended.

The next course on 29 June, 1984, in the General Hospital, Letterkenny comprised a lecture on Class II division I malocclusion followed by a demonstration; a lecture on Varieties of Class II division I followed again by a demonstration; two lectures on Functional Appliances, their background and description, with appropriate demonstration, and Comparisons and Generalizations given with a clinical course on Case Presentation of Functional Appliances. 12 dentists attended.

A video course on "Duralay Post" attended by 10 dentists was held in Sligo, on 25 April, 1984.

14 dentists attended an evening course on 8 July, 1984, in Sligo on Occlusion.

A Clinical Course, organised in conjunction with the Irish Society of Periodontology was held in Sligo on 20 October, 1984. The course commenced with a lecture on scaling and root planing teeth including video of procedure. There was a demonstration of scaling on Phantom Head and patient. Following lunch there was a clinical course confined to 12 dentists. This consisted of a participation course on scaling and root planing.

The regional committee held its annual conference on 17 November, 1984, in the General Hospital, Letterkenny. The title of this course was "Pain — Real or Imaginary". It commenced with a lecture on the Anatomy & Physiology of Facial Pain followed by a lecture on the Dental Aspects of Facial Pain. There then followed two lectures: "Diagnostic features of some classical facial pain — e.g. Trigemminal neuralgia, migraine, paroxsymal migraine neuralgia" and "Psychogentic Facial Pain & Drug Therapy for facial pain".

In addition to the above the regional committee has under consideration the formation of a number of small study groups which would use video and/or case presentations as their principal teaching/learning method.

The Postgraduate Medical and Dental Board is very pleased with the progress made by the North-West Regional Dental Committee and is pleased to take this opportunity to congratulate it on its achievements to date. The work achieved by this committee illustrates, as do the achievements of the general practitioners pilot studies, the potential of delivering continuing education through the active involvement of committed individuals supported by enthusiastic and dedicated course organisers. The Board is satisfied that with proper motivation a great deal is in fact being achieved for a relatively small financial investment through harnessing the goodwill and active involvement of many.

South and Mid-West Regional Dental Committee

5.20 The second regional committee established, also as a pilot study, covers the Mid-Western and Southern Health Board area i.e. Clare, Limerick, Tipperary (NR), Cork and Kerry. There are some 285 dentists in practice in the area. This committee was established in partnership with the two health boards in the area and held its first meeting in Mallow in May, 1984. Its members are **Professor L. Buckley,** Cork; **Mrs. N. Coleman,** Castletroy; **Messrs. J. Dodd,** Nenagh; **J. Gleeson,** Killarney; **J. F. Lemasney,** Limerick **(Chairman); Mrs. J. McLoughlin,** Castletroy; **Messrs. P. J. O'Connor,** Cork: **C. P. O'Malley,** Limerick; **D. O'Meara,** Fermoy; **W. Palmer,** Tralee and **P. A. Sheehan,** Mid Western/Southern Health Boards.

At its first meeting on 10 May, 1984 the regional committee decided to proceed with the appointment of a course organiser. The position was advertised among all dentists practising in the area. **Dr. G. J. Buckley** of the Cork Dental School and Hospital was appointed and took up duty in January, 1985.

The regional committee is now in the process of consulting with the various interests in its area with a view to drawing up its work programme and programme of activities. It has already decided that priority should be given to participatory courses.

Establishment of other Regional Committees

5.21 Subject to an evaluation of what the existing regional committees achieve, and the indications based on an assessment of the work in the North-West are positive, the Board would intend to proceed with the establishment of three further committees as soon as finances allow. The Board has sought additional finances to enable at least one further regional committee to be established in 1985.

CHAPTER 6

Finance

Source of Board's Finance

6.1 Section 39(2) (d) of the Medical Practitioners Act, 1978 provides that the Minister for Health may, out of moneys provided by the Oireachtas, make grants towards the expenses of the Board.

Income and Expenditure

6.2 In the period 7 March, 1980 to 31 December, 1984 grants totalling **£959,500** were received by the Board. Expenditure in the same period amounted to **£955,200** — details are given in **Table I.**

Audit of Accounts

6.3 Section 21 of the Medical Practitioners Act, 1978 provides for the accounts of the Board to be audited by an auditor appointed by the Minister for Health. The Minister has appointed the Comptroller and Auditor General. The accounts in respect of the periods ended 31 December, 1980, 1981 and 1982 have been audited and have, as required by the Act, been printed, published, put on sale and laid before each House of the Oireachtas. The accounts in respect of 1983 have been audited and signed and are with the printers.

Board's Finance Committee

6.4 The Board has appointed from within its own membership a Finance Committee to advise it on all aspects of its financial affairs including:-

- monitoring expenditure on its behalf
- preparation of estimates and budgets
- advising on the cost implications of proposals submitted to the Board
- advising on financial policies to be adopted.

The members of the Finance Committee during the period covered by the report were **Professor A. D. H. Browne,** (Chairman), **Professor B. E. Barrett, Dr. M. M. Berber, Professor G. Bourke, Mr. G. MacGabhann, Dr. C. S. Macnamara, Dr. N. Tierney** and **Dr. W. Wren.**

Policy Statement on the Financing of Postgraduate Education and Training

Board's functions in regard to financing of Postgraduate Education and Training

6.5 The Board has the function, after consultation with various bodies, of advising the Minister for Health on all matters, including financial matters, relating to the development and co-ordination of postgraduate medical and dental education. Following these consultations it has been agreed that postgraduate education should be financed as set out in this policy statement. It deals with finance under two main headings:-

(a) Programmed Training,

(b) Continuing Education.

PROGRAMMED TRAINING

Position of Professional Bodies

6.6 As indicated in paragraph 2.2 the Board accepts, in principle, that programmed training should be under the immediate guidance of professional bodies. The Board

has, however, been given the responsibility of promoting and co-ordinating the development of postgraduate education, of providing career guidance and, as already stated, of advising the Minister on financial matters. To fulfil its functions, and with its overall view of the situation of postgraduate education, the Board reserves the right to ask questions, or to make suggestions on particular programmes, e.g. on programmes which seem to depart seriously from the general trend, on numbers being trained and on co-ordination between different programmes. The general aim of the Board, however, is to help and it anticipates that any differences of opinion between it and the professional organisations can be solved amicably. To fulfil its functions the Board has to exercise a general over-view of postgraduate education — subject to any criteria and standards laid down by the Medical Council. Its primary objective, however, is to help the professional bodies and if it thinks that modifications in any programme are desirable it proposes to discuss the matter with the body concerned and try to reach a solution acceptable to both sides. As indicated in Chapters 2 and 5 the Board has recognised ten main Irish professional bodies as filling major roles in programmed training. Details as regards these bodies are given in the chapters referred to.

Method of Financing

6.7 Broadly, the Board visualises that:-

(a) contributions towards the expenses of professional bodies which would not be applicable to any employing authority (health board or voluntary hospital) should be paid directly by it,

(b) that agreed expenses directly related to trainees should be paid by the employing authorities i.e. health boards and voluntary hospitals.

6.8 **Expenses payable by the Board**

6.8.1 The Board assists the professional bodies in their exercise as national bodies, of a general control over programmed training in the specialties dealt with by them. The following are the types of expenditure on which the Board helps:-

(a) the organisational costs of the professional bodies in activities wholly or substantially concerned with the development of post-graduate education in a recognised specialty or sub-specialty. These organisational costs relate to the approval of programmes, the setting of standards and similar matters (not the costs of running individual programmes) and cover administrative and travelling costs;

(b) expenses of representatives of Joint Committees, or similar bodies, who are visiting Irish hospitals, or programmes of training;

(c) approved expenses of representatives of the Irish professional bodies who have to attend meetings of Joint Committees, or similar bodies, or their Specialist Advisory Committees;

(d) contributions of the Irish branches of the Joint Committees towards the expenses of the Joint Committees.

6.8.2 The normal level of help from the Board in respect of organisational (other than travelling) costs and in respect of financial contributions of Joint Committees is calculated at two-thirds of the cost to the Irish professional body. There is one principal variation from this — the Board provides the administrative service to the Irish Psychiatric Training Committee.

The Board's assistance to the training bodies to meet the various travelling expenses referred to in paragraph 6.8.1 are calculated by reference to the prevailing rates applicable in the health services generally and only in exceptional cases are rates in excess of public transport costs applied.

6.8.3 Each professional body submits to the Board, an annual estimate of the costs, as set out in 6.8.1, in which it will be involved. Subject to agreement on the nature and extent of costs in these estimates the Board visualises that claims for expenses should be submitted by the professional bodies as they arise in the case of travelling claims and quarterly in the case of administrative expenses. In this way the professional body and its members should not be out of pocket for extended periods and the Board should not be faced with unforeseen expenditure.

6.8.4 As shown in Table 1 the payments made by the Board to professional bodies during the period 7 March, 1980 to 31 December, 1984 amounted to £308,500 (32% of all expenditure). The distribution of those payments between the specialties is shown in Table 1. Table 2 shows the distribution of these payments by function.

TABLE 1

THE POSTGRADUATE MEDICAL AND DENTAL BOARD

Expenditure 7 March, 1980 - 31 December, 1984

	£	£
Salaries		149,750
Travelling and Subsistence		29,200
General Administration		92,700
Payments to Professional Bodies		
— Anaesthetics	24,300	
— Dentistry	10,550	
— General Practice	71,100	
— Medicine	83,850	
— Obstetrics/Gynaecology	18,850	
— Pathology	13,350	
— Psychiatry	23,250	
— Radiology	20,800	
— Surgery	42,450	308,500
Co-ordinators of Postgraduate Education		222,350
Pilot Studies (General Practice)		44,950
Audit Fees		1,100
Career Guidance		10,650
Grants to Postgraduate Centres		26,750
Grants to Health Boards and Hospitals		56,800
Transnational Training Programme		300
Regional Dental Committees		12,150
Total		955,200

TABLE 2

Grants paid to Training Bodies

1980 - 1984

Purpose of Grant	**Amount**
Administrative Costs	£83,800
Travel expenses (a) abroad	£64,000
(b) Ireland	£61,600
Contributions to Joint Committees	£50,950
Grants for Audio-Visual equipment, libraries, etc.	£36,500
Joint Committee/SAC Visitations to Ireland	£11,650
Total	£308,500

6.9 **Expenses attributable to employing authorities**

6.9.1 Most persons undergoing programmed training are employed by health boards and voluntary hospitals as House Officers, Registrars or Senior Registrars. A considerable amount of service will be provided by the person in training. The Board does not regard it as feasible or desirable to attempt to cost, or to draw a clear distinction between the service element and the training element. Similarly it regards training by precept and example, by supervision, by clinical demonstration, by case conferences etc. as forming part of the normal life of any hospital providing training. Again it considers that it would not be feasible or desirable to attempt to differentiate between the training element and the service element of the training staff, except in regard to some activities which are primarily related to training e.g. the giving of special lectures. The major cost of training i.e. the salaries and emoluments (if any) of the trainees will be borne automatically by the employing authority. Additional costs may also arise. Some of these relate to a limited number of trainees e.g. travelling expenses, and have to be dealt with on an individual basis. The question of whether such costs should be borne by the trainees, or by the employing authority, may be related to the question of the terms and conditions of the trainees' employment — a matter which is outside the functions of the Board. Some suggestions (paragraph 6.9.4-6.9.8) are made, however, regarding costs of a more general nature which may arise.

6.9.2 Some trainees will work outside hospital e.g. doctors receiving training in the community. The Board considers that similar financial arrangements should apply to them as apply to hospital doctors employed by health boards; their salaries and other approved expenses should be paid by health boards.

6.9.3 Costs which are not strictly applicable to a particular employing authority (e.g. a lecture, or course of lectures, provided for trainees from a number of centres) may have to be apportioned between the authorities concerned e.g. on the basis of the numbers of trainees catered for in each centre. In the event of disagreement, the matter should be referred to the Department of Health for an apportionment of costs.

6.9.4 Most trainees will purchase standard text books and some journals for their own use. It is not practicable, however, to expect trainees to buy the wide range of literature, the study of which is an essential part of their training, and the Board considers that health boards and voluntary hospitals engaged in training should provide adequate library facilities and teaching aids either in hospitals or other centres, or by arrangement with other centres. Regard will be had, of course, to the number of trainees who will use the facilities provided and the ease, or otherwise, of access to alternative facilities.

6.9.5 The Board regards special lectures as an essential part of training. The number and range of such lectures which are desirable is a matter for consideration, in the first instance, by the professional body concerned. Some consultants regard the giving of lectures as part of their normal commitment to teaching. If a fee is claimed the question of whether it is to be regarded as payable, or as covered by the lecturer's normal duties, is a matter for consideration, in the first instance, by the employing authority. The rate of fees payable is subject to the approval of the Minister.

6.9.6 Health boards and voluntary hospitals should make provision for study leave for trainees. In discussions in 1973 between the Department, representing the Minister, and the Irish Medical Association and the Medical Union it was agreed that adequate study leave arrangements were

desirable for junior hospital doctors. It was not accepted that training requirements should take absolute preference, nor that officers had "entitlements" irrespective of the needs of the service. It was, however, recognised that essentially certain hospital posts were training posts, the holders of which provided a level of service on behalf of the hospital compatible with their grade and experience; in other words each post comprised two basic elements — training and service. It is understood that the Department has urged health boards and voluntary hospitals that in any conflict of needs they should, in a spirit of goodwill, try to work out a satisfactory solution in consultation with the staff concerned. It was agreed that study leave as follows may be allowed:-

(a) for sitting examinations, which in the opinion of the Chief Executive Officer or voluntary hospital authority are relevant to the work on which the officer is engaged — the leave necessary for the examination only with pay;

(b) for attendance at courses, conferences, etc. recognised and approved by the Minister for Health and which the Chief Executive Officer or voluntary hospital authority is satisfied are relevant to the work on which the officer is engaged — special leave with pay for 7 days in each year;

(c) for examinations for higher degrees or diplomas — any 14 days with pay prior to the examination;

(d) to attend clinical meetings of societies appropriate to their specialties — not more than 7 days in any one year, with pay.

6.9.7 Where health boards, or voluntary hospitals, agree that trainees, as part of their training, should attend particular courses in Continuing Education appropriate costs should be paid (see the following section on Continuing Education).

6.9.8 In general, it is the view of the Board that if health boards and voluntary hospitals wish to have trainees for programmed training there is an obligation on them to create the conditions which will attract trainees and which will permit of their receiving adequate training.

6.9.9 In correspondence with the Board, the health board chief executive officers mentioned that there should be some guidelines on the limit of study leave (and repeat study leave) for programmed training. The grant of study leave and the limits allowable are covered by the NCHD uniform contract of service and the Board would not wish to impinge on the operation of that contract nor does it see a role for itself in the area of industrial relations. Difficulties which can arise for the orderly functioning of hospital departments where groups of NCHDs seek study leave or repeat study leave have been brought to the Board's attention. The NCHD contract does not, of course, bestow rights on individual doctors to study leave at any given particular time and regard has to be had in the making of arrangements for the continuing of the service commitment of the hospital. Perhaps the difficulties which arise would be minimised if there were agreed local procedures governing the making of applications for study leave well in advance. As regards the question of repeat study leave it would not come within the Board's functions to interpret the NCHD contract of service but perhaps the grant of study leave of fourteen days on one occasion each year for any particular examination would constitute a reasonable approach. Circumstances might arise, however, in individual cases, which would warrant special consideration and the Board would hope that in such cases, hospital authorities would deal with them sympathetically.

6.9.10 The Board regards most of the costs mentioned as part of the on-going costs of health boards and voluntary hospitals. It does not regard it as necessary that professional bodies should be involved in the payment of these costs.

CONTINUING EDUCATION

6.10 Method of Financing

6.10.1 In general the Board feels that courses, seminars, etc. organised by different bodies should be self-supporting e.g. by fees payable by or on behalf of those attending. There are, however, occasionally very important lectures to which it is desirable to attract as many doctors or dentists as possible and where the charging of a fee is not practicable. In such cases the Board may be able to help provided the organisers obtain prior agreement of the Board where its aid is being sought.

6.10.2 Health Boards and voluntary hospitals already pay, or contribute towards the costs of Continuing Education of doctors and dentists employed by them. The Board has already recommended, see Chapter 3 of this Report, that health boards and voluntary hospitals should make adequate budgetary provision for the continuing education of their medical and dental staffs. The Board is strongly of the view that budgetary provision should be made to finance the level of continuing education which the Department of Health has traditionally been prepared to approve and which is incorporated into the contracts of consultants and non-consultant hospital doctors — this provides broadly for leave with pay and recoupment of course fees (if any) and travelling expenses in respect of attendance at courses, conferences etc. to a limit of seven days in each year and attendance at clinical meetings of societies appropriate to the officer's specialty, again with a limit of seven days in one year. Guidelines for the operation of specific budgets for continuing education are detailed in paragraph 3.5 of this report.

6.10.3 The Board has already indicated to the Department of Health that the same arrangements should apply to all doctors and dentists providing services for public patients.

6.10.4 As indicated in Chapters 3 and 5 the Board is helping to fund (a) three pilot studies on a system of providing continuing education for general practitioners and (b) two regional committees for continuing education for dentists. In the case of the three medical pilot studies the bulk of the expenses are met by the Board and some expenses are funded with the aid of the pharmaceutical industry. As already indicated the Report of the Working Party on the General Medical Service envisages a national network of such continuing education programmes. The Board welcomes and endorses this recommendation. It has stated, however, that it could not finance such a network from within its own resources. It is willing to enter into discussions with the various interests to help draw up a plan for implementing the recommendation and would hope that a satisfactory funding arrangement, either by the State, the profession or a combination of both can be found.

6.10.5 The funding arrangements for the two regional dental committees include course organiser fees and their travelling together with the travelling expenses of the members of the committees being met by the Board. In the case of one committee the secretarial services are funded by a health board while the Board meets these costs in the other case. Health Board hospital clinics and premises are of course made available at no cost to the committees. As indicated in Chapter 5 a national network of five such

regional committees is envisaged — these of course can only be established if adequate funding for them is forthcoming to the Board and/or the health boards.

Grants paid by the Board

6.11 Information has already been provided in Chapters 3 and 5 on some special grants which have been made available by the Board for continuing medical and dental education — mainly for the purchase of some teaching equipment or other resources and in some limited number of cases for help towards course costs or helping to defray deficits incurred in programmes. The Board is pleased that it has been able to provide such help but wishes to stress that this help should not be seen as a substitute for adequate budgetary provision being made by health boards and hospital authorities. The need to make such provision is strongly recommended and attention is drawn to the guidelines proposed in paragraph 3.5 as to the operation of specific budgets for continuing education.

CHAPTER 7

Career Guidance and Medical Manpower

CAREER GUIDANCE

Introduction

7.1 The Postgraduate Medical and Dental Board has the function of providing career guidance for doctors. This is an important but difficult task. Career Guidance is concerned with the provision of advice to individual doctors as to careers they might choose, and once a choice has been made it is concerned with providing guidance as to how to progress in that career.

7.2 It is not practicable nor indeed possible for the Board to provide individual career guidance to every young doctor in training. Career guidance and advice of that nature must be provided on a personal level by those who know the doctor and his/her aptitudes and abilities and by those involved in providing training programmes. Ultimately decisions in relation to career choice must be made by the individual bearing in mind his/her own talents and interest, while assessing the advice given by others and availing of the opportunities presented. It will never be easy to arrive at a final decision. The advice and information given to a young doctor will play a crucial role in helping him/her to come to a decision. This information should be readily available and there should be opportunities to obtain more should it be required.

7.3 The Board sees its role in the area of Career Guidance as ensuring that adequate information is available to young doctors both on the career prospects in the various branches of medicine and on the training requirements for each of these branches. This means that when a young doctor decides on a particular career pathway, the decision will have been taken with the fullest possible knowledge.

7.4 The aim of the Board's career guidance programmes and activities is to help a young doctor to choose the field of medicine in which he or she might make a career. This choice is of course entirely personal, but the opportunity to discuss the career prospects and the training needs of each discipline must be available to each doctor who might seek it.

7.5 It is clear that the advice provided for young doctors is not given on a once-and-for-all basis, nor is it given by one person. The individual consultant should be only one of the first of a group with whom a young doctor will confer. The group will also include the Co-ordinator of Postgraduate Education (employed by the Postgraduate Medical and Dental Board) and the persons designated by the training bodies to give information on their specialties. The choice of whom is consulted must always lie with the individual who seeks information. Fortunately, there are many who are knowledgeable, sympathetic and willing to give time to young aspirants. What has been a problem in the past has been to find in one place information which might lead to an appreciation of the real prospects of advancement in the varying disciplines of medicine.

Launch of the Board's Career Guidance Programme

7.6 The Board launched its career guidance programme at a Symposium in 1982. The main elements of the programme are outlined in the following paragraphs.

Board's Symposium

7.7 The Board held a Symposium on Career Guidance in Medicine in June, 1982. The main aims of the Symposium were to:-

— enable an exchange of information to take place on how the professional training bodies were then providing career information and guidance; and

— help towards the development of an overall policy for the provision of career guidance.

Dr. Alton, Chairman of the Board presided and there were speakers from each of the professional training bodies as well as from Comhairle na nOspidéal, Department of Health, Higher Education Authority, Irish Medical Association, Medical Union and from the Irish Medical Students' Association. The attendance at the Symposium included representatives of all the Bodies already mentioned as well as from the Medical Schools.

7.8 Two issues which were raised frequently during the course of the Symposium namely, the medical manpower issue and the need to involve peripheral hospitals in rotational training programmes, were outside the immediate scope of career guidance but undoubtedly would impact on it. These two issues are dealt with in other parts of this Report.

7.9 In relation to Career Guidance there was general agreement that an organised structure was essential. This would ensure that a young graduate would have easy access to information concerning the different careers in medicine, the job opportunities, the skills required and details of the various training programmes. In addition to the advice normally obtainable from one's own teachers, a nationwide network of knowledgeable and interested doctors nominated by professional bodies and available to give individual advice to young doctors would be essential.

Four important points emerged:-

— it is essential to provide frequently published and updated data giving information on the numbers in the different specialties and branches of medicine;

— there is a critical need to provide programmed career guidance in the form of lectures, question-and-answer sessions, etc. in the intern year giving basic information about the points mentioned above. Final year students could, if they so wished attend these lectures;

— information should be available and published on the lesser known career outlets such as academic medicine, the army medical corps, pharmaceutical medicine and so forth;

— the possibilities of job opportunities/prospects abroad must be explored on a wider basis and the data made available. This would apply, more especially, to positions where permanency and job satisfaction are most likely.

Panel of Doctors available to provide career guidance

7.10 The Board has established, with the co-operation of the training bodies, a panel of doctors who are available to give career guidance and information to non-consultant hospital doctors. There are over 80 doctors on this panel, located in Cork, Dublin and Galway with a small number outside of those centres. Details are given in Appendix 4.

Career Guidance Publications

7.11 The Board has published the following booklets and leaflets as part of its career guidance programme:-

1982: **Careers in Medicine** — a booklet giving a general description of the pattern of training for Careers in Medicine;

Medical Careers In Ireland — a leaflet giving an edited version of a presentation by the Board's Chief Officer at a seminar held in the RCSI in March, 1982 on the general medical manpower situation;

1983: **Medical Manpower in Ireland** — the first edition of a booklet providing data on the numbers of doctors in the different specialties and branches of medicine;

A Career in Surgery — a careers information leaflet dealing with training for surgical specialties;

A Career in Community Medicine — a careers information leaflet dealing with training in community medicine;

1984: **Medical Manpower in Ireland** — the second edition of a booklet providing updated data on the numbers of doctors in the different specialties and branches of medicine.

The publications listed above were circulated to all interns, first-year house officers and final year medical students at the time of publication. They were also circulated to training bodies and to health boards and hospital authorities.

7.12 Further publications are planned giving careers information on training for other specialties. Work is in progress on the preparation of further leaflets but shortage of staff is an inhibiting factor. It is hoped to publish either annually or biannually an edition of the booklet Medical Manpower in Ireland.

Career Guidance Meetings for Interns and House Officers

7.13 The Board and the Co-ordinators of Postgraduate Education organised four career guidance meetings (2 in Dublin, 1 each in Cork and Galway) both in 1982 and 1983. These meetings were aimed primarily for interns and first year house officers but others, including final year medical students, were welcome to attend and in fact many have done so. The overall attendance at the meetings each year has been over 200. The principal format adopted at these meetings was to have up to twelve papers of about eight to ten minutes duration dealing with the main career options and providing ample opportunities for questions from the audience both in relation to the formal presentations or in relation to medical careers and training generally. This programme is still at an early stage of its development, and the approaches adopted have evolved and altered in the light of experience gained and in response to the evaluation forms completed by those attending. Audience participation has tended to be variable, with some groups very vocal and asking many questions whereas on one or two occasions it proved fairly difficult to stimulate discussion from the floor. It has been the policy at the Dublin meetings to provide comprehensive handouts, dealing with the main presentations and also providing information on aspects of training or careers not covered in the formal papers.

7.14 The issues raised by the non-consultant hospital doctors and by medical students attending the meetings have been very varied but have, in the main, concentrated on:-

- training pathways,
- job prospects,
- medical manpower,
- the possibility of being able to train on a part-time basis,
- the relatively few number of places available on general practitioner vocational training schemes,
- the value of working in the Developing World and the effects of this on subsequent training,
- how to obtain good training posts abroad, particularly in Canada, UK and the USA.

Arising from the frequency with which questions are raised about working in the developing world, the Board has prepared, after consultation with the Agency for Personal Service Overseas (APSO), a short hand-out on the subject.

7.15 The meetings referred to formed a very important part in the development of the Board's overall career guidance programme. They enabled young doctors to get at one time an overview of the training pathways and prospects in many different specialties. The meetings also provided an important forum through which the Board was able to get, at first-hand, an insight into the type of information young doctors wish to obtain as well as providing a source of information on the issues with which young doctors are concerned. This two way flow of information helps to shape the programme for the coming year. The potential attendance at these meetings will hardly justify holding meetings in Cork and Galway each year, rather the present feeling is that meetings on alternate years should suffice — the Board has agreed to this revised arrangement but will be prepared to revert to an annual programme if a sufficient demand is shown to exist.

Medical Careers Fair

7.16 A different approach was tried in Dublin in 1984. Rather than holding two meetings, with formal papers and presentations, it was decided to hold a "medical careers fair" at which each main specialty manned a booth to which interested doctors or students could call to obtain data on training, prospects, etc. All who attended obtained comprehensive handout material. The fair attracted an attendance of about 90 and was very well received with over 85% of those who completed evaluation forms preferring the revised format. Those who manned the booths also felt that the format adopted was more effective in conveying information to individuals than formal papers. The detailed responses received in the evaluation forms are being studied with a view to preparing the 1985 programme.

School-leavers

7.17 Many comments were made at the Board's Symposium in 1982 that the type of information provided to school-leavers in relation to medical careers was inadequate. The points made most forcibly were that information was not generally provided in relation to the medical manpower situation nor in relation to the nature of posts held during postgraduate training, involving as they do applying in many cases at regular intervals for new positions. The Board sought to bring these aspects to the notice of school-leavers and their parents through the correspondence columns of the national daily and Sunday newspapers in July, 1982. The Board has also suggested a number of changes in the Department of Labour career information leaflet "The Doctor". The Board is pleased that these changes have been incorporated in the latest issue of the leaflet. The publication of the presentation by the Board's Chief Officer at the RCSI 1982 seminar on the general manpower situation has and still does elicit a number of enquiries from parents seeking general career information.

Medical Manpower

7.18 Career guidance cannot be divorced from career prospects. Career prospects are inextricably linked with medical manpower. The Board's tasks in relation to career guidance are made much more difficult because of the many uncertainties affecting Irish medical manpower. Medical manpower is a much written and spoken about topic, but unfortunately it is not a topic which has generated much real action. It is a topic bedevilled by a myriad of confusing facts and projections as well as discussions on such diverse aspects as the role of the consultant, career structures, doctor/population ratios, percentage participation levels of female doctors to mention but a few. It is difficult to escape the conclusion that medical manpower can provoke endless debate but little enough in the way of solutions or action. It seems to be difficult even to assemble the most basic of information — how many doctors are

there in active practice in Ireland? There is no single agency which has the task of collating what information is available; the Board has done this to some extent but clearly it is difficult to vouch for the accuracy of some of the figures obtained.

7.19 In its second and final report published in December, 1977 the former Council for Postgraduate Medical and Dental Education devoted considerable attention to the question of medical manpower in Ireland. The material in that report provided information on the then number of doctors, doctor/population ratio, possible scale of increases, medical student numbers, career aspirations of non-consultant hospital doctors. Many of the basic points made in that report are still relevant today. It's two concluding paragraphs on the subject are worth repeating:-

> "6.17 The Council's aim has not been to suggest solutions to problems in which many other organisations may be involved, but to demonstrate that there are very serious problems which need urgent consideration. It appreciates that some of what it has recorded has already been pointed out by individuals, or by other bodies. It feels that the difficulty has been that there are so many interests involved that none has accepted overall responsibility. It regards the position as so grave that it must now be rectified as a matter of urgency.
>
> 6.18 The Council recommends that immediate action should be taken to give some body or bodies overall responsibility for the examination of the different aspects of medical manpower in this country".

7.20 The Board is disappointed that it must report that the principal recommendation of its predecessor quoted above has not been acted upon nor has any alternative approach been adopted and implemented.

7.21 A number of changes have occurred since the Council for Postgraduate Medical and Dental Education reported in 1977 which of course have a bearing on the scale of the issue today. The most important changes are listed in this paragraph:-

7.21.1 The number of doctors in active whole-time medical practice has risen from 3,925 in 1976 to 5,160 in April/May, 1984; giving 14.9 doctors per 10,000 population as compared with 12.0 in 1971;

7.21.2 Hospital consultants in practice have risen by about 159 in this period, non-consultant hospital doctors have risen by 513 (an increase of over 50%), the numbers of general practitioners are estimated to have increased by at least 300;

7.21.3 In the period 1978 to 1984 the number of graduates from the five Irish medical schools was 3,275, some 2,675 of whom were Irish;

7.21.4 The intake to UK medical schools, which was around 2,150 in 1963/64, has now reached close on 3,800;

7.21.5 Medical unemployment has begun to feature in fair numbers in European countries e.g. 713 doctors were unemployed in the Netherlands at the end of 1981, 1,700 were unemployed in France in January, 1980, on 30 June, 1982 965 doctors were registered at employment offices in the UK as seeking work as medical practitioners; West Germany has been reported as over-producing doctors at the rate of 3,500 - 4,000 a year. A recent survey among junior doctors reported (Br Med J, 1984, 289, 936) that on a weighted basis 20% of the doctors sampled had experienced unemployment in the past two years — the largest period of unemployment experienced was two months or less in 59% of cases and between three and six months in 20% of cases. While unemployment has not been reported among junior doctors in this country it seems likely that some must exist and that it may grow;

7.21.6 Some difficulties were experienced by Irish medical graduates i.e. nationals, in obtaining intern posts in 1983 and arising from this the Department of

Health introduced new arrangements for appointing interns the purpose of which is to give preference to Irish nationals and nationals of other Member States of the EEC.

7.21.7 There has been no significant change in the percentage of non-consultant hospital doctors filled by non-nationals with 16% of all registrars and house officers being non-nationals;

7.21.8 The Higher Education Authority proposed that an upper limit of 300 (later altered to 305) be placed on Irish admission to medical schools, the quota to be introduced in the academic year 1980/81. This figure compared with 414 and 382 in 1978/79 and 1979/80 respectively. While the number of Irish medical students has fallen from the levels of the 1970's the target figure of 305 still had not been achieved by 1983, the average number of students from the Republic of Ireland in each of six years of the undergraduate medical course at 1 January, 1984 was 325, with 333 being the actual figure in respect of pre-med;

7.21.9 The Report of the Working Party on the General Medical Service published in August, 1984 contains the following statement "the management side consider that an open-ended commitment to future entry to the General Medical Service is not tenable and this is especially the case in the face of present manpower projections". If this is followed through it obviously has important implications for Irish medical manpower;

7.21.10 The same report calls for steps to be taken as a matter of urgency to reduce substantially the annual intake of Irish students to medical schools; it is understood that the Department of Health indicated in 1983 to the Higher Education Authority that an intake of 250 would easily meet projected manpower requirements;

7.21.11 1981 saw the publication in the UK of the Fourth Report from the Social Services Committee of the British House of Commons. This report — 'The Short Report' — concerns medical education with special reference to the number of doctors and the career structure. Its best known recommendations indicate that (a) a much higher proportion of patient care should be provided by fully trained medical staff than at present and (b) in most hospitals and most specialties there should be an increase in the number of consultants and a decrease in the number of junior doctors. These recommendations have been accepted by the British Government. The Department of Health and Social Security has adopted targets for the doubling of the number of consultants over a 15 year period and the reversal of the 1982 ratio of 1 consultant to 1.8 juniors to 1.8 consultants to 1 junior in the same period. The reaction of the medical profession in the UK to the Short Report has been, perhaps predictably, mixed but the report has generated much debate on medical manpower and career structures and produced a number of possible options and models. No such debate is taking place here — it is true that various bodies have concerned themselves with the issue insofar as it impinges on their own role but no national debate or consideration comprising all or most of the interested parties is underway.

7.21.12 Staffing increases, which characterised much of the late 1970s, cannot now be regarded as an option for the future.

7.21.13 As from 30 April, 1985 the bilateral agreement concluded in 1927 with Great Britain and Northern Ireland, which provided for mutual recognition of medical qualifictions, will cease to have effect. While the provisions of that agreement may be largely unnecessary by reason of accession to the EEC the cessation of the agreement will have some effects on medical manpower, the precise impact of which is difficult to determine at this stage. It is understood that revised criteria will apply after 30 April, 1985 in

respect of (a) EEC nationals who are graduates of Irish medical schools seeking registration in the UK and (b) third country nationals (i.e. non-EEC nationals) who are graduates of Irish medical schools seeking registration in the UK. It is probable that the revised criteria referred to will be more restrictive than the existing arrangements. Graduates under (a) above will be eligible to apply for limited registration for the purposes of holding pre-registration appointments in hospitals approved by the Universities in the U.K. Details on the arrangements for such registration are currently being finalised between the Medical Council and the General Medical Council, London. The qualifications of graduates under (b) above will be accepted for limited registration in the U.K. but the graduates concerned will not be eligible to complete an internship in the U.K.

7.22 This report will return later to the absence of debate on medical manpower. In the paragraphs immediately following information is given in relation to medical manpower in Ireland.

MEDICAL MANPOWER IN IRELAND

7.23 **General**

7.23.1 As part of its remit in relation to the provision of career guidance for registered medical practitioners the Postgraduate Medical and Dental Board circulates at intervals leaflets giving updated data on the numbers of doctors in the different specialties and branches of medicine. As mentioned in paragraph 7.11 two such leaflets have already been published.

7.23.2 Part 1 of the General Register of Medical Practitioners published by the Medical Council shows that there are over 7,600 doctors who are fully registered. About 6,000 of those are resident in Ireland and about 1,000 are over 65 years of age.

7.23.3 In addition to those doctors who are fully registered there are in the region of 620 other doctors in practice — those who are registered either provisionally or temporarily (e.g. about 370 interns and 250 doctors from outside the E.E.C.).

7.23.4 **Number of Doctors in Practice**

Based on the numbers outlined in paragraph 7.23.2 and 3 there could be up to 7,000 doctors engaged in the practice of medicine in the State. However, a number of those on the register would have retired and many more are probably either not medically employed or are practising on a very part-time basis.

Based on information which has been published elsewhere and on information it has gathered from various sources the Postgraduate Medical and Dental Board estimates that at present there are in the region of 5,160 doctors in wholetime medical practice in the State made up as follows:-

(a)	Interns		368
(b)	Non-Consultant Hospital Doctors		1,453
	— senior registrars	66	
	— registrars	493	
	— house officers	894	
(c)	General Practice Trainees		28
(d)	Hospital Consultants		1,113*
(e)	Community Medicine		231
(f)	Academic Medicine		90
(g)	Defence Forces		30**
(h)	General Practice		1,800
(i)	Occupational Medicine		15
(j)	Others		32
	Total		5,160

*(includes 76 temporary/locums). **(45 posts).

7.24 **Medical Posts in the Hospital Service**

Appendix 5 shows the number of consultant posts by specialty as at 1 May, 1984 and the number of anticipated retirals to 1995. The appendix also shows the number of house officer, registrar and senior registrar posts by specialty during 1984 and indicates the intake levels to general professional training.

Appendix 6 gives a more detailed breakdown of the distribution of house officer and registrar posts between the specialties.

7.24.1 Further information in relation to consultant manpower can be obtained from the publications of Comhairle na nOspidéal.

7.24.2 A survey of non-consultant hospital doctor staffing as at 1 April, 1984 showed that:-

— 1,825 NCHDs were employed on 1 April, 1984 (70 senior registrars, 493.5 registrars, 893.5 house officers, 368 interns);

— 35% of all NCHDs employed were female, 39% of all Irish NCHDs were female;

— 13.35% of all NCHDs were non-nationals, 21% of all registrars were non-nationals as were 13.3% of all house officers;

— a number of areas, notably the Midlands, Mid-West, North-East and North-West, were very dependent on non-nationals for their registrar and house officer staffing;

— very high percentages of registrar and house officer staffing in the surgical specialties are filled by non-nationals;

— 193 registrars and 57 house officers had higher degrees.

Further information is given in Appendix 7.

7.25 **Community Medicine**

206 of the 231 doctors in community medicine identified in a recent survey (O'Se, L., Reilly W.B. and Hurley, M. Survey of Doctors in Community Medicine, I Med J 1982, 75, 74 - 78) were employed by the Health Boards — 32 Directors of Community Care and Medical Officers of Health, 33 Senior Area Medical Officers, 126 Area Medical Officers and 15 engaged in environmental health work. The other doctors working in community medicine are employed in the Department of Health, the Medico-Social Research Board and the Universities. There are now 12 funded posts for higher professional training in community medicine.

7.26 **Academic Medicine**

There are in the region of 65 permanent wholetime medical career posts in the pre-clinical departments in Irish medical schools. Figures published in 1982 (Hooper A.C.B., The Staffing of Preclinical and Paraclinical Departments in Irish Medical Schools, I Med J 1982, 75, 145 - 148) showed 61 permanent medical academic staff employed in the following departments:- Anatomy 17; Physiology 11; Microbiology 8; Pathology 19; Pharmacology 6.

Of these 61 staff, some 45 held exclusively wholetime academic appointments; 36 were lecturers and 25 were professors.

In addition to the permanent appointees, in the region of 30 doctors were employed in a wholetime non-permanent capacity (mainly as demonstrators and temporary lecturers).

There are 7 permanent medical academic staff working in the Community Medicine departments of the universities. They are included in paragraph 7.25 above dealing with Community Medicine. There are 3 academic general practitioners in the Department of Community Medicine, TCD.

7.27 **Occupational Medicine**

While it is difficult to be precise about the number of doctors engaged in occupational medicine, as very many doctors hold part-time or sessional appointments, the number is in the range 200-250. It is estimated that about 120 doctors devote at least 25% of their time to occupational medicine. About 10% of these latter doctors work in the specialty on a wholetime basis.

7.28 **General Practice**

Precise figures are not available on the number of doctors engaged in general practice. The Postgraduate Medical and Dental Board estimates that there may be up to 1,800 wholetime general practitioners. At 31 December, 1983 there were 1,440 doctors participating in the General Medical Service as follows:-

Health Board	Number	Health Board	Number
Eastern	485	North-Western	98
Midland	81	South-Eastern	160
Mid-Western	115	Southern	220
North-Eastern	115	Western	166

The Working Party on the General Medical Service (August, 1984) says that there are over 300 doctors in private practice awaiting entry to the G.M.S.

The annual intake to vocational training schemes in general practice is 28. In addition many young doctors aspiring to a career in general practice follow self-structured training arrangements.

7.29 **Number of Medical Graduates**

Year	Total	Irish		Non-Irish
		Male	Female	
1980	466	226	146	94
1981	465	235	149	81
1982	458	240	130	88
1983	460	227	149	84
1984	477	225	156	96

7.30 **Undergraduates in Irish Medical Schools**

At 1 January, 1985, there was a total of 2,740 (1,614 male and 1,126 female) undergraduates in Irish medical schools.

The numbers in each year were as follows:-

pre med:	452 (264 male and 188 female)
1st Year:	480 (287 male and 193 female)
2nd Year:	441 (254 male and 187 female)
3rd Year:	464 (279 male and 185 female)
4th Year:	453 (269 male and 184 female)
5th Year:	450 (261 male and 189 female)

822 of the 2,740 students in the five medical schools were from outside the Republic of Ireland. 120 (63 male and 57 female) were from Northern Ireland and 702 (509 male and 193 female) were from elsewhere.

7.31 **Survey of Recent Consultant Appointments**

In the period 1 April, 1976 to 31 March, 1981 a total of 225 persons took up duty as consultants for the first time in this country. Information has been obtained indicating the countries in which 221 of those consultants spent the four year period prior to their first consultant appointment in this country. This information shows that 16.3% of the consultants spent the entire four year period in Ireland, a further 30.5% spent some of the period in Ireland while 53.2% spent none of the four years in question in Ireland. Further information on this survey can be obtained from the Postgraduate Medical and Dental Board.

In the period 1 May, 1982 to 30 April, 1983 a total of 53 persons took up duty as consultants in this country for the first time — 30 of those were working in Ireland at the time of their appointment, 11 were working in the UK and 12 were working elsewhere (6 in Canada, 4 USA, 1 Australia, 1 West Germany). There are indications that in most recent years about two thirds of candidates for consultant appointments are working in this country at the time of their applications.

7.32 **Concluding Remarks**

7.32.1 In this section on medical manpower attention has been drawn to recommendations made in 1977 by the former Council for Postgraduate Medical and Dental Education, the principal changes which have occurred since those recommendations were made have been listed and these have been followed by the most up to date medical manpower statistics available to the Board.

7.32.2 Nothing has happened in the period since 1977 to invalidate the recommendation made then that "immediate action should be taken to give some body or bodies overall responsibility for the examination of the different aspects of medical manpower in this country". In point of fact it is even more valid today and the Board repeats it in the strongest possible terms. That recommendation was generally endorsed at a Symposium held by the Board in 1980 to highlight the medical manpower issue. It looked in 1980 that steps were being put in motion to go someway towards implementing the recommendation when it was agreed that representatives of the Department, the Comhairle and the Board would meet regularly, about every six months but it is a matter of record that that arrangement never became operative. An attempt was made in 1983 to revise the idea and indeed some progress was made towards agreeing on the objectives and framework for a medical manpower study but this too has failed to get off the ground. It is not the Board's desire to apportion blame — it perceives goodwill but unfortunately the issues while seen as important and requiring action do not present themselves as of immediate importance and have tended to get pushed aside by the pressures of day to day problems. This is no recipe for planning, it is in fact the very opposite and unless some initiative is soon adopted it may well prove to be too late — if it is not already so. Medical manpower issues are not amenable to quick resolution — for example the medical school output to 1990 has already been determined; any decision to alter career structures needs careful thought, planning, negotiation and implementation. The Board strongly urges that the process of looking at the issues in a planned cohesive integrated way must begin now. In the Board's opinion it might be helpful at this stage to establish a special committee or body with representation drawn from the various statutory agencies, medical schools with an independent chairman, charged with the task of bringing forward proposals.

CHAPTER 8

The Immediate Future

8.1 The purpose of this report has been to provide basic background information on postgraduate medical and dental education as well as to provide brief information on the activities undertaken by the Postgraduate Medical and Dental Board in relation to such education and in relation to career guidance. This report has been concerned mainly with the period to March, 1985 but would, however, be incomplete without a very brief look to the immediate future. The purpose of this Chapter is to mention some of the activities which lie ahead of the incoming Board.

8.2 **Budgets**

The functions of the Board as defined by statute to promote the development of postgraduate medical and dental education, to co-ordinate such developments, to advise on all matters, including financial matters relating to such development and co-ordination and the provision of career guidance will, of course, remain unaltered. It is likely, however, that in the period immediately ahead health agencies will continue to strive to provide services against a background of severe financial constraint. This being the case it is obviously important that health agencies do not overlook the needs of postgraduate education including continuing education when preparing their estimates and budgets. As already mentioned in Chapter 3 of this report the Board is strongly of the view that each health agency involved in postgraduate medical and dental education should have a specific budget for this purpose. In the Board's view the need for such budgets becomes essential when demands on financial allocations are likely to be greater than in the past and it is hoped that the Department of Health would look sympathetically on such budgets.

8.3 **Monospecialist Training/Multidisciplinary Needs**

The approaches adopted to the issues raised at the Board's Symposium on Monospecialist Training and Multidisciplinary Needs could have an important influence and bearing on medical manpower and training issues in the future. The pursuit of excellence in training programmes should not be seen as incompatible with ensuring that the training provided is responsive to the population's health needs and demands. A greater involvement, than hitherto, of "peripheral" hospitals in training programmes must surely be an attainable goal.

8.4 **General Practice**

Work towards the implementation of the Report of the Working Party on the General Medical Service is likely to be an area of high endeavour and priority in the years immediately ahead. As indicated in this Report the Board looks forward to working with all interested parties in the implementation of the recommendations regarding education and training in so far as these relate to the Board's remit. The Board has been greatly encouraged by the achievements of the Pilot Studies on the provision of continuing education for general practitioners and it looks forward to the development of a national programme as envisaged in the Working Party Report.

8.5 **Dentistry**

The Board has devoted considerable attention to Dentistry during the past five years. The two pilot Regional Committees, in the North West and in the South/Mid-West, point the way towards an effective means of providing continuing education for dentists. The Board hopes that finances will be made available to enable such committees to be developed nationwide. The establishment of a representative Committee (paragraph 5.4 of this report refers) to oversee higher training in dentistry should provide an impetus towards the development of such training.

8.6 **Career Guidance**

Much has been achieved in the development of a programme of career guidance for doctors. The further development of this programme is likely to be of major importance to young doctors and those currently in medical schools. The development of a programme of Career Guidance for dentists is a task which will, no doubt, receive early attention from the incoming Board.

8.7 **Medical Manpower**

The need for action in relation to medical manpower has been highlighted in Chapter 7. Medical manpower permeates much of the Board's activities and the Board is therefore keen that action should be taken as an urgent priority. No single agency or body has sole responsibility in this area and it is for this reason that the Board suggests in Chapter 7 the establishment of a representative committee charged with the task of bringing forward proposals for further action.

8.8 **Dental Manpower**

There is growing awareness on the need to focus attention on dental manpower. The Postgraduate Medical and Dental Board was pleased therefore to be able to provide financial assistance towards the study commissioned by the Dental Board on Irish Dental Manpower 1941-2001 and published in August, 1984. It is not intended to summarise that report here but it did show that the Dental Register doubled in size between 1941 and 1981, with about half of the growth occurring in the period 1971-81. The percentage of females on the register in 1941 was 4% and this increased to 17% by 1981 and is expected to reach 32% by the year 2001. 4% of those on the register in 1941 qualified outside the Republic of Ireland while the corresponding figure for 1981 was 6%. Just 12% of all dentists on the 1981 register were over 55 years of age. There is increasing concern that Western countries are over-producing dentists. A leading implication of the study commissioned by the Dental Board is that a rise in the proportion of Irish graduates who decide to practice dentistry in the Republic of Ireland could have a substantial effect on the future growth of the register even if the output of the Dental Schools were held constant. The Postgraduate Medical and Dental Board welcomes the publication of the report of this important study which it sees as a valuable and indeed essential contribution to the developing debate on Irish dental manpower. The Board endorses the view expressed in the report that a system of on-going monitoring of the supply and utilization of dental manpower is required which would inform public discussion and allow policy makers to see trends and respond to changing circumstances.

8.9 **Continuing Education**

The Board's views of the importance of continuing education for doctors and dentists are outlined in Chapters 3 and 5 of this report. The main activities undertaken by the Board in this regard relate to the development of the pilot studies for general medical practitioners and of the regional committees for the co-ordination/promotion of continuing education for dentists. These activities are to be the forerunners of the development of a system of continuing education for the groups mentioned. In this report the Board's views generally in relation to making adequate financial provision for continuing education are described and the Board urges the various employing authorities to adopt the measures outlined. The Co-ordinators of Postgraduate Education have devoted considerable time and energy to the provision and the development of continuing education during the past five years and their activities in this regard are illustrated in chapter 4. In the period ahead the Board will seek to build on the activities and initiatives it has already taken in relation to continuing education and will continue to promote its development and seek to keep the effectiveness of its delivery under review.

8.10 **Other Issues**

The development of the services provided by the Co-ordinators of Postgraduate Education and progress on the issue of seeking some financial help towards training

abroad will, no doubt, be issues which will occupy the incoming Board. In the case of the latter the various requests and approaches made by the Board to date are outlined earlier in the report. It is to be hoped that some early progress can be made on this important issue. Seeking solutions to the stalemate which has arisen about the funding/filling of senior registrar posts will also continue. Another goal will be to encourage the transformation of the commitments to part-time training to positive fruition. The professional training bodies are mainly responsible for the organisation of programmed training and in seeking to promote, develop and co-ordinate such training the Board works closely with them. Such training by its very nature must evolve to take account of developments in medical science, new technologies etc. Its organisation must similarly evolve to meet the needs of a particular time and the Board and the training bodies must be constantly aware of the importance to keep such organisation under review to ensure that it is effectively meeting such needs and is responsive to changing circumstances.

8.11 **Concluding Remarks**

Board members are frequently asked "What does the 'Postgraduate Board' do?"It is not always easy to provide a simple answer. This report has set out to provide some of the answers as to how the Board seeks to promote the development of postgraduate medical and dental education and training, including continuing education. The Board does not itself provide such education and training but, of course, seeks to promote, develop and co-ordinate it. It also endeavours to make it more widely available and to this end has been instrumental in funding the various pilot studies referred to during the course of this report. The Board can only successfully carry out its functions with the active help and co-operation of many other bodies and persons — be they training bodies and hospitals, employing authorities, individual doctors and dentists. Perhaps the most important role of the Board is to help create an environment in which the activities of all those mentioned are harnessed so as to provide a comprehensive range of medical and dental postgraduate education. The Board is delighted to be able to put on record its appreciation of the help and co-operation which it has received from the various bodies and individuals with which it comes in contact.

There are other statutory bodies whose functions relate to or impact on postgraduate education. The principal bodies concerned are Comhairle na nOspideal and the Medical Council. The Board has established satisfactory working relationships with them and looks forward to continuing to work with them in the future. The Board is also sure that it will develop such relationships with the Dental Council when established.

Last, but by no means least, the Board is happy to be able to record its appreciation of the sympathetic manner in which its requests for financial assistance for its own activities have been heard in the Department of Health and its final word must be that it hopes that this will continue to be the case.

APPENDIX 1

RECOGNITION OF TRAINING POSTS

Details of the bodies responsible for the recognition of posts in training programmes are set out below.

(a) **Hospital Specialties**

Specialty	Body Responsible for recognition	Notes
Anaesthetics	The Faculty of Anaesthetists of the Royal College of Surgeons in Ireland recognises posts for general professional training and the Joint Committee recognises posts for higher specialist training.	
Medicine	The Royal College of Physicians of Ireland recognises posts for general professional training and the Irish Committee on Higher Medical Training recognises posts for higher specialist training.	The Joint Committee also recognises the posts for higher specialist training.
Obstetrics and Gynaecology	The Institute of Obstetricians and Gynaecologists of the Royal College of Physicians of Ireland recognises posts for training for the D.Obst. RCPI (designed to meet the requirements of general practice) and for the MRCPI (Reproductive Medicine) and for higher specialist training.	Posts are also recognised by the Royal College of Obstetricians and Gynaecologists (London) for training for MRCOG.
Pathology	The Royal College of Pathologists recognises posts for training for the Primary Examination and the Final Examination for Membership-M.R.C. Path.	Pathology differs from most other specialties in that the Membership examination comes towards the end of training.
Psychiatry	The Irish Psychiatric Training Committee recognises posts both for general professional training and for higher specialist training.	The Joint Committee also recognises the posts for higher specialist training.
Radiology	The Faculty of Radiologists recognises posts for training for the Primary and Final Examinations for the Fellowship.	
Surgery	The Royal College of Surgeons in Ireland recognises posts for pre-Fellowship training and the Irish Surgical Postgraduate Training Committee recognises posts for higher specialist training.	The Joint Committee also recognises the posts for higher specialist training.

(b) **General Medical Practice**

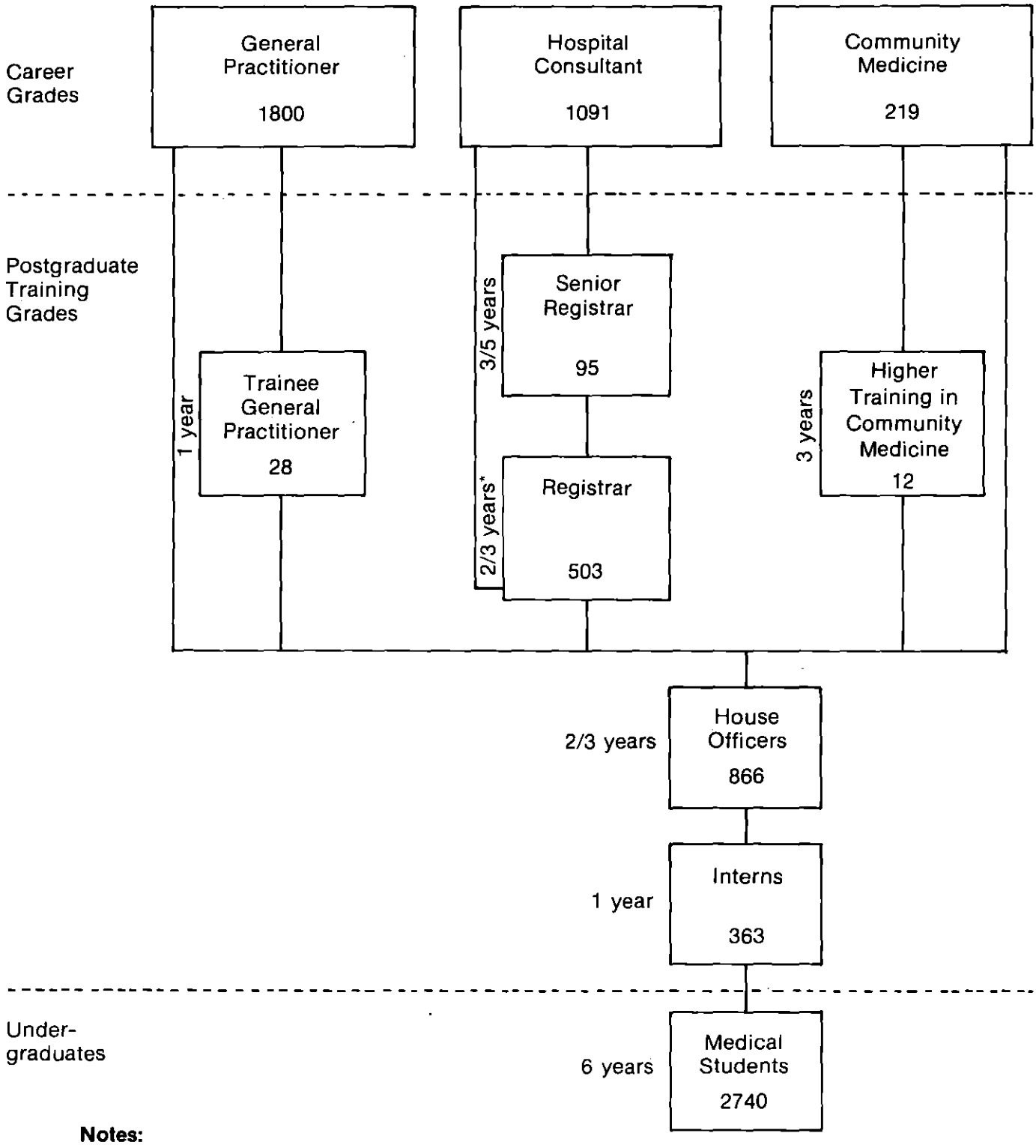
The Irish College of General Practitioners approves vocational training schemes in general practice and the Royal College of General Practitioners recognises posts for training for the examination for the Membership of that College.

(c) **Community Medicine**

The Royal College of Physicians of Ireland recognises posts for general professional training and the Irish Committee on Higher Medical Training recognises posts for higher specialist training.

APPENDIX 2

THE PRINCIPAL CAREER STRUCTURES



Notes:

1. The figures shown for the establishment of each grade are the latest published for the grades shown. Attention is drawn to Chapter 2 and Appendix 3 in relation to senior registrars.
2. The length of time spent in individual grades varies as between specialties.
3. This chart does not deal with careers in academic medicine or in occupational medicine.

*Where higher training takes place in the registrar grade this period would be extended to 5/8 years depending on the specialty.

APPENDIX 3

NUMBER OF SENIOR REGISTRAR POSTS AT 1st SEPTEMBER, 1984

Specialty	No. of Recognised Programmes	Training Period (years)	No. of Senior Registrar posts approved* (no. filled)
Surgical Group of Specialties			
Ophthalmology	1	4	1(1)
Otolaryngology	3	3	2(—)
Orthopaedics	8	4	8(6)
Cardio-Thoracic	1	4	2(2)
General	18	4	15(15)
Neuro	1	4	1(—)
Paediatric	1	4	1(—)
Plastic	2	4	1(1)
Urology	4	4	3(3)
Medical Group of Specialties			
General Internal Medicine	15	4	12(5)
Paediatrics	7	4	not yet decided
Geriatrics	5	4	1(—)
Cardiology	3	4	3(—)
Endocrinology	2	4	2(—)
Gastroenterology	2	4	2(1)
Neurology	1	4	—
Nephrology	1	4	—
Respiratory	3	4	1(—)
Rheumatology/Rehabilitation	3	4	—
Haematology	3	4	—
Anaesthesia	17	3	17(17)
Obstetrics/Gynaecology	10	3	5(3)
General Psychiatry	13	4	10(5)
Child Psychiatry	7	4	7(6)
Radiology	9	2	not yet decided
Mental Handicap	1	4	1(1)
	141		95(66)

*'approved' means approved by the Comhairle na nOspidéal. See also paragraph 2.13 of this report.

APPENDIX 4

PERSONS NOMINATED BY TRAINING BODIES TO PROVIDE CAREER GUIDANCE ADVICE/INFORMATION

Anaesthetics:	Dr. S. M. Hart, Regional Hospital, Wilton, Cork. Dr. P. Keane, Regional Hospital, Galway. Dr. K. Moore, Our Lady's Hospital for Sick Children, Crumlin, Dublin 12.
General Practice:	Dr. M. M. Berber, Dublin Regional Vocational Training Scheme for General Practice, Corrigan House, Fenian Street, Dublin 2. Dr. D. Bonar, The Medical Centre, Dungloe, Co. Donegal. Dr. D. A. Heraughty, The Mall House, Sligo. Dr. C. S. Macnamara, Chatsfort, Newtown, Waterford. Dr. E. O'Dochartaigh, General Practitioner Training Scheme, c/o Regional Hospital, Galway. Dr. W. Shannon, Vocational Training Scheme for General Practice, University College, Donovan's Road, Cork.
Medicine: **General Professional Training:**	Professor C. F. McCarthy, Regional Hospital, Galway. Dr. B. Ferris, Regional Hospital, Wilton, Cork. Professor J. S. Doyle, St. Laurence's Hospital, North Brunswick Street, Dublin 7. Dr. G. Burke, Regional Hospital, Dooradoyle, Limerick. Dr. B. Callaghan, General Hospital, Letterkenny. Dr. D. Collins, General Hospital, Sligo. Dr. G. Fitzgerald, Ardkeen Regional Hospital, Waterford. Dr. P. Kiernan, General Hospital, Wexford. Dr. B. C. Muldoon, Our Lady of Lourdes Hospital, Drogheda. Dr. C. Quinlan, General Hospital, Mullingar.
Cardiology:	Dr. G. F. Gearty, 1 Belmont Gardens, Donnybrook, Dublin 4.
Chest Diseases:	Dr. P. J. Keelan, 46 Cowper Road, Dublin 6.
Community Medicine:	Dr. B. Herity, Faculty of Community Medicine, Royal College of Physicians of Ireland, 6 Kildare Street, Dublin 2.
Dermatology:	Dr. D. O'C. Donelan, 22 Fitzwilliam Place, Dublin 2.
Gastroenterology:	Dr. J. F. Fielding, Eagle Lodge, Sydney Avenue, Blackrock, Co. Dublin.
General Internal Medicine:	Professor M. X. Fitzgerald, St. Vincent's Hospital, Elm Park, Dublin 4.
Geriatrics:	Dr. D. Coakley, St. James's Hospital, Dublin 8.
Haematology:	Dr. I. Temperley, 20 Rathdown Park, Dublin 6.
Nephrology:	Dr. Brian Keogh, Meath Hospital, Dublin 8.
Neurology:	Dr. N. Callaghan, Department of Neurology, Ward 2BM, Regional Hospital, Cork.
Occupational Medicine:	Dr. I. E. Eustace, Faculty of Occupational Medicine, The Royal College of Physicians of Ireland, 6 Kildare Street, Dublin 2.
Oncology:	Professor J. J. Fennelly, St. Vincent's Hospital, Elm Park, Dublin 4.
Paediatrics:	Professor O. C. Ward, Our Lady's Hospital for Sick Children, Crumlin, Dublin 12.
Rheumatology:	Dr. Ciaran Barry, 9 Upper Fitzwilliam Street, Dublin 2.

Obstetrics/ Gynaecology:	Professor A. D. H. Browne, Rotunda Hospital, Dublin 1. Professor D. Jenkins, Erinville Hospital, Western Road, Cork. Professor E. O'Dwyer, Regional Hospital, Galway. Dr. H. Lamki, Royal Maternity Hospital, Grosvenor Road, Belfast.
Pathology:	Professor C. T. Doyle, Regional Hospital, Wilton, Cork. Professor J. Flynn, Regional Hospital, Galway. Dr. S. Kirrane, Mater Hospital, Eccles Street, Dublin 7. Professor E. C. Sweeney, St. James's Hospital, James's Street, Dublin 8. Dr. R. P. Towers, St. Vincent's Hospital, Elm Park, Dublin 4.
Psychiatry:	Dr. P. A. Carney, Department of Psychiatry, Regional Hospital, Galway. Dr. A. G. Carroll, Department of Child Psychiatry, Regional Hospital, Galway. Dr. P. Kirwan, Regional Hospital, Dooradoyle, Limerick. Dr. F. LeGear, Our Lady's Hospital, Cork. Professor R. J. Daly, Department of Psychiatry, Regional Hospital, Wilton, Cork. Dr. P. Melia, St. Finan's Hospital, Killarney, Co. Kerry. Advice in the Eastern Region may be obtained from anyone of the recognised psychiatric tutors in the region. (Current up-to-date lists may be obtained from Dr. F. P. O'Donoghue, St. Patrick's Hospital, PO Box 136, James's Street, Dublin 8).
Radiology:	Dr. M. Daly, Department of Radiology, Regional Hospital, Dooradoyle, Limerick. Dr. D. P. MacErlean, Faculty of Radiologists, Royal College of Surgeons in Ireland, St. Stephen's Green, Dublin 2. Dr. L. MacFeeley, Department of Radiology, Regional Hospital, Wilton, Cork. Professor J. Murray, Department of Radiology, Regional Hospital, Galway. Dr. N. O'Connell, Faculty of Radiologists, Royal College of Surgeons in Ireland, St. Stephen's Green, Dublin 2.
Surgery:	Professor D. Bouchier-Hayes, Professor of Surgery, Royal College of Surgeons in Ireland, St. Stephen's Green, Dublin 2. Professor M. P. Brady, Professor of Surgery, University College, Cork. Professor H. Given, Professor of Surgery, University College, Galway. Professor W. A. L. MacGowan, Registrar, Royal College of Surgeons in Ireland, St. Stephen's Green, Dublin 2.

APPENDIX 5

Consultants (Position at 1st May, 1984)	Anaesthetists	ENT Surgeons	Obstetrician/ Gynaecologists	Ophthalmic Surgeons	Orthopaedic Surgeons	Paediatricians	Pathologists	Physicians [1]	Psychiatrists	Radiologists	Surgeons [2]	Total for all Specialties
1. Establishment (1/5/84)	159	30	99	37	42	51	90	184	201	95	151	1,139
2. Vacancies	17	3	6	6	4	8	8	15	13	12	10	102
3. No. of retirals by end 1989.	24	22	14	7	5	8	7	24	25	8	31	164
4. No. of retirals 1990 to 1995.	27	—	9	6	4	4	20	25	43	7	20	165
NCHDs (1984)												
5. House Officer Posts	50	10.5	82	18.5	39	100	28	234.5	97	13	152	866 [3]
6. Registrar Posts	37	11	25	8	24	27	22	101	143	11	79	503 [4]
7. Senior Registrars filled (establishment)	17(17)	-(2)	3(5)	1(1)	6(8)	—	—	6(21)	12(18)	—	21(23)	66(95)
8. Annual intake into General Professional Training	15	2/3	25	3/4	—	—	8	410	25	4 [5]	33	
9. Approximate No. in general professional training.	54	13	75	9	—	—	40	900	85	22	69	

Footnotes:

1. Radiotherapists are included with physicians.
2. In this table surgeons excludes obstetrician/gynaecologists and surgeons in ophthalmology, orthopaedics and ENT.
3. This total includes 42 House Officer posts not listed under the specialties — they are in Casualty Departments.
4. This total includes 15 Registrar posts not listed under the specialties — they are in Casualty Departments.
5. The intake to the radiology scheme takes place on alternate years — 8 or 9 doctors are recruited per intake.

APPENDIX 6

DISTRIBUTION BY SPECIALTY OF REGISTRAR AND HOUSE OFFICER COMPLEMENT AS AT 1 APRIL, 1984

SPECIALTY	REGISTRARS	HOUSE OFFICERS
Anaesthetics	37	50
Cardiology	11	7.5
Communicable Diseases	—	9
Dermatology	1	3.5
Endocrinology and Diabetes Mellitus	4	8
Gastroenterology	5	7.5
General (Internal) Medicine	42	125
Geriatrics	8	26
Renal Medicine (Nephrology)	6	7
Neurology	4	9.5
Paediatrics	26	98
Radiotherapy	10	5
Chemotherapy	—	1.5
Oncology	1	1
Respiratory Medicine	3	14
Rheumatology (Physical Medicine)/Rehabilitation	6	10
Obstetrics/Gynaecology	25	77
Perinatal Medicine	—	5
Neonatology	1	2
Chemical Pathology	3	5
Clinical Immunology	—	1
Microbiology	3	4
Morbid Anatomy/Histopathology	10	8
Haematology	4	9
Pathology	2	1
General Psychiatry	115	96
Child and Adolescent Psychiatry	16	1
Mental Handicap	7	—
Forensic Psychiatry	5	—
Diagnostic Radiology	11	13
General Surgery	61	121
Casualty	12	30
Accident & Emergency	3	12
Neurological Surgery	1	8
Ophthalmology	8	18.5
Orthopaedic Surgery	24	39
Otolaryngology	11	10.5
Paediatric Surgery	2	8
Plastic Surgery	3	2
Thoracic Surgery	5	6
Urology	6	6
Vascular Surgery	1	1

Notes:

1. Approved complement means the complement authorised and funded by the Department of Health.
2. The totals for registrars and house officers are overstated and understated respectively. This arises because some employing authorities classify all NCHD posts in psychiatry as "registrars/house officers".
3. The information in this Appendix excludes senior registrars - the position in relation to that grade is shown in Appendix 3.

APPENDIX 7

SURVEY OF NCHDs EMPLOYED AT 1 APRIL, 1984

1. The following statement shows the numbers of NCHDs employed on 1 April, 1984:-

Grade	Approved Complement (a)	Numbers employed						
		Nationals		Non-Nationals		Total		
		M.	F.	M.	F.	M.	F.	T.
Senior Registrars (b)	72	52	16	2	—	54	16	70
Registrars	503	226.5	163	98	6	324.5	169	493.5
House Officers	866.5	472.5	302	108	11	580.5	313	893.5
Interns	363	212	138	11	7	223	145	368
Totals	1804.5	963	619	219	24	1182	643	1825

(a) Approved complement means the complement authorised and funded by Department of Health.

(b) Information was sought only in relation to Senior Registrar posts which are approved by the appropriate Joint Committee or Training Body **and** which have been funded either specifically or by the 'conversion' of some other NCHD post.

2. **MALE/FEMALE RATIOS**

The following table shows the percentages of males and females employed:

	Nationals		**Non-Nationals**		**Totals**	
	M.	F.	M.	F.	M.	F.
Senior Registrars	76	24	100	—	77	23
Registrars	58	42	94	6	66	34
House Officers	61	39	91	9	65	35
Interns	61	39	90	10	65	35

3. **NUMBERS OF NON-NATIONALS EMPLOYED**

3.1 The survey shows a total of 243 non-nationals employed as NCHDs at 1 April, 1984 (which represents 13.35% of the total) made up as follows:-

Senior Registrars	2
Registrars	104 (21% of all Registrars)
House Officers	119 (13.3% of all House Officers)
Interns	18
Total	243 (13.35%)

3.2 **Non-nationals employed as Registrars**

(a) A number of health boards were very dependent at 1 April, 1984 on non-nationals for their registrar staffing. For example, 87.5% of registrars employed by the Midland Health Board were non-nationals. The corresponding percentages in a number of other health boards were as follows: Mid-Western and North-Eastern 55.5%, North-Western 58.8%, South-Eastern 47%.

(b) 47% of all Registrars in General Surgery were non-nationals, as were 50% of all Registrars in Orthopaedic Surgery and 66% of all Registrars in Otolaryngology.

Very high percentages of the registrars in the numerically small surgical specialties (plastic surgery, thoracic surgery, urology) were non-nationals.

3.3 **Non-nationals employed as House Officers**

(a) A number of health boards were very dependent at 1 April, 1984 on non-nationals for their house officer staffing. For example, 43.3% of house officers employed by the North-Eastern Health Board were non-nationals. The corresponding percentages in a number of other health boards were as follows: Midland 41.9%, Mid-Western 29%, North-Western 27.4%.

(b) 36% of all House Officers in General Surgery were non-nationals, as were 46% of all House Officers in Orthopaedic Surgery, and 4 of the 9 House Officers in Otolaryngology were non-nationals.

Source: Survey conducted by Postgraduate Medical and Dental Board.