

An Bord Míochaine agus Deidliachta Iarcheime

The Postgraduate Medical and Dental Board

SECOND REPORT

June 1985 - May 1990

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PREFACE

Between 1985 and 1990, financial stringencies imposed severe strains on the medical career structure, on postgraduate training capabilities and on the adequacy of educational funding at local levels. The Postgraduate Medical and Dental Board found that, despite excellent support from the Department of Health, it was very difficult to maintain momentum.

On the positive side, the Board was able to designate 10 new areas, with tutors, for the Continuing Education of General Practitioners. This brings the total number of such areas to 13 - almost half the number required for a national network. We were also able to appoint, on a part-time basis, a National Director for such activities.

Continuing dental education has blossomed and the Board can report that four Regional Committees, with course organisers, are now in place and very active. Up to 3 more, however, are needed to adequately serve the community. It will be necessary, in the near future, to consider the desirability of introducing Vocational Training for General Dental Practice.

Career guidance has also been emphasised but the value and effect of this has been sadly eroded by negative factors which will be outlined below.

There are many problems to be faced and to solve these, the Board will require policy decisions and commitments to be made at other levels.

A simple example is that employing authorities, in times of financial stress, find that their education budgets are amongst the easiest items to curtail. This devastates hospital libraries (both book and video tape) and other educational facilities including in-house training, course attendances and so forth. Education budgets need not be lavish but they should be sacrosanct.

It is also obvious that, if medicine is to be cost-efficient in the future, the postgraduate curriculum (and, indeed, possibly the undergraduate) will have to include training in management, resource utilisation, medical audit and peer review. A system of credits for continuing education will have to be considered as will the possibility of re-certification. There will also have to be training in the horizontal integration of hospital, general practitioner and community services.

At this point in time, there is a pressing need for the serious re-assessment of the training programmes which are needed and geared specifically to meet our own national medical requirements. The increasing importance of the European single market should not be overlooked when this is being done. Obvious Irish needs are increased training in geriatrics and, especially, in general practice. We are committed to the European Directive concerning general practice training but, currently, we have only 28 new trainees coming on stream each year as against the 75 required.

Do we need, and can we afford, "super-specialisation" everywhere or would we be better served by looking for the training which would, in all save a few well-defined areas, produce a consultant with an advanced special interest - which would, of course, have to be adequately resourced - combined with multi-disciplinary expertise?

Medical manpower is another problem - this has been on the agenda for many years but, perhaps because of the need for consultation with so many bodies and organisations, it has never been properly considered. There is little doubt that restriction of entrance to medical schools is not the answer. The important decisions have to do with the career structure and training facilities in Ireland.

The latter is shown, very clearly, by the increasing number of NCHD posts filled by non-nationals in the country. This is most marked in some disciplines e.g. surgery and in some regions e.g. the Midland, West-Midland, North-Western and North-Eastern Health Board areas. It is not that there are not enough Irish doctors to fill these posts - it is simply that they do not perceive many of these Irish posts as being adequate to fulfil their training and career aspirations.

Another important aspect has to do with lady doctors. Over 50% of our graduates are now women and they are, naturally, looking for their place in the scheme of things. A firm policy on Part-Time Training and Job-Sharing, as advocated for so many years by the Board, is now imperative.

Over and above these serious problems, the Board is also working on two innovative schemes. The first of these is DELTA - a satellite-broadcast TV programme, suitable for video-recording and devoted to medical education programmes, most relevant to the general practitioner field. The second is our proposed NCHD matching scheme. This would be of very considerable benefit to both young doctors and employing authorities and would, at the same time, be a big step forward in medical personnel policy. Both these ventures are worthy of support.

In conclusion, I would like to thank the members of the Board for their support, advice, willingness to help and wholehearted co-operation. Perhaps our main regret was that we had to depend, entirely, on persuasion and goodwill and that we lacked the necessary powers to enforce some very important changes.

In its turn, the Board has asked me to convey our appreciation and thanks to our Co-ordinators, to the National Director and General Practice Tutors and the Dental Course Organisers. Special reference must be made to our small and extremely hard-working office staff who not only looked after the Board so well but also succeeded in servicing the Irish Psychiatric Training Committee and the Dublin Regional Vocational Training Scheme for General Practice. I refer, of course, to John Gloster, our Chief Officer, to Jim Cosgrave, Staff Officer and to Assumpta Linnane, Clerical Officer.

Bryan G Alton
Chairman
May 1990

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. The first appointment of members was for the period to 6 March, 1985. Following a short interregnum the Minister for Health announced in June, 1985 the names of the members of the Board for the period to 31 May, 1990 and this report relates to their period of office.

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 postgraduate 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 Council, 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 In June, 1985 the following persons were appointed by the Minister for Health to be

members of the Board for the period ending on 31 May, 1990.

Dr. B.G. Alton*, 19 Temple Gardens, Rathmines, Dublin 6.

Professor B.E Barrett*, University College, Cork.

Dr. M.J. Boland, Cork Road, Skibbereen, Co. Cork.

Professor D. Bouchier-Hayes, Royal College of Surgeons in Ireland, Dublin 2.

Dr. J. Buttimer, Medical Officer, Department of Health, Hawkins House, Hawkins Street, Dublin 2.

Dr. P.A. Carney, University College Hospital, Galway.

Professor J.B. Coakley, University College, Earlsfort Terrace, Dublin.

Mr. D.J. Doherty, Chief Executive Officer, Midland Health Board, Arden Road, Tullamore, Co. Offaly.

Professor C.T. Doyle, Department of Histopathology, Regional Hospital, Wilton, Cork.

Dr. Y. Doyle, Boyne House, Church Hill, Navan, Co. Meath.

Professor M.X. Fitzgerald, St. Vincent's Hospital, Elm Park, Dublin 4.

Dr. M. Glacken, Westport Road, Castlebar, Co. Mayo.

Dr. G.R Henry, Rotunda Hospital, Dublin 1.

Dr. M. Henry, 12 Burlington Road, Dublin 4.

Dr. G.D. Hurley, Meath Hospital, Heytesbury Street, Dublin 8.

Mr M Lyons, Principal Officer, Department of Health, Hawkins House, Hawkins Street, Dublin 2

Professor C. F. McCarthy*, University College Hospital, Galway.

Dr. C.S. MacNamara*, Chatsfort, Newtown, Waterford.

Dr. J.O. Mason, The Surgery, Johnstown Road, Dun Laoghaire, Co.Dublin.

Dr. D.C. Moriarty, Mater Hospital, Eccles Street, Dublin 7.

Mr. V. Morris*, Dublin Dental Hospital, Lincoln Place, Dublin 2.

Dr. S. O'Hickey, Chief Dental Officer, Department of Health, Hawkins House, Hawkins Street, Dublin 2.

Dr. J. P. R. Rees, Mandeville, Torquay Road, Foxrock, Dublin 18.

Dr. P. J. White, 40 Grattan Park, Grattan Road, Galway.

Dr. A. J. Woolfe, 14 Harcourt Street, Dublin 2.

(*outgoing member, re-appointed for a further term of office).

- 1.5 There have been six changes in the membership of the Board during the period under review. Mr. M. Lyons resigned in May, 1987 and was replaced by Mr. M. Whelan, Department of Health. Mr. Whelan resigned in February, 1988 and was replaced by Mr. D. McCarthy of the Department of Health. Dr. P. J. White resigned in July, 1988 and was replaced by Dr. Fiona Bradley, Delgany, Co. Wicklow. Drs. Y. Doyle and F. Bradley resigned in February and May, 1989 respectively - the consultation process was not completed in time to enable replacement appointments to be made.

Chairman and Vice-Chairman

- 1.6 At their first meeting in July, 1985 the new Board members appointed **Dr. B. G. Alton** and **Professor B. E. Barrett** to be Chairman and Vice-Chairman respectively.

Staffing

- 1.7 Chief Officer: **Mr. J. Gloster**
Staff Officer: **Mr. J. Cosgrave**

Clerical Officer: **Ms. A Linnane**.

Meetings

- 1.8 During the period covered by this report the Board held 35 meetings. In addition there were many committee meetings - mainly concerned with finance and with dentistry and also dealing with training structures.

Representatives of the Board also met with representatives of Comhairle na nOspideal, Department of Health, Training Bodies and the Irish Medical Organisation.

In 1986 the Board organised one day-long Symposium to review postgraduate medical and dental education. In 1990 the Board organised a Conference on the theme of Clinicians and the Management Process. These meetings are referred to later in this report.

Board's representatives or nominees in other Bodies

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

Irish Committee on Higher Medical Training: Dr. M. Henry

RCPI Sub-Committee on General Professional Training: Professor M.X. Fitzgerald and Dr. M. Henry.

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;
- (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 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".

Experience in specialised units must be gained in a general hospital. Experience in Obstetrics should not form part of the Intern year.

The Council emphasises that great care should be taken to ensure that interns are not allowed to undertake duties and responsibilities for which, by reason of their inexperience, they are unsuited.

Interns should live in residential accommodation provided by the hospital."

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 specialties - Anaesthetics, Medicine, Obstetrics and Gynaecology, Pathology, Psychiatry, Radiology and Surgery. There are several major sub-divisions in some of these specialties - (29 in medicine, 4 in obstetrics and gynaecology, 5 in pathology, 5 in psychiatry, 2 in radiology and 9 in surgery) so that there are over 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 relevant Royal College or other appropriate Irish training body. In the case of higher specialist training the programme is laid down by the Irish training body concerned 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 speciality.

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 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 hospital 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 Colleges 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 general professional training in radiology which consists of a three year course in a recognised hospital.

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. Training 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**. The requirements for training in Pathology in Ireland are being reviewed at present and up to date details can be obtained from the Faculty of Pathology.

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 general professional training required for **Community Medicine** conforms to the recommendations of the committee of the Royal College of Physicians of Ireland which has been nominated to control General Professional Training in Medicine in Ireland. It is recommended that this period of training should last at least three years following completion of the intern year with a minimum of two years spent in clinical medicine posts. Recognition for six months is given for undertaking a degree course in community medicine. Experience in community medicine is not mandatory for entry to Higher Specialist Training but candidates must have passed

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.

The terms of an EC Directive require that all general practitioners who enter the GMS Scheme from 1 January, 1995 must have completed and graduated from a recognised specific vocational training course in general practice. The existing minimum experience required of general practitioners for entry to the GMS will be revised in due course to reflect this requirement.

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 (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 recommended in 1984 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 welcomed and endorsed 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. The Board is strongly of the view that structured vocational training for general practice should be expanded - paragraph 2.16 of this Chapter refers. The Board is now firmly of the view that structured vocational training schemes should be the norm for entry to general practice.

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 so involved. 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, 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, and by the Mid-Western Health Board in the case of the scheme in the Mid-West.

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

Training Schemes in General Practice

- 2.8 There are at present 5 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 and community medicine, 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. Posts of senior registrar in pathology and radiology have not been created and higher specialist training in those specialties takes place in registrar posts designated/approved for such training.

The number of senior registrar posts is regulated by Comhairle na nOspideal. 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. 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 in reality 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. 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 so 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. The issue is discussed in some greater detail in paragraph 2.13 of this Report

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 accreditation 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 Postgraduate 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),
- wrote on a number of occasions to the Department of Health, health boards and hospital authorities indicating that structured training posts and schemes (including facilities for attendance at courses) must be preserved if organised postgraduate education is to survive without severe disruption or without being seriously jeopardised,
- urged Medical Schools not to diminish facilities for postgraduate education and research during the present financial stringency,
- circulated, for consideration by training bodies, employing authorities and other interested agencies the report of the Board's 1986 symposium on the theme 'Postgraduate Medical and Dental Education in Ireland - A Review',
- asked the professional training bodies to begin to consider and review the

role evaluation, assessment, peer review, credits, recertification do, can and should play in postgraduate education,

- asked the training bodies to consider issues, prompted by the findings of the 1988 survey of NCHD staffing, relating to (i) the individual specialties and (ii) NCHD staffing generally, in particular the training bodies were asked to consider the possibility of introducing rotational arrangements on a wider scale than have applied heretofore,
- met (in 1987) with representatives of the Manpower Sub-Committee of the Irish Medical Organisation to discuss that Committee's 1986 report on future medical manpower requirements,
- instituted an arrangement whereby each of the recognised professional training bodies shall submit an annual report to the Board,
- agreed in principle to hold a Symposium in 1990 on issues relating to preparing clinicians to fulfil their management responsibilities,
- furnished views to the Department of Health regarding the Department's Consultative Statement on Health Policy: "Health - The Wider Dimensions",
- submitted observations to the Department of Health on the Clinical Trials Bill, 1986,
- made a submission to the Commission on Health Funding and submitted comments to the Department of Health on the Commission's report,
- provided grants to the Irish College of General Practitioners to help with the funding of workshops (a) to further develop the Objective Structured Clinical Examination (OSCE) method of examination in relation to the introduction of the MICGP Examination and (b) to review the first such Examination,
- provided financial assistance towards the costs incurred by the Irish Psychiatric Training Committee in holding a Conference in 1986 to discuss the implications for training schemes arising from changes then being introduced in the format of the MRCPsych. examination,
- subsidised the library information service operated by the Sligo General Practitioner Vocational Training Scheme and by the North-West Regional Dental Committee,
- encouraged the medical libraries in the Dublin area to continue their exploration of the development of greater co-ordination, co-operation and liaison in relation to medical library provision,
- met some of the deficit incurred in the organisation of the 1987 meetings of the Association of Medical Deans in Europe (AMDE) and the Association for Medical Education in Europe (AMEE) which were held in Dublin,

- agreed, as a special measure, to provide financial assistance to the Faculty of Pathology towards the costs incurred by it in (a) subsidising the costs of its higher specialist trainees who attend courses in the UK specifically orientated towards the final MRCPPath. examination and/or (b) holding such courses in Ireland,
- provided financial assistance to the Faculty of Occupational Medicine to help fund the appointment of its Tutor/Co-ordinator for a Common Core Course in Occupational Safety and Health,
- provided financial assistance towards the Faculty of Anaesthetists being represented at the 5th International Conference of English-speaking Faculties and Boards of Anaesthesia,
- conveyed observations to the Faculty of Anaesthetists on changes the Faculty proposed in the composition of interview boards it convenes for senior registrar posts,
- following a series of meetings in 1987/8 with the Institute of Obstetricians and Gynaecologists and the Masters of the Dublin Maternity Hospitals established a working party to consider and make recommendations on a range of issues (e.g. selection, rotations, number of posts etc.) in relation to the organisation of higher specialist training in obstetrics and gynaecology; The Board adopted the working party's report in 1989 and asked the Institute of Obstetricians and Gynaecologists to take the necessary steps to implement the recommendations made,
- asked the Institute of Obstetricians and Gynaecologists to consider the possibility of (a) designating additional house officer posts for recognised general practice vocational training schemes and (b) structuring a number of rotational schemes at NCHD level,
- following the development by it of detailed draft proposals on the feasibility of introducing a national matching programme for the appointment of non-consultant hospital doctors (NCHDs) the Board sought the necessary funds from the Department of Health to enable it to prepare for the establishment and introduction, with effect from July, 1991 of a matching scheme for house officer appointments,
- in 1988 circulated to the Training Bodies information compiled with the assistance of the Department of Education and of various embassies in Dublin giving details on fellowships and scholarships etc. available which would enable Irish doctors and dentists to visit centres of excellence abroad,
- provided financial assistance in 1988 to the Royal College of Physicians of Ireland to enable it to arrange with the Director, Time Project, National Library of Medicine, Bethesda to demonstrate in Ireland the computer assisted instruction and interactive video disk method of providing CME which he has developed,

- agreed to meet some of the deficits, if any, incurred in the organisation of (a) the 20th International meeting of Organisation Gestosis which was held in Cork in July, 1988 and (b) the 10th Biennial meeting of European Association for Cancer Research which was held in Galway in September, 1989,
- provided financial assistance towards the costs incurred by the Faculty of Community Medicine in subsidising the expenses incurred by its trainees undertaking training at the Communicable Disease Surveillance Centre, Colindale, London,
- received in 1989 the report of a survey on the level of interest in part-time training in community medicine,
- arising therefrom requested UCD to provide an MPH course organised in a series of modules spread over two years,
- brought the findings of the survey to the attention of UCC and UCG and requested them to consider the possibility of they providing suitable courses,
- recommended to health boards that their staffs in community medicine should be facilitated by way of special leave to attend MPH courses,
- made an oral submission to the Working Party established by the Minister for Health to "define the role of community medicine in the health services in the medium to longterm",
- urged Comhairle na nOspideal to consider the possibility of creating additional posts of Physician in Geriatric Medicine,
- urged hospitals with such Physician posts to make NCHD posts available for general practice vocational trainees,
- encouraged the ICGP and the General Practitioner Vocational Training Schemes to seek out opportunities to provide experience in geriatrics to greater numbers of vocational trainees than heretofore,
- continued to urge that senior registrar posts be funded and filled,
- furnished views to the Department of Health regarding the Department's draft guideline's for a common selection procedure for consultants and senior registrars,
- asked the Department of Health to consider again the possibility of introducing a scheme of disturbance allowances for doctors undertaking part of their higher specialist training abroad,
- wrote in 1989 to the Revenue Commissioners indicating that as the funds being made available by health boards and hospitals for continuing education are being curtailed income tax relief in respect of such education

should be made available to salaried doctors and dentists on the same basis as applies to those who are self-employed,

- considered repeatedly issues relating to general practice vocational training - full details are given in paragraph 2.16,
- provides an administrative service for the Irish Psychiatric Training Committee and in addition provides secretarial services for the Dublin Regional Vocational Training Scheme for General Practice,
- provided financial assistance to health boards, voluntary hospitals and postgraduate centres to purchase teaching resources.

Senior Registrars

2.13 As at 1 February, 1990 there was an approved establishment (i.e. approved by Comhairle na nOspideal) of 104 senior registrars of which 77 were filled. Details are given in Appendix 3. 26% of the total number of posts are vacant. The position differs little from that which obtained in September, 1984 when only 66 of the then 95 approved senior registrar posts were filled.

While practically all the posts in General Surgery, Orthopaedic Surgery, Anaesthetics and many of the posts in the Psychiatry specialities were filled in February, 1990 just 6 of the 21 posts in the medical specialties were filled.

Whereas some of the 27 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. Where senior registrar posts are not funded and filled it is difficult to distinguish, from a manpower point of view, between general professional and higher specialist training. This in turn means that the identification of the number of higher training positions/programmes becomes increasingly complicated and well-nigh impossible. This has implications for manpower planning and makes career guidance extremely 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.

It is disappointing that so little has changed over the past five years in relation to the funding and filling of senior registrar posts in the medical specialties. If progress is to be made there is a clear need for the issues involved to be addressed with renewed commitment and vigour. The principal responsibility in this regard must rest with the training body concerned viz the Irish Committee on Higher Medical Training (ICHMT). The ICHMT should undertake a thorough review and identify

the means open to it, in the light of circumstances prevailing now, to have additional posts at senior registrar level filled. The Board will be prepared to participate in the charting of a way forward. The steps identified by the Board in 1985 as being essential if programmes for higher specialist training in Ireland are to survive and be effective remain as valid today as when they were first written - those steps were:-

- 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.

The Board has previously asked the Department of Health to consider the possibility of introducing a scheme of disturbance allowances for doctors undergoing part of their 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.

Part-time Training and Job-sharing

2.14 The Board held a Symposium on the topic of part-time (including job-sharing) training in medicine in October, 1984. The topic is dealt with at some length in the Board's First Report. It was clear from the papers delivered at the Board's 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. The Board adheres to the view expressed in its first report that part-time 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. It was acknowledged, in the Board's first report, that individual doctors, however, found it very difficult, to obtain part-time (or shared) training opportunities. The Board felt that the principal reason for this was because there was no organised framework and that the various steps which a young doctor has to take are first of all not well known and are in any event time consuming. The Board recommended that the following measures should

be adopted as an initial step towards rectifying this position -

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

Most training bodies have nominated a person (or persons) to liaise with and advise young doctors interested in training on a part-time basis. All health boards and a number of voluntary hospitals have nominated persons to provide advice to persons interested in applying for posts on a part-time basis. The nomination of these panels should considerably aid young doctors interested in part-time or shared training arrangements. The Board would recommend that those training bodies which have not already done so should nominate persons to provide advice and guidance in this area. It remains the Board's view that employing authorities should jointly develop a protocol or procedure for dealing with applications for part-time or shared training - the existence of such a protocol could help to ensure that applications were dealt with systematically and efficiently.

Training on a part-time or shared basis can be done successfully. It needs careful organisation and monitoring. 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. It is probable that most people who would wish to train on a part-time basis would wish to do so for part of their postgraduate training. The adoption of the measures recommended by the Board would greatly assist those who wished to process an application to pursue training other than on a wholetime basis.

Doctors and Management

- 2.15 The Board supports the view put forward in the Report of the Commission on Health Funding on the need to involve and facilitate the involvement of members of the health professions in the management of the health services. In the Board's view this facet of the health professionals role should be fully taken into account in all phases of a health professional's education, that is at undergraduate, postgraduate and continuing education levels. The Board held a Conference on 18/19 May, 1990 on issues related to management training for clinicians. The Conference Report will be issued in the Autumn of 1990.

General Practice Vocational Training

2.16 The Board probably devoted more time to considering issues relating to general practice vocational training than to any other single facet of programmed training. There are at present five recognised vocational training schemes for general practice in the country. The annual intake of trainees to those schemes is 28. It is widely acknowledged that this intake level is far below national requirements, it being generally accepted that the capacity of structured vocational training for general practice should be expanded to 75. Clearly any expansion of that magnitude would need to be carefully planned and co-ordinated. The provision of structured vocational training on that scale would require the commitment and mobilisation of substantial resources. There is an acceptance that any such expansion would need to be phased. The timespan over which such phasing should take place would necessarily be contingent on the availability of resources - in the Board's view a timespan of five years would be appropriate provided, of course, that the necessary financial resources were committed. That the Board has devoted considerable time to examining issues relating to vocational training for general practice over the past five years may be gauged from the following listing of decisions taken and viewpoints adopted by it -

- accepted in 1985 an invitation from the Department of Health to join with it in an examination of the operation of vocational training schemes in general practice and of the implications, including resource implications, of any expansion in the scope of such schemes,
- indicated that the continuing uncertainties relating to the financing of existing general practice vocational training schemes must be addressed,
- paid grants totalling £54,270 to the Cork Vocational Training Scheme in General Practice to help it meet shortfalls in its financing in the years 1985 - 1988,
- continued to press that guaranteed funding be provided to enable the intake to the general practitioner vocational training scheme in the Dublin Region to be maintained at 10 per annum,
- accepted in November, 1986 the general thrust of the report of an Informal Review Group (representative of the Department of Health and of the Board) on an examination of the operation of vocational training schemes in general practice and of the implications, including resource implications, of any expansion in the scope of such schemes,
- agreed to the principle of considerably expanding the availability of specific structured/integrated vocational training for general practice; also agreed that ideally full integrated training programmes should be the norm for entry to general practice but accepted the need to (a) maintain an element of flexibility and (b) avoid rigidity and accepted the need for agreement on an appropriate timespan within which to adopt and implement suitable measures for expanding vocational training; agreed that a timespan of five years would be appropriate in this regard,

- agreed that a planned phased approach to the development of increased programmed training opportunities for general practice is required allied with the need to keep the number of those in training under regular review,
- agreed that in planning for increased places on general practitioner vocational training schemes priority attention should probably be afforded to those areas where schemes do not currently exist,
- agreed that there is a need to include community care posts in rotations in general practitioner vocational training schemes,
- welcomed and supported the proposal to establish a National Joint Committee, as recommended by the Informal Review Group mentioned earlier, to oversee the operation and development of vocational training for general practice, and agreed, subject to being adequately resourced, to service that National Joint Committee,
- urged the Department of Health in 1987 to arrange for the early circulation of the November, 1986 report of the Informal Review Group already referred to,
- convened a meeting in 1988 involving representatives of the various health boards and hospitals involved with the Dublin Regional Vocational Training Scheme for General Practice to obtain a renewal of commitment of the resources to the training scheme and to seek to ensure the continuity of such commitment of resources,
- in 1988 reiterated its view on the need for considerably expanding the availability of specific structured/integrated vocational training for general practice and indicated that there was a need for agreement on an appropriate timespan within which to adopt and implement suitable measures for expanding vocational training,
- was represented at a one day workshop hosted by the Department of Health on 21 June, 1989 to examine the requirements of expanding vocational training for general practitioners and the implications of meeting those requirements,
- requested in 1989 views from the Dublin Regional Vocational Training Scheme for General Practice on how structured general practice vocational training in the Dublin area could best be expanded and how best to utilise and avail of the facilities and resources of the Dublin Medical Schools in any such expansion,
- in 1989 asked the Department of Health to finalise as a matter of urgency its consideration of the review of the organisation and funding of general practice vocational training.

The Board is anxious that progress be made quickly on making arrangements to expand the numbers of places on structured vocational training schemes for general practice. There is an acceptance that the current intake levels to the five

existing schemes do not nearly meet national requirements. This fact alone requires that the issue continue to be addressed. The EC Directive adopted on 24 July, 1986 gives added urgency to the issue. That directive requires Member States to institute specific training in general medical practice so that the first certificates are issued not later than 1 January, 1990 and also requires that from 1 January, 1995 the exercise of general medical practice under national security schemes shall be conditional on possession of a certificate of satisfactory completion of a specific training programme. The principal way forward has been charted in the report of the November, 1986 report of the Informal Review Group referred to earlier. The conclusion/consensus at a one day workshop hosted by the Department of Health in June, 1989 did not differ in any significant way from the 1986 recommendations. What is needed now is the decision to proceed in a planned co-ordinated way under the general aegis of a national co-ordinating committee. The Board would hope that the Department of Health could finalise as a matter of urgency its consideration of the type of approach which was generally favoured by the parties represented at the June, 1989 Workshop and that the necessary steps were then quickly taken to adopt and implement a specific funded programme of action.

Matching Programme for NCHD Appointments

- 2.17 An unsatisfactory feature which exists in postgraduate medical education is the "scramble" which takes place each six months as NCHDS apply for posts. There are of course a number of contributory factors including the underdevelopment of rotational training schemes, the wishes of young doctors to work in or close to main teaching centres, the need for young doctors to make multiple applications to various employing authorities etc. The principal underlying reason is, however, the medical manpower situation. It is inevitable under the present arrangements that doctors and posts are not always matched to the optimum. This clearly is unsatisfactory and when allied to the amount of resources devoted to advertising, interviewing, selecting etc. represents an inefficient and ineffective use of talent and resource. While tackling the medical manpower situation could of course go a long way towards providing solutions to this problem there is a need for a better more streamlined system for matching candidates for NCHD appointments to the posts available.

The Board has had under study the feasibility of having a national computerised matching programme for NCHD appointments. A matching programme is essentially an orderly process to help applicants to obtain the positions of their choice in postgraduate training, and to help hospitals/institutions to obtain the applicants of their choice. It alleviates unfair pressures, premature decisions, and other factors which generate inequity. Applicants and employers would continue to contact each other directly, and interview and evaluate each other independently of the Matching Programme. **The Match is not concerned with how the participants reach their decisions.** No offers are made during the interview period. Applicants and employers can properly evaluate each other before the employers must decide on their preferences for making offers, and before applicants must decide on their preferences for accepting offers. After all interviews are completed, each applicant submits a confidential Rank Order List (priority or preference list) on which the applicant lists the posts which he/she would accept in order of preference. Similarly, each employer completes a confidential priority list on which it indicates, in order

of preference, the applicants to whom it is prepared to offer a position.

The computer Matching Programme merely serves as a clearing-house, matching the applicants' and the employers' preference lists. The best possible matching combinations are listed. The result is that the applicant is matched with his/her highest ranked job from all jobs which institutions are prepared to offer him/her and which do not fill with applicants the institution preferred. **The employers get the applicant they ranked highest from among those prepared to consider their post and who do not receive positions/posts that the applicants prefer. A person may not always get his/her first priority but he/she cannot achieve a better match with another post which will accept him/her.**

A matching programme does not have to be computerised - it can be done manually. The computer system is used only to facilitate and ensure the accuracy of the matching process.

In a Matching Programme, applicants and employers may safely list preferred choices first, without consideration for how they will be ranked by the other party. Therefore decisions by applicants about accepting offers can be based on preference rather than on the likelihood of receiving other offers.

All information submitted to the Matching Programme is kept confidential. Applicants and employers are not told how they were ranked by each other. Each applicant is given only the final result he/she obtains and each employer is provided only with the names of the applicants it obtains in the match.

For a matching programme to work well, most (in the region of 80%) of the posts with which applicants will be seeking employment should be involved. Applicants and employers should send their priority lists to a central matching office by a specified date. All must agree to be bound by the results which are issued at a specific time and date in the same way as they will be bound when the written contract is signed. **Participants do not ask each other how they will rank each other and no premature offers are made before the match.**

The Board has had a very high level of favourable response to the documentation it issued in December, 1987 to employing authorities (health boards, voluntary hospitals) and to other interested health agencies (including training bodies) seeking to gauge what level of support there might be for the possible introduction of a matching scheme for NCHD appointments. The vast majority of responses received have been favourable to the principle of a Matching Scheme. The favourable response rate in respect of House Officer posts was 92%. (A small number of agencies have either reserved their positions or indicated they would be unlikely to participate in a national matching scheme. In the instance of one training body it has been indicated that there is a general level of satisfaction with the matching scheme that it operates for its own trainees. If a national matching programme were introduced the Board would be disappointed if any substantial block of posts remained outside it and would seek to achieve as wide a coverage as possible).

Arising from the responses received the Board has sought the necessary funds to enable it to prepare for the establishment and introduction of a matching scheme

for house officer appointments from July, 1991, probably on a manual basis initially and with a view to being computerised within a two to three year period. The Department of Health's response to the request for funds is awaited.

The development of such a matching programme on a national basis would of course be a very ambitious and large undertaking. It would be proposed to commence with house officers and as experience is gained extend to other NCHD grades. A long planning introductory period would be involved. To operate a match in July, 1991 would require considerable preparatory work during 1990 as the legal contracts and registration and advertisement process would have to be in place by early January, 1991 at the latest.

The Board has had extensive contacts with and advice from the Canadian Intern and Resident Matching Service and with National Matching Service of Toronto (which runs and/or licences a number of matching programmes e.g. Canadian National Intern Matching Programme, National Resident Matching Programme in the USA, US National Matching Programmes in Oral Surgery and General Practice et al). From these contacts the Board feels that it could operate a matching programme with a small core staffing working wholetime on the scheme. A matching scheme has the potential to be self financing if it were decided after a period of experience to charge fees to hospitals/health boards and to job applicants. It would not be possible, however, to establish a scheme without specific funding being made available for it initially. A matching scheme also has the potential to develop/evolve into a central applications service but this is an issue which would require further consideration as agreement to it would be unlikely to be forthcoming from health boards and voluntary hospitals until they had gained experience of the matching process itself and were thus reassured that their independence as employers was not being compromised.

CHAPTER 3

The Board and Continuing Education in Medicine

- 3.1 Continuing medical education is, broadly, postgraduate education following programmed training and has been defined by an Expert Committee of the World Health Organisation (WHO) "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).

Financing of Postgraduate Medical Education

- 3.2 The remit of the Postgraduate Medical and Dental Board includes the promotion of the development of postgraduate continuing medical education and the co-ordination of such developments. The Board believes that such education is essential and the need for appropriate funding is inescapable. Continuing education is necessary to maintain and improve competence. It must be borne in mind that with the rapid and increasing developments in medical knowledge and technology the half life of much of what young doctors learn is quite short. Continuing education is an essential component of professional life, and is necessary for continued efficiency, effectiveness and morale. The provision of future and updated expertise is very much part of sound economic planning. Medical staff must be enabled to participate in continuing education on a regular on-going basis. Similarly there is no doubt that ongoing investment in medical libraries and in audio-visual facilities etc. must be maintained, holdings updated and improved. Without such an approach the standard of Medicine would gradually decline thus affecting the ultimate welfare and care of patients.
- 3.3 In its First Report published in March, 1985 the Board indicated that each employing authority (i.e. health boards and voluntary hospitals) should have a specific budget for postgraduate medical and dental education. During the course of that report the Board foresaw that in the period immediately ahead health agencies would have to strive to provide services against a background of severe financial constraint. That being the case the report stressed the importance of health agencies not overlooking the needs of postgraduate education, including continuing education, when finalising their budgets. The report further stressed that the need for specific budgets for postgraduate education becomes essential when there is great demand on the resources available.
- 3.4 There is a tendency on the part of some agencies when faced with budgetary difficulties to seek to solve some of these difficulties by drastically reducing or eliminating provision for training generally, and in particular for continuing education. While recognising the difficult financial and resource decisions which health agencies must make the Board strongly urges that an enlightened approach should be adopted in ensuring that an investment continues to be made in maintaining and developing the expertise of their medical staffs. Without such an approach the maintenance of standards will be seriously jeopardised.

3.5 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. Health Boards and hospital authorities are empowered to pay or contribute towards the costs of Continuing Education of doctors employed by them. The Board has already recommended, see Chapter 3 of its First 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. It should be a matter for each employing authority in consultation with its medical staff to decide on the expenditure for its continuing education budget within certain guidelines. The Board wishes to repeat the guidelines for the operation of specific budgets for continuing education detailed in Chapter 3 of its First Report. Those guidelines are as follows:

- (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 course 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.

3.6 The Board has previously indicated to the Department of Health that the same general arrangements as regards continuing education should apply to all doctors (and dentists) providing services for public patients. The provisions in the new GMS contract relating to study leave etc. are welcome and it is hoped that they will be brought into operation without further delay. The principal activities undertaken by the Board in relation to continuing education for general practitioners are dealt with in paragraph 3.11 onwards of this Chapter.

Grants Paid by the Board

3.7 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. Nonetheless, as mentioned in its First Report, the Board would hope to be in a position on occasion to provide some assistance. When available such financial assistance from the Board will normally 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. Grants from the Board to assist health boards and hospital authorities with the purchase of teaching resources are unlikely to be available on an annual basis. Indeed no such grants were paid in 1989.

3.8 During the period 1985 to 1988 the Board paid grants to health boards, hospitals and to postgraduate centres amounting to £95,050. These grants, the payment of which was concentrated in the period 1985-6 were designed not only to help towards the purchase of teaching equipment but also in a number of cases to help to upgrade library facilities.

3.9 During the period covered by this report the Board has continued to provide some annual funding towards the costs incurred by the library information service operated by the Sligo General Practitioner Vocational Training Committee. This scheme commenced in March, 1983 and is described in paragraph 3.19 of the Board's First Report. A parallel scheme operated by the North-West Regional Dental Committee was launched in 1986. The Board's contribution to the combined schemes in the period 1985 - 1989 amounted to £3,680.

Co-ordinators of Postgraduate Education

3.10 Chapter 4 deals with the role 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:-

- 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.,
- 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,
- participation in the development, management and administration of postgraduate centres and in the organisation of the programmes of activities in such centres,
- participation in the consultative groups associated with general practitioner continuing education programmes.

General Practice Continuing Education Schemes

3.11 The Board's First Report set out the background leading to the submission to it in 1980 by the then Irish Institute of General Practice of proposals for a national structure of continuing education for general practice. In summary these proposals 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. The proposals produced by the Irish Institute of General Practice aimed 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.

In submitting its proposals in 1980 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 was then served by 65 general practitioners with their centres of practice 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.

3.12 The first thirty months of the pilot study are described in some detail in paragraph 3.14 of the Board's First Report. Information is provided on motivation and response, numbers of groups established, determination of learning needs, methods used by the groups and the content thereof, assessment and feedback, funding and monitoring. 56(86%) of the general practitioners in the area agreed to join in small group learning activity. Seven groups of eight doctors in each were established, meeting monthly, eight times per year. The overall monthly average attendance at the group meetings was 35, i.e. over 63% of those who had joined 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. Experience showed that a group of eight is perhaps 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 from 8 to a maximum of 12.

3.13 The Board's First Report also relates the first twelve months experience of a similar pilot study commenced in Waterford in July, 1983 and mentions that a third scheme commenced in October, 1984 in the West Midlands.

3.14 The Leeuwenhorst European Working Party (a grouping of European general practitioners aiming to promote general practice as a discipline by learning and teaching) 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 and Waterford the Working Party recommended "that this mode of provision of continuing education be developed and expanded to the point when all doctors who are able and willing to participate have the opportunity to do so".

- 3.15 The Postgraduate Medical and Dental Board welcomed and supported this recommendation. Indeed in April, 1984 the Board had already indicated to the Department of Health and to the Irish Institute of General Practice that it wished to encourage the expansion of such continuing education programmes and that it supported the concept that there should be a national network of such schemes.
- 3.16 The Board had envisaged that there would be discussions with the various interested parties on how such a national network should be funded. The cost of such a network of about 25 schemes was estimated in 1984 to be of the order of £250,000. Expenditure of that magnitude would have been very much outside the capacity of the Board to fund even if the principle were to be adopted that the Board should be the funding authority for the network referred to.
- 3.17 In the period since 1984 the Board has continued to lend its support to the concept of the development of a national network of GPCME schemes. It has in its annual budgetary submissions sought funds to enable progress to be made towards the establishment of the network. To date a total of 13 schemes have been established - the fourth scheme was set up in Sligo in 1985; 6 schemes were established in 1987 based on Carlow/Kilkenny, Cavan/Meath, Louth/Monaghan, Mayo, North and East Cork, Dublin (William Stokes and Mount Carmel ICGP Faculty areas) and in 1988 three schemes were established based on Cork City, Limerick and Dun Laoghaire/Merrion. A further important step towards the development of the national network was also taken in 1986 with the decision to appoint a National Director for the GPCME schemes (paragraph 3.19 refers). Dr. Michael Boland took up duty as National Director in September, 1986. The general practitioners holding posts as tutors at 1 January, 1990 are listed beneath.

Carlow/Kilkenny:

Dr. James Drynan, The Mall House, Thomastown, Co. Kilkenny.

Cavan/Meath:

Dr. George Doyle, High Street, Trim, Co Meath

Cork City:

Dr. Ciaran Donovan, 11 Woodbrook Road, Bishopstown, Cork

North/East Cork:

Dr. Brian Jordan, Medical Centre, Suncourt, Midleton, Co Cork

South-West Cork:

Dr. Thomas O'Leary, "Fuchsia", Fortview, Kinsale, Co Cork

Dublin: (Mount Carmel/William Stokes ICGP Faculty Areas)
Dr. John D. Latham, 31 Eden Park Drive, Goatstown, Dublin 14

Dun Laoghaire/Merrion:
Dr. Paul Lacey, 48 Upper George's Street, Dun Laoghaire, Co. Dublin

Limerick:
Dr. Michael Griffin, "Dromlinn" Monaleen Road, Limerick

Louth/Monaghan
Dr. Michael McDonnell, Main Street, Emyvale, Co Monaghan

Mayo:
Dr. Pat Durcan, Cathedral Close, Ballina, Co Mayo

Sligo: (Sligo, Leitrim, Roscommon)
Dr. Frank Dobbs, Castletown, Drumcliffe, Co Sligo

Waterford City and County:
Dr. Martin Rouse, 12 Tudor Drive, Clonmel, Co. Tipperary

West Midlands: (Ballinasloe, Loughrea, Ballygar, Athlone, Moate, Birr etc.)
Dr. Henry Finnegan, Ambleside, Parkmore, Creagh, Ballinasloe, Co. Galway.

The Board wishes to express its appreciation to the following who have also held appointments as Tutors for various periods during 1985 to 1990: Dr. E. Caulfield, Sligo and Dr. E.L. Grant, Waterford.

Job Description and Conditions of Service of GPCME Tutors

- 3.18 Tutors are appointed following competition for an initial period of two years, subject to review. They are responsible to the Council of the Irish College of General Practitioners (ICGP) and report to the National Director. They will normally remain in post for five years and are eligible to reapply.

Tutors undertake to devote at least two sessions per week of their time to the following activities:

- motivating all active GPs in the designated area to undertake CME including where possible participation in small group learning and performance review,
- notifying all participating GPs, where possible by personal contact, of all small group meetings. A minimum of 10 hours of CME should be provided directly by the tutor for each participant per annum. A tutor should ensure that at least 15 hours of formally organised accessible and worthwhile CME is available to GPs in his/her area,
- providing a curriculum for all the small groups in consultation with the participants, with the National Director and with other providers of CME within faculties in the designated area. Where necessary tutors will prepare

material for discussion and/or use prepared material from other sources. Copies of all material used should be forwarded monthly to the National Director CME,

- maintaining full attendance records of all meetings and returning these monthly to the National Director. These monthly reports should include the number of meetings held, their format, the attendance at each meeting, a copy of the agenda and material used, and any other relevant comments,
- working closely with those who submitted the proposal for a tutor (usually a local faculty or other representative GP group); where possible joining with them in the preparation of their educational programme for the coming year which should be so constructed as to enable the tutor to discharge his/her responsibilities,
- convening a local advisory committee composed of participants (normally individual group leaders). Advisory Committees should meet 2-3 times a year,
- convening a local consultative group consisting of the tutor, the advisory committee, the Co-ordinator of Postgraduate Medical Education appointed by the Board, a representative of local faculty(s) of the ICGP and other relevant CME organisers. This group should help in the planning of the curriculum, provide advice in relation to the ongoing running of the scheme, and help to provide feedback from all the doctors in the area. The group should meet at least once a year,
- being available to attend national/regional tutors' meetings at least three times per year and to attend courses relevant to their role as tutors,
- being available to serve from time to time on interview boards for new tutors and on visiting teams evaluating other schemes,
- using methods of assessment to evaluate the benefits of the programme to individual participants,
- co-operating with the Co-ordinator of Postgraduate Medical Education in the area in organising multidisciplinary CME activities involving GPs.

The Board pays the Tutors' sessional fees (2 sessions per week) and their travelling expenses. The Board also makes a contribution towards their secretarial and other administrative costs. Tutors are provided at the outset with the means to prepare and copy typed material. The average cost per scheme per annum in respect of fees, travelling and administrative expenses is of the order of £9,500

Appointment of National Director of GPCME Schemes

- 3.19 With monies specially provided by the Department of Health the Board was in a position in 1986 to fund the appointment, under the auspices of the Irish College of General Practitioners, of a National Director of general practice continuing education schemes. Following public competition Dr Michael Boland was appointed to the

post for a three year period with effect from 15 September, 1986. Following a review in 1989 Dr. Boland's appointment has been extended for a further three year period.

Purpose of the Job:

The purpose of the post of National Director is to provide at national level the administration, co-ordination, education support and assessment necessary for the efficient running of existing schemes within the national network of GPCME schemes, and to encourage promote and develop new schemes to complete the network.

The National Director's principal duties and responsibilities are -

(a) In relation to existing schemes:

- (i) to monitor the objectives, methods and curricular content of each scheme on an annual basis.
- (ii) to maintain a register of the number of GPs within each tutor's area, the number and membership of all small groups and their attendance records.
- (iii) to assist in the education and training of small group leaders; in co-operation with the tutors arranging where necessary for national and regional courses.
- (iv) To establish the necessary national structures for tutors to meet and formulate educational priorities in consultation with interested statutory and academic bodies such as the Department of Health, the Board, the medical schools, and the Colleges, Faculties and Institutes representing other professional colleagues.
- (v) To establish and keep up to date a bank of educational resources for use by small groups including a library of simulated problems, patient management problems, topic discussions and a relevant index of review articles on subjects related to general practice. To establish a computer link with the RCGP on line search service and through it to other larger data bases. To maintain a list of GPs, Consultants, and others with areas of special expertise willing to become involved in education.
- (vi) To establish and maintain a system whereby group participants could gather information about different aspects of their practice activity and relay it confidentially for statistical analysis. To process each doctor's individual results and present them in an understandable form using computer graphics together with national and area comparisons so that they can be used as the basis for group discussion. To liaise with the GMS Payments Board for the purpose of using their practice profile and prescribing information to supplement such data.

- (vii) To arrange the regular visitation of schemes for the purposes of continuing approval and funding by the Board. To provide for the nomination of visitors by the Board and the College. To provide a framework of assessment for their approval and use. To ensure that regular meetings of monitoring committees are held and that tutors' reports are received.
 - (viii) To integrate the activities of the schemes with the educational policies and activities of the ICGP and others involved in organising meetings.
- (b) In relation to new schemes
- (i) To identify areas where new schemes might successfully be established.
 - (ii) To travel to all parts of the country to describe the advantages of small group education the principles of performance review and the practicalities of establishing a scheme and becoming a GP tutor.
 - (iii) To keep under review the approved guidelines for selecting tutors and to make the necessary arrangements for holding competitions for the appointment of new and/or replacement Tutors.
 - (iv) To advise newly appointed tutors on the establishment of groups, their size and composition. During the initial six month start up period to assist in generating interest amongst the participants.

The National Director reports annually to the Board on the activities he undertakes and on the operation of the GPCME schemes generally.

As in the case of the Tutors, the Board pays the National Director's sessional fees (currently three per week, but under review for upward revision) and his travelling expenses. The Board also contributes towards his secretarial and other administrative costs and has helped in the purchase for him of teaching and secretarial equipment.

3.20 GPCME Schemes: Summary of Activities

The first GPCME scheme funded by the Board formally commenced in 1981. Thirteen tutors are now in post serving areas which include 1,078 general practitioners. Of these 690 (64%) have agreed to participate in the programme and have been organised in 55 peer-review groups. In the academic year 1988/89 376 meetings were held and in almost all areas these were additional to already existing traditional educational meetings. The average monthly attendance is 386 (56% of those participating). A very varied selection of methods are used by the small groups within the GPCME schemes including Topic Discussion, Simulated Problem Cases (Short), Simulated Problem Cases (Long), Problem Case Discussion, Video Recordings (Outside Material), Medicolegal Matters, Specific Research Projects, Practice Activity Analysis, Multiple Choice Questions, Random Case Discussion, Experts sitting in, Experts Consulted (but not sitting in), The Doctor's Bag, Random Prescriptions Review, Principles of Research, Content Planning, Theory of Groups,

The 'Check' Programme, The 'Case' Programme, Attitude Statements, 'Mea Culpa', Video Recordings (Own Consultations), Modified Essay Questions, Equipment Review, 'Prompt' Cards, Review of Records, Practice Visiting, Skills Training, Practice Management, Members' presentations.

A formal reporting system for the tutors is operating satisfactorily. It includes twice yearly reporting to the National Director of plans for the year, number of GPs in the tutor's area, number and size of groups formed and tutor's expenses. Reports are returned on the date, time and venue of every meeting, and the numbers attending. The content of every agenda and summary information on the feedback obtained from participants together with all written material prepared is returned and lodged in a material bank where it can be used by other tutors.

Levels of participation and attendance suggest that city areas will prove to be the most difficult to motivate. It now seems clear that the earlier policy of giving city tutors responsibility for larger population of GPs will need to be revised. This in turn suggests that the number of schemes required to complete a national network will have to be revised upwards from 25 to about 30.

Scheme visits (somewhat akin to the 'approval visits' which take place to inspect/approve NCHD posts for training purposes) are the most important element in the evaluation of the programme. The stated aim is to seek to visit every scheme every two to three years. To achieve this a substantial investment in manpower and resources would be required - three persons visit each scheme and each visit lasts a minimum of 9 hours, and with the present 13 schemes about five visits should take place every year. To achieve that level of visiting will require the commitment of greater finances than has been possible in the past. Seven scheme visits were undertaken in the period 1986 to 1989; all of the schemes established in the period April, 1981 to July, 1987 have been visited at least once, and more frequently in the case of the first schemes. None of the seven schemes established after July 1987 have yet been visited.

The visit reports provide detailed information on the schemes and give a general indication of both the theoretical basis for this form of CME and the practical difficulties in implementing it. The reports generally contain sets of recommendations dealing, inter alia, with organisational and educational matters. While all of the recommendations relate specifically to the scheme visited, many can have application to other schemes and in such cases form the basis of joint action/study by the national tutors group.

The form of evaluation produced by scheme visits has provided both the visited and the visitors with a very valuable learning experience. For that reason it is the practice to include as far as possible one new tutor on each visiting team. It is intended also that a non general practitioner member of the Board will be included in a number of visiting teams.

The tutors on the 13 existing schemes meet four times a year with the National Director and thus form a national tutors group. The network of GPCME schemes is unique in that it offers for the first time an opportunity to co-ordinate continuing education nationally. The development of the national tutors group provides the means by which this can be achieved. It has been decided that two of the meetings

of the national tutors group each year will become two-day educational workshops devoted to the preparation of suitable educational material of a higher standard and to the refinement of small group leadership skills. A national CME material bank is already in existence in the Irish College of General Practitioners. The first such workshop was held in Malahide in December, 1989.

In many of the GPCME schemes group-leaders have been identified for each of the groups. Worthwhile discussion often depends on the skill of the group leader and the group-leaders group becomes an important source of advice and support to the tutor in planning and delivering the programme. Since most GPs have little experience in this role a training programme is required. In 1988 general practitioners from some schemes took part in courses run by the HPU/Mental Health Association. In 1989 the tutors formed four regional committees to plan similar courses on a regional basis. The first such regional course is planned to take place in Cork in March, 1990. Among other courses which many of the tutors have attended were a national course organised by the ICGP in 1986 for doctors running or intending to run small group CME activities and a Leadership Course, with a particular emphasis on peer review, organised jointly by the ICGP and MSD Foundation in three modules in 1988 and 1989. Individual Tutors have attended courses in the Centre for Medical Education, University of Dundee and at the Department of General Practice, Postgraduate Medical School, University of Exeter.

The Board has sought to ensure that the GPCME schemes develop and maintain international contacts. The Board funds the expenses incurred by the National Director as a member of the New Leeuwenhorst Group - the group are currently concentrating on assessment in relation to CME and that topic is to be the principal item on their agenda of their April, 1990 meeting which is being held in Ireland. The National Director has also attended two world international conferences on continuing medical education and presented a paper at the 1988 annual meeting of the Association of Medical Education in Europe - this latter meeting was held in Dublin. The National Director is a member of the Council of the Royal College of General Practitioners (RCGP) and is a member of that College's education committee. It is understood that the RCGP is currently seeking British Government support for the concept of a national network of CME tutors very similar to that being developed in this country.

3.21 Delta Project

The national GPCME Tutors Group has become involved in an EC funded educational project - DELTA (Development of European Learning through Technical Advancement). The project at this stage is aimed at demonstrating the feasibility of producing medical television programmes for transmission to five EC States (Belgium, Netherlands, Ireland, Spain and the UK). Three programmes will be broadcast, each lasting approximately 30 minutes. The material will be prepared by British Medical Television (BMTV) in consultation with the academic partners. It will be transmitted at night using existing satellite channels (Entel 2 and Astra Ch E) and later the newly launched Olympus Satellite. The programmes will be encrypted and will use a special device which both de-encrypts and initiates recording on a domestic VCR. In the final phase of the project feedback will be provided by using a hand-held micro-computer to record responses to the programmes.

From the educational point of view the project will pilot the use of language - English, English with subtitles, and voice-overs in French, Spanish, and German. It will also test the cultural relevance of the programmes. Programmes will attempt to serve the needs of GPs trained in different medical education traditions, working in different health care systems, and dealing with patients with different health beliefs. Finally the views of a sample of GPs in the five countries on the value of the programmes as an addition to existing forms of continuing medical education will be sought. The National Tutors Group will constitute the user group in respect of Ireland.

The Tutors will receive the programmes, view them individually and later meet to discuss their reactions to them. A questionnaire will be circulated as an aid to critical viewing. It is expected that the project will be completed by October, 1990.

Continuing Medical Education: Concluding Remarks

- 3.22 The Board is very pleased with the experience gained in the operation of the 13 GPCME schemes to date. The existing schemes serve areas which include 1,078 general practitioners, of whom 64% have agreed to participate in the programme. In the academic year 1988/9 (the latest full year in respect of which statistics were available at the time of going to press) 376 small group CME meetings were held and in almost all areas these were additional to already existing traditional education meetings. The percentage of doctors attending each month averages 56% of participating doctors.

The Board is committed to the concept of a national network of such GPCME schemes. To achieve national comprehensive coverage would require an additional 16 or 17 new schemes. It is unlikely that such an expansion could take place immediately - a phased approach would probably need to be adopted. The Board would like to see sufficient additional funds being made available which would enable 4 or 5 new schemes to be commenced in each of the next 4 years so as to enable the national network to be fully in place by 1994.

It will be evident that a substantial beginning has been made in structuring continuing medical education for general practitioners. Structuring of CME for other medical practitioners has not been undertaken on the same scale and indeed in many specialties it remains largely unstructured. This lack of structuring represents a serious gap in the overall organisation of postgraduate medical education. Information is currently unavailable on the level of provision of and participation in continuing medical education generally. It must be remembered that continuing medical education needs to be a lifelong pursuit and as such the overall period of a doctor's life devoted to it will far exceed the time spent in undergraduate and postgraduate programmed training. The Board would strongly advocate that each professional training body should consider the development of a planned approach to the delivery of continuing medical education. Elements to be included in such a plan would include aims, objectives, content structure, targets to be achieved, evaluation and assessment, funding. Finally the Board wishes to repeat that not only is continuing medical education essential but there is an inescapable need to fund it - such funding should be provided in a planned budgeted way as recommended earlier in this Chapter.

CHAPTER 4

Co-ordinators of Postgraduate Medical Education

- 4.1 The Board now employs a regional network of Co-ordinators of Postgraduate Medical Education. The Board's first report traced the history of the initial establishment of these posts;
- 4.2 The initial six appointments in 1977 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 and subsequently, 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. Two additional appointments were made in 1983 - one each in the North-Western and South-Eastern Health Board areas; an appointment was made in 1984 in the Mid-Western Health Board area and in 1986 an appointment was made in the North-Eastern Health Board area.

4.3 Co-ordinators in post at 1st January, 1990

Eastern and Midland Health Board areas:

Professor D. Coakley, The William Stokes Postgraduate Centre, St James's Hospital, James's Street, Dublin 8.

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

Dr. S Murphy, Beaumont Hospital, Beaumont, Dublin 9.

Dr. D. O'Donoghue, St. Vincent's Hospital, Elm Park, Dublin 4.

Mid-Western Health Board area:

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

North-Eastern Health Board area:

Mr. F. Lennon, Our Lady of Lourdes Hospital, Drogheda.

North-Western Health Board area: (filled on a job-sharing basis)

Dr. S. Healy, General Hospital, The Mall, Sligo.

Dr. M. Lawler, St. Conal's Hospital, Letterkenny, Co. Donegal.

South-Eastern Health Board area:

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

Southern Health Board area:

Dr. H. Comber, Aldworth, Donovan's Road, Cork.

Western Health Board area:

Dr. Fiona Stevens, University College 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 1985: Dr. L. Bannan, Letterkenny; Dr. R. Godfrey, Cork; Professor J.F. Greally, Galway; Dr. P. Keane, Galway; Professor R. Mulcahy, Dublin.

4.5 Co-ordinators Duties, Responsibilities and Conditions of Service

The purpose of the post of Co-ordinator of Postgraduate Medical Education is to aid the Board in the co-ordination and promotion of postgraduate medical education.

Duties and Responsibilities

- (a) to seek to co-ordinate and encourage the development of postgraduate medical education, both at the level of programmed training and continuing education,
- (b) to help to stimulate learning by all trainees,
- (c) to co-operate with the Board, the professional training bodies, the health boards and the teaching hospital authorities in the promotion of postgraduate education,
- (d) to seek to identify the educational requirements of groups and individuals and help in ensuring that adequate programmes are available to meet these needs,
- (e) to seek to ensure that adequate educational resources are available for teaching and learning throughout his/her assigned area,
- (f) to promote the development of educational expertise at all levels,
- (g) to participate in the management and administration of postgraduate centres, where such exist, and in the organisation of the programmes of activities in such centres,
- (h) to help the Postgraduate Medical and Dental Board in the development and organisation of its career guidance programmes,

- (i) to participate in the consultative groups which have the tasks of helping the tutors on the General Practitioner Continuing Education Schemes in curriculum planning, advising in relation to the ongoing running of those schemes, and helping to provide feedback from the participants,
- (j) to help to foster links between postgraduate medical education provided for those who work in hospitals, general practice and community medicine,
- (k) to undertake any special tasks or projects assigned by the Board.

Reporting and Working 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 or three times yearly to exchange views and to report generally on their activities and plans. Each of the professional training bodies has nominated an officer with whom the Co-ordinators liaise. These liaison officers as a group meet annually with the Co-ordinators. 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 two Co-ordinators to attend each Board meeting.

Conditions of Service

The appointments are temporary and are for a period of three years which may be renewed. The current appointments are for the period to 30 June, 1990. Remuneration is at the rate of two sessions per week.

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 illustrates the position generally:-

- (a) organisation of basic science courses and symposia for those non-consultant hospital doctors who have not yet entered formalised training programmes; The format adopted in the Dublin area comprises a Friday night/Saturday morning symposium on a specialty topic, normally with five or six local experts and sometimes including a speaker from abroad. Topics covered in those symposia in the period since January, 1988 have included Management of Infections, Rheumatology, Emergencies in Medicine, Gastrointestinal Disorders, Ophthalmology for Physicians,

Medicine of the Elderly, Hyperlipidaemia, Growth and Short Stature, CABG in the '90s, Neurology, Cutaneous Manifestation of Systemic Disease, Anaesthetics and the Physician, Diseases of the Traveller,

- (b) organisation of clinical science courses suitable for non-consultant hospital doctors intending to specialise in Medicine,
- (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: UCC/Wellcome Postgraduate lecture programme: regional medical monthly conferences in the South-East; inter hospital medical conferences in the North-East, regional surgical conferences in the North-East and in the South-East,
- (d) organisation of inter-hospital clinico-pathological conferences,
- (d) meeting with liaison officers nominated by the training bodies to exchange information on a wide range of issues relating to postgraduate education,
- (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 postgraduate centres and in the organisation of the programmes of activities in such centres - in 1988 the William Stokes Postgraduate Centre on the campus of St. James's Hospital was completely replaced and enlarged and one new centre - the Sylvester O'Halloran Postgraduate Medical Centre - based on the campus of Limerick Regional Hospital opened in 1989,
- (i) participation in the consultative groups associated with the general practitioner continuing education programmes,
- (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, Drogheda, Dublin, Galway and Limerick the career guidance symposia and fairs held under the aegis of the Board,

- (l) exploration of educational needs, at local level, of doctors in community medicine,
- (m) helped the Board in its research on the feasibility of introducing a national computerised matching programme for the appointment of NCHDs,
- (n) monitoring postgraduate education activities and facilities in their areas and reporting on same to the Board.

4.7 Tasks in the Immediate Future

Co-ordinators will of course continue to carry out in the immediate future many of the tasks set out above. In addition it is intended that in the period immediately ahead particular attention should be paid to and a special emphasis placed on issues and topics listed beneath -

- in the areas outside the main teaching centres a particular emphasis should be on the "co-ordinating functions" and helping to develop and foster links between hospitals, general practice and community medicine,
- in those areas as well the Co-ordinators should monitor postgraduate education activities and facilities and report on same to the Board,
- in the Cork, Dublin and Galway areas in addition to the role of "co-ordinating" it is envisaged that there should be particular emphasis on the development and/or initiation of new projects e. g. rotations, special projects at the Board's request,
- all Co-ordinators should continue to be involved in multidisciplinary activities e.g. career guidance, development of suggested library lists etc.,
- special attention should be paid to those specialty groups most directly interfacing with general practice e.g. psychiatry, community medicine, obstetrics and gynaecology, paediatrics,
- in liaison with the professional bodies there should be a greater involvement by the Co-ordinators in continuing education.

Concluding Remarks

- 4.8 The Co-ordinators of Postgraduate Education continue to perform a range of important functions on behalf of the Board. They have helped in the initiation of many worthwhile undertakings such as the Basic Science Symposia referred to, the regional medical and surgical conferences and the Career Guidance Symposia. They are of course 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. The Co-ordinators are only too pleased, however, 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. These are to (a) promote the development of postgraduate education and training and to co-ordinate such developments; (b) advise the Minister for Health on all matters, including financial matters, relating to the development and co-ordination of postgraduate education and training; and (c) provide career guidance.
- 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), Mr. D. Doherty, Dr. M. Glacken, Messrs. V. Morris, S. O'Hickey and A. J. Woolfe.**
 - (i) **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 **Messrs M. Dunleavy, J. C. Healy, S. Keating, J. F. Lemasney, S. McMahon, B. O'Loughlin and K. Quinlan. Mr. F. Rafter** was also a member of this Committee until December, 1989 when he resigned because of pressure of other commitments. Mr. J.F. Lemasney was nominated to the Committee by the Society of Chief and Principal Dental Surgeons of Ireland, Dr. S. McMahon is Chairman of the Board's North-West Regional Dental Committee and the other six persons 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. During the period under review the Dental Committee was the more active of the two Committees concerned and the Board wishes to express its particular appreciation of the contributions made to its deliberations by those members nominated by the Irish Dental Association and by 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 was reached towards the end of 1984 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".

- 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. There are also a number of specialist societies which concern themselves, among other matters, with the provision of continuing dental education for their members.

5.6 Hospitals Approved for Training

Hospitals approved for full period of General Professional Training:-

Cork Dental Hospital
Dublin Dental Hospital

Programmes in Higher Specialist Training in the Republic of Ireland have been approved in Orthodontics, Paediatric Dentistry, Restorative Dentistry and in Oral Surgery and Oral Medicine. In early 1990 five senior registrars were in post - 2 in Orthodontics, 2 in Restorative Dentistry and one in Paediatric Dentistry. This position records the progress which has been made in the past five years - when the Board's First Report was published in 1985 there were no higher trainees then in post.

Special Considerations in regard to Dentistry

5.7 In its First Report the Board stated that in many ways the position in regard to postgraduate education in dentistry is similar to that in medicine, but acknowledged that in addition there are several factors which make continuing education in dentistry, if anything, more necessary than in medicine. It is worth repeating here the principal such factors enumerated in that report:-

- (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 31 December, 1989 there were 1,242 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. Health Boards can 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 by the Board and the health boards to the regional committees in the North-West, South-East, South/Mid-West and in the West.
- (ii) There is not in Dentistry, as in Medicine, a pre-registration year during which a graduate can gain increased practical experience .
- (ii) 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.

5.8 Outline of Board's activities in relation to Dentistry

- 5.8.1 One of the first reports considered by the Postgraduate Medical and Dental Board when first appointed in March, 1980 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."

There are some 28 whole-time consultant posts in dentistry (Restorative Dentistry (including Conservative Dentistry, Periodontology and Prosthetic Dentistry) 9; Oral Medicine and Surgery 6; 13 posts in Child Dentistry, Orthodontics and Preventive Dentistry). 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 endorsed 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 1970s 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 was reached with the Faculty of Dentistry on the establishment of a new committee to oversee higher training. The new Committee commenced work in 1985.

- 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.
- 5.8.5 Since 1985 the Board has helped towards the funding of a number of specific projects relating to dentistry viz:-
- made financial contribution towards updating/restocking of Irish Dental Library collection,
 - met the deficit incurred by the Cork Dental School in the running of a postgraduate course in Oral Medicine held in association with the 1985 meeting of the Association Stomatologique Internationale,

- was represented at the 12th Meeting of the Association for Dental Education in Europe (ADEE) and provided financial assistance towards the Faculty of Dentistry being represented at the 13th meeting of that Association,
- as already mentioned in paragraphs 3.7 and 3.9 the Board paid grants to health boards, hospitals and centres to help towards the purchase of teaching equipment. While much of this equipment was specifically for medical education some of it would be available for dental education also.

5.8.6 During the period 1 January, 1985 to 31 December, 1989 the Board's direct expenditure on dentistry - related matters amounted to £182, 050 or 8% of total expenditure. The corresponding expenditure in the period 7 March, 1980 - 31 December, 1984 was £22,700 (or 2.4% of all expenditure during that period). Expenditure related to the Board's regional dental committees amounted to £156,800 during the period January, 1985 to December, 1989 and further details in this regard are given in paragraphs 5.22 and 6.10.5. Financial assistance to the Faculty of Dentistry during that period amounted to almost £24,000 and the Board's expenditure on the dental library information scheme in the North-West totalled £ 780 .

5.8.7 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 As in the period 1980-85 the main thrust of the Board's 1985/90 activities in relation to dentistry has concentrated on the development of continuing education. Soon after its establishment in 1980 the Board considered how best to promote continuing dental education. This appraisal or review 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 specifically 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 was 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 (in respect of the five year period to 31 May, 1990) and terms of a reference are set out in paragraph 5.2(ii).

Regional Committees

5.11 The Postgraduate Medical and Dental Board and its Dental Committee adopted proposals in 1981 which envisaged the establishment of 5 or 6 regional committees. Stated in general terms the role/function of a regional committee would be the promotion of continuing dental education within its area. Particular functions of a regional committee would be as follows:-

- (a) Co-operation with other bodies involved in postgraduate dental 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 dental education with its area.
- (c) The making of recommendations to the Dental Committee as to the developments necessary in its area.
- (d) A consideration of the education 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 it was agreed that each regional committee when established 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 dental 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 in 1981 envisaged 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 would serve the Western Health Board area and the North-West and South-Eastern Regional Committees would serve the North-Western and South-Eastern Health

Board areas respectively. It was not intended however that there should 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.

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 was left in abeyance until experience was gained in the operation of a regional dental committee spanning both the Mid-Western and Southern Health Board areas. In the event that committee has worked very well and there are no proposals at this time to alter its functional area.

Membership of Regional Committees

- 5.14 The Board's wish was that the regional committees should be as representative as possible of the dentists in the area they are serving. In general it was felt 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 was recognised that in some instances local circumstances might make it desirable to vary these numbers. It was also envisaged that the dental schools would be represented on the Dublin and Cork regional committees and it was hoped to appoint dental consultant to the other committees. The membership of the regional committees established to date conforms to the general scheme set out in this paragraph, save that dental consultants have not been specifically appointed.

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 individually. 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 the North-West in 1983 and to establish a second in the South and Mid-West in 1984. The Board subsequently established further regional dental committees in the South-East and in the West in 1986 and 1987 respectively. 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 60s 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".

Establishment of Regional Dental Committees: Phased Approach

- 5.17 Financial constraints have dictated that a phased approach be adopted in establishing a national network of regional dental committees. It has been possible to date for the Board to establish in partnership with the relevant health boards the regional dental committees listed beneath:-

1983	:	North-West
1984	:	South and Mid-West
1986	:	South-East
1987	:	Western.

North-West Regional Dental Committee

- 5.18 The Board's first regional dental committee was established in 1983 in the North-Western Health Board area i.e. Donegal, Leitrim and Sligo.

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 in July 1983 Mr. S. McMahon, Sligo was appointed Chairman and the regional committee agreed to proceed to appoint a Course Organiser. Following competition Mr. B. Flanagan was appointed to this post and took up duty in September, 1983.

In the period since its establishment to end 1989 the North-West Regional Dental Committee has organised a total of 38 courses which attracted total attendances of 694. The courses have been held mainly in Sligo and Letterkenny, with one course being held in Dublin. Particular features of the programmes organised in the North-West include an Annual Conference held in Letterkenny generally each October and two 'hands-on' Orthodontic Courses, each confined to eight participants, held once per month for eighteen months.

South and Mid-West Regional Dental Committee

- 5.19 The South and Mid-West Regional Dental Committee held its first meeting in Mallow in May, 1984 and elected Mr. J.F. Lemasney, Limerick as Chairman. Following a competition Dr. G.J. Buckley of the Cork Dental School and Hospital was appointed as Course Organiser and took up duty in January, 1985. Dr. Buckley held that post for a year and on taking up an assignment abroad was replaced, following competition, by Professor L. Buckley in 1986. Mr. J.F. Lemasney completed his term of office as Chairman in August, 1983 and was replaced in that position by Mr. M. O'Boyle, Mallow.

The first academic activity organised by the South and Mid-West Regional Dental Committee took place in May, 1985. In the period since then to end 1989 59 courses have been organised by the South and Mid-West Regional Dental Committee. Those courses, which have been held in a total of 18 different centres, have attracted 1,017 attendances by dentists.

One particular feature of the programme in the South and Mid-West has been the number of Dental Updates which have been held. The concept of the updates is to provide current knowledge on dental subjects to the practising dentist by means of a series of short lectures given concurrently at a local meeting. These lectures are condensed information given by experts on the subject. They are of 15-20 minutes duration; a number of different subjects can be covered in a session of say 2 hours. At the end of the session the participating dentists are encouraged to question the speakers who come together and hold a seminar for 20 minutes approximately. By this means the graduate dentist is provided with information which helps him in his practice and may also encourage him to apply for more formal postgraduate courses such as participatory courses. The Dental Update programme

has also resulted in a number of study groups being set-up in local areas.

A total of 17 such Updates have been held - the venues being Bantry, Charleville, Cork, Dunmanway, Ennis, Killarney, Listowel, Mallow, Midleton, Nenagh and Thurles.

South-East Regional Dental Committee

- 5.20 The first meeting of the South-East Regional Dental Committee was held in Kilkenny in April, 1986 and Mr. J.C. Healy, Clonmel was appointed Chairman. Its Course Organiser, Mr. J. Browne, Wexford took up duty in July, 1986.

The 17 courses organised by the South-East Regional Dental Committee in the period to end 1989 have been held in 5 different centres and have attracted overall attendances of 251. Included in this regional dental committee's programme has been an extended (initially 18 months, and now continuing for a further similar period) 'hands-on' Orthodontics course confined to six participants.

Western Regional Dental Committee

- 5.21 At the first meeting of the Western Regional Dental Committee held in Tuam in June, 1987 Mr. M. Dunleavy was appointed Chairman. Its Course Organiser, Mr. J. Griffin, Ballyhaunis took up duty in November, 1987. Its first academic activity was held in Castlebar at the end of January, 1988 and in the two years to end December, 1989 the Western Regional Dental Committee has held a total of 12 courses which have attracted attendances of 180 dentists. Two of those twelve courses were held in Castlebar and the remainder in Galway.

Summary of Activities of Regional Dental Committees

- 5.22 The four regional dental committees have between them organised some 126 courses in the period to end December, 1989. These 126 courses, which have been held in a total of 28 venues, have attracted total attendances of 2,142 dentists. Course topics have included Crown and Bridge, Cross Infection Control, Dental Materials, Endodontics, Paedodontics, Preventive Dentistry, Periodontics, Resin-Bonded Bridges, Osseointegration, Other Restorative, Hepatitis B/AIDS, Oral Surgery, Orthodontics and the Updates already referred to. Various course types have been adopted e.g. lecture programmes, participation/demonstration courses, evening lectures, extended 'hands-on' courses. Six informal study groups have been established in the South and Mid-West and the Western Regional Dental Committee is actively considering the establishment of such groups. Library information services are operated by the regional dental committees in the North-West, South-East and in the South and Mid-West. A dental video-loan service is also operated in the South and Mid-West.

The Board wishes to take this opportunity to pay tribute to the work undertaken by the four regional dental committees under their chairmen and assisted by their Course Organisers. The Board is more than satisfied that by their combined efforts all involved have contributed significantly to stimulating the growth of continuing dental education.

Most of the organisational costs of the regional dental committees are met by the Board. These costs include the sessional payments of the Course Organisers, their travelling expenses and those of the members of the regional dental committees (who generally meet about 5 times a year) together with a contribution towards the administrative/secretarial costs provided by the health boards and by the Cork Dental School and Hospital (in the case of the South and Mid-West Regional Dental Committee). The Board has also provided some grants, amounting to £9,525 in the period 1985 - 1988, towards the purchase of some teaching aids. The Board's total expenditure on regional dental committees in the period 1985 - 1989 amounted to some £156,800 and more information in this regard is given in paragraph 6. 10. 5.

Some Issues for the Future

- 5.23 The Board is conscious of the fact that although the four existing regional dental committees have been successful in undertaking the task of stimulating and co-ordinating continuing dental education they do not provide national coverage. Three health board areas viz the Eastern, Midland and North-Eastern, are not covered. Somewhere in the region of 53%, of the dentists in the country practise in those three areas. The recommendations initially accepted by the Board envisage the establishment of one regional dental committee to serve those three health board areas. As explained earlier a phased approach has had to be adopted to the establishment of regional dental committees and funds have not yet been available to the Board to enable it to complete the national network. The Board is keen to proceed as quickly as possible towards providing for the co-ordination of continuing dental education nationwide. That said it is unlikely that the structure of the regional dental committees as implemented to date could without modification be applied to a region embracing the functional areas of the Eastern, Midland and North-Eastern Health Boards. As soon as funds become available the Board and its Dental Committee will discuss with the main interests involved the precise structure which should be established in those areas.
- 5.24 Impressive as the successes of the existing regional dental committees have been there is a need to guard against complacency. While the activities organised by the existing four regional dental committees have attracted combined attendances of 2,142 in the period to December 1989 it is also a fact that somewhere in the region of 100 dentists in the areas concerned may not have taken part in any formalised continuing dental education activities. Particular attention has been paid to this issue by the regional dental committees and the numbers of non-participants has been decreasing. The numbers involved represent in the region of 20% of the dentists in the areas concerned. While similar information is not available in relation to those parts of the country where regional dental committees have not yet been established it is likely that a similar or may be greater, percentage of dentists in those areas may not be active participants in continuing dental education. The Board's Dental Committee has been keeping this position under review. The Dental Committee does not favour the introduction of a mandatory system of continuing dental education believing there is insufficient evidence to demonstrate that such a system would be effective in delivering and in ensuring participation in worthwhile quality continuing dental education. The Dental Committee has had under consideration the possibility of formulating proposals relating to the introduction of a voluntary system of credits for continuing education. The Committee broadly favours the principle of such a system but as it reached the expiry of its term of office

it had not yet formulated detailed draft proposals. Stated in general terms the dental committee would like to see a system which was voluntary, national in character where worthwhile targets were set, took full account of developments in adult education, provided for a variety of methods including self learning; attendance at courses, participation in study groups and was not too complex nor bureaucratic in its operation. The Dental Committee had begun the task of addressing these issues and will look forward to the deliberations of its successors thereon.

5.25 As indicated earlier the regional dental committees in the North-West and in the South-East have organised hands-on Orthodontic courses confined to small numbers of participants and extending over a period not less than 18 months. The first course of this type organised by a regional dental committee was in the South-East and it commenced in April 1988. Two similar courses commenced in the North-West - one in early 1989 and one towards the end of 1989. The courses in question are expensive and demand considerable commitment from the participants and resource personnel. The poor regional distribution of consultants in orthodontics poses difficulties for the regional dental committees in planning, organising and delivering continuing dental education in the specialty. Those courses which have been organised have managed to meet only some of the demand that exists for continuing education in orthodontics. Further similar courses have been under consideration in the South-East and in the West. The commencement of those additional courses has been postponed while issues relating to professional indemnity insurance have been addressed. The Dental Committee hopes that the commencement of those additional schemes will not be too long delayed. The Dental Committee has also commenced work on the formulation of a policy statement in relation to the provision by regional dental committees generally of continuing dental education in orthodontics.

5.26 The Board would anticipate that in the years immediately ahead consideration will be given to the question as to whether vocational training should be introduced for those who wish to pursue careers in general dental practice and in the public dental service. Vocational training was introduced as a condition of employment for newly qualified entrants to the community dental services in the UK in 1982. Over the past five years there has been a significant growth in the existence of vocational training schemes for general dental practice in England and Wales. In 1984 7 such schemes existed and these had grown in 1988 to 19 with over 200 trainees. Schemes also exist in Scotland and there is one scheme in Northern Ireland. The aims and objectives of the schemes have been identified as follows -

'At the end of the vocational training period, as a result of working within a sheltered environment with an appointed trainer and participating in an educational course, trainees should be better able: (a) To provide unsupervised and with confidence a full range of general treatment and care for patients. (b) To be aware of their clinical limitations and to refer patients for specialist opinion and treatment when necessary. (c) To undertake the management skills necessary for the practice of dentistry. (d) To understand the organisation of the National Health Service. (e) To understand the legal and ethical aspects of the practice of dentistry. (f) To be self-critical and be conscious of the responsibility to apply new knowledge to practice. (g) To understand that professional training and education should be a continuing process'.

The General Dental Council in the UK in a Statement of Intent on Postgraduate Dental Education said in November, 1988 that the transition to independent and unsupervised practice, although legally permitted on qualification, requires careful preparation. That General Dental Council trusted that the current national voluntary vocational training scheme introduced in the UK in January, 1988 presages the introduction of mandatory arrangements in the UK so that no dentist will be able to enter the general dental service as a principal without having undergone a structured period of vocational training. Vocational training schemes in dentistry do not exist in this country. The question as to whether they should be introduced will no doubt be a topic to be considered in the future. Should they be introduced careful attention should be paid in planning them to ensure that their aims and objectives and educational programmes are geared to the delivery and organisation of the Irish dental services. Should such vocational training schemes be introduced the Board would see its role in relation to them as being similar to that which it exercises in relation to vocational training for general medical practice.

- 5.27 In its First Report the Board endorsed the view that a system of ongoing monitoring of the supply and utilisation of dental manpower was required which would inform public discussion and allow policy makers to see trends and respond to changing circumstances. The Board still adheres to this view. In its Consultative Statement on health policy - "Health - The Wider Dimensions" the Department of Health acknowledged that there is an urgent need to strengthen the manpower planning capacity in the health services. The report of the Commission on Health Funding published in September, 1989 drew attention also to the need for improved manpower planning. There is no doubt that manpower planning in relation to dentistry can and has given rise to vigorous debate and controversy. There is also no doubt, however, that there is need to keep dental manpower under review.
- 5.28 The General Dental Council in the UK in a statement in November, 1988 referred to the ethical obligation on each dental practitioner to continue professional education for the duration of practice and went on to say that failure to do so is tantamount to an abnegation of professional responsibility. The Board and its Dental Committee has devoted considerable attention to continuing dental education. It is envisaged that it will continue to do so. It looks forward to being able in due course to ensure that its continuing dental education structure provides national coverage. The challenge which faces it and its regional dental committees will include ensuring that the programmes which are developed and co-ordinated meet real needs and are accessible to all practising dentists. As in the past various means of delivering the programme will be availed of and much of the detailed organisation and decision making in this regard must be left to regional and local interests. The role of the Board and of its Dental Committee will be to co-ordinate these activities, help to promote good practice and to stimulate local effort. The Board's role should not be purely financial but it should also be seen to set goals and targets and endeavour to see to it that its regional structure is enabled to meet the targets set.

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 1 January, 1985 to 31 December 1989 grants totalling £2,256,300 were received by the Board from the Minister for Health. The grant received in 1985 amounted to £362,000 which represented an increase at constant prices of 9.7% over that received in 1984. The grants received in each of the next three years increased by 9.95%, 18.09% and 11.98% respectively over those received for the preceding year. This trend was reversed in 1989 when a grant of £500,000 was received (as compared with £526,000 in 1988). The Board's 1990 grant has been determined at £510,000.

The Board's expenditure in the five year period 1985 - 1989 amounted to £2,258,100 - details are given in Table 1. The increased grants received by the Board in the years 1985 - 1988 enabled it not only to maintain existing services and projects but also to fund the following additional activities -

- the establishment of ten new general practitioner continuing education schemes together with the appointment of a National Director of the GPCME schemes (chapter 3 refers),
- the appointment of an additional Co-ordinator of Postgraduate Medical Education (Chapter 4 refers), and
- two new regional dental committees (Chapter 5 refers).

It was not possible in 1989 to fund any additional activities or developments. Indeed it was found necessary to impose cash ceilings on the level of grants payable to the training bodies - the level of those grants in 1989 was £114,586 as compared with £158,674 in 1988. It is intended to maintain during 1990 the level of services and activities undertaken in 1989.

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, 1985 and 1986 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 1987 and 1988 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 this report were **Dr. C.S. MacNamara (Chairman), Professor B. E. Barrett, Mr. D. J. Doherty, Professor M.X. Fitzgerald, Drs. M. Glacken, M. Henry, Professor C.F. McCarthy and Dr. D. Moriarty.**

Policy 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.

Methods of Financing

6.7 As indicated in the Board's First Report, the Board visualises broadly 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) the 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 in respect of which the Board helps:-

- (a) the organisational costs of the professional bodies in activities wholly or substantially concerned with the development of postgraduate 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 are two principal variations from this - the Board provides the administrative services for the Irish Psychiatric Training Committee and for the Dublin Regional Vocational Training Scheme for General Practice.

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 in respect of journeys within Ireland. Prior to April, 1989 the Board met the full approved travel and subsistence costs of representatives of Irish professional bodies who attend meetings of Joint Committees and their Specialist Advisory Committees. The Board's budgetary position in 1989 did not permit it to continue meeting these full costs and as from April, 1989 the professional bodies themselves have been responsible for meeting one-third of the costs concerned.

- 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. In recent years the Board has adopted the practice of indicating to the training bodies as early as possible in the year the likely financial assistance the Board should be able to make. In practice in the period prior to 1989 the Board was able to meet, within the broad policy outlined above, all the claims made on it by the professional bodies. In 1989 it was found necessary to impose cash ceilings on the level of financial assistance provided and as already indicated the Board altered its policy relating to funding of 'foreign travel'. When account is taken of the revised rules relating to travel to meetings of Joint Committees etc. the Board in effect met 83.5% of all approved claims submitted to it in 1989 by the professional training bodies.

- 6.8.4 As shown in Table 1 the payments made by the Board to professional bodies during the period 1 January, 1985 to 31 December, 1989 amounted to £653,850 (29% of all expenditure). The distribution of those payments between the specialties is shown in Table 1. Table 2 shows the distribution of those payments by function. The Board has set aside £129,000 for payments to professional bodies in 1990 - the corresponding figure in 1989 was £114,586.

TABLE 1**THE POSTGRADUATE MEDICAL AND DENTAL BOARD****Expenditure 1 January, 1985 - 31 December, 1989**

Salaries		242,900
Travelling and Subsistence		56,700
General Administration		102,300
Accommodation/Servicing		45,000
Rates and Insurance		12,450
Payments to Professional Bodies		
- Anaesthetics	51,800	
- Dentistry	25,250	
- General Practice	171,450	
- Medicine	164,350	
- Obstetrics/Gynaecology	23,250	
- Pathology	24,850	
- Psychiatry	52,000	
- Radiology	25,650	
- Surgery	115,250	653,850
Co-ordinators of Postgraduate Education		454,300
General Practice CME		422,950
Audit Fees		4,000
Career Guidance		11,800
Grants to Postgraduate Centres		26,400
Grants to Health Boards and Hospitals		68,650
Regional Dental Committees		<u>156,800</u>
		2,258,100

TABLE 2**Grants paid to Training Bodies
1985 - 1989**

Purpose of Grant	Amount
Administrative Costs	£219,800
Travel expenses (a) abroad	£162,250
(b) Ireland	£127,150
Contributions to Joint Committees	£ 82,750
Grants for Audio-Visual equipment, libraries, etc.	£ 41,100
Joint Committee/SAC Visitations to Ireland	<u>£ 20,800</u>
Total	£653,850

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 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 trainee, 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 (paragraphs 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. The Department at that time 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 Employing authorities have in the past 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. Regard has to be had in the making of leave arrangements for the on-going service commitments of the hospital. The difficulties which can 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. The expenses involved relate primarily to salaries for the trainees, travelling costs, provision of library facilities, payment, where appropriate, of lecture fees, provision, where appropriate, of locums, provision of study leave, etc. These items are for the most part clearly known to employing authorities in advance and they should therefore budget therefor. Some training bodies and trainees have in the recent past had to suffer funding uncertainties or have been faced with inadequate provision. Structured training posts and schemes, postgraduate training (including programmed training, continuing education, research) must be preserved if organised postgraduate education is to survive without severe disruption or without being seriously jeopardised. Without such an approach the standard of Medicine and Dentistry would gradually decline thus affecting the ultimate welfare and care of patients.

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. The Board does not have funds at its disposal from which it can normally provide sponsorship for individual meetings. In a small number of cases the Board has been

able to provide to the Irish organisers of international postgraduate meetings being held in this country a commitment to provide some assistance should the organisers incur a deficit. The amount of money which the Board can set aside for this purpose in any one year is severely limited and applications must be made well in advance. The Board is pleased to record that in the vast majority of cases where a guarantee was given in the past five years to help meet such deficits the organisers did not in the event have to have recourse to such funds.

- 6.10.2 Health Boards and voluntary hospitals are empowered to 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 general arrangements as regards financing continuing education 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) thirteen continuing education schemes for general practitioners and (b) four regional committees for continuing education for dentists. In the case of the thirteen GPCME schemes 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 in Chapter 3 the Board envisages and is committed to the concept of a national network of such GPCME schemes. It is its intention to provide funding for additional schemes as and when its overall finances permit. The scale of development which has occurred over the past five years can be gauged from the fact that in the period 1985-89 18.7% of the Board's total expenditure was devoted to the GPCME schemes as compared to 4.7% in the period 1980-84. Expenditure by the Board in 1989 related to the GPCME schemes amounted to £134,605 which represented 27% of the Board's total expenditure. The Board has set aside £153,000 for the schemes this year. At the costs prevailing in 1989 finances of the order of £310,000 would be required to support the national network of GPCME schemes.
- 6.10.5 The funding arrangements for the four regional dental committees include the course organisers' fees and their travelling together with the travelling expenses of the members of the committees being met by the Board. (The

regional dental committees generate income from the fees charged to course participants - the fees in question are designed primarily to cover course costs and are not designed to generate profits although the fees received for some very well attended courses do provide subsidies in some instances for other courses which are expensive to mount, and which by their nature, in many cases, have to be confined to a smaller number of participants). In the case of one committee the secretarial services are funded by a health board while the Board meets these costs in the case of the other committees. 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 or six such regional committees is envisaged - these of course can only be established when and if the Board has adequate funding therefor. In the period 1985 — 1989 the Board has provided £156,800 in support of the regional dental committees - this represents 6.9% of overall expenditure and compares with expenditure of £12,150 in the period 1980 — 1984 which represented 1.3% of total expenditure during that period. In 1989 7.9% of the Board's expenditure was devoted to the regional dental committees and this amounted to £39,396. The sum set aside for this purpose in 1990 is £41,500. In the absence of firm decisions as to the precise nature of a complete network of regional dental committees it is difficult to estimate the costs involved but at the costs prevailing in 1989 finance in the range of £50,000 — £60,000 would be required.

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 As stated in the Board's First Report 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.
- 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 There was general agreement at the Symposium that an organised structure for the provision of career guidance was essential. Such a structure 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

- 7.8 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 almost 100 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

- 7.9 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;
- 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;

1985: **Career Guidance and Medical Manpower** - a booklet comprising in the main extracts and tabular statements relating to career guidance and medical manpower taken from the Board's First Report;

1986: **Careers in Psychiatry** - a careers information leaflet dealing with training in psychiatry.

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.

7.10 In 1986 the Board reviewed its policy regarding the publication of careers guidance literature. It found that while there was (and continues to be) a demand for information dealing with training for and prospects in individual specialties the frequency of changes in the organisation of training programmes and the continuing changes which occur in the detailed manpower statistics meant that any publication had a very short lifespan. The Board does not have the resources to revise, and prepare for printing, numerous updated leaflets on a regular ongoing basis and in any event it was doubtful whether such an arrangement would continue to make economic sense. The Board felt that it could provide a more useful service by ensuring that comprehensive hand-out material is available for distribution at its career guidance fairs and symposia. This material comprises about 60 pages of information relating to training for different specialties together with some general information on medical manpower and is fairly easily updated. The Board has not ruled out, however, the possibility of periodically publishing booklets on Medical Manpower - such publications would have the dual purpose of contributing not only to the Board's career guidance programme but contributing also to an informed discussion on medical manpower generally.

Career Guidance Fairs and Meetings for Interns and House Officers

7.11 In the period 1985 to 1989 the Board and its Co-ordinators of Postgraduate Medical Education organised 17 "Medical Careers Fairs" and Career Guidance Symposia. This programme of activities was aimed primarily for interns and first year house officers but others, including final year medical students, were welcome to attend and in fact many did so. The overall attendance at the Fairs and the Symposia was close on 1,000. The principal format adopted at the four symposia (3 in Cork and 1 in Drogheda) was to have up to 12 papers of about 8 to 10 minutes duration dealing with the main career options and providing ample opportunities for questions from the audience both in relation to the formal presentations and/or in relation to medical careers and training generally. The format adopted at the Fairs

consists of each main specialty having a manned booth to which interested doctors or students can call to obtain data on training, career prospects, etc. In total 13 medical careers fairs were held in the period 1985 - 1989 - fairs were held each year in question in Dublin and Galway while such fairs were held in Limerick in 1986 and 1987 and in Cork in 1989. While undoubtedly some young doctors prefer the symposium/meeting format the vast majority much prefer the fair format. Those who manned the booths also generally feel that the fair format is more effective in conveying information to individuals than formal papers. In the period immediately ahead it is envisaged that medical career fairs will continue to be held on an annual basis in Cork, Dublin and Galway and the Board will keep under review whether a similar programme should be held in other parts of the country, but the size of the potential audience in those other areas would not be such as to justify annual programmes.

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

- training pathways,
- job prospects,
- seeking information on sub-specialties,
- 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 effects of the EC Directive relating to specific training for general practice,
- 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.

As indicated in the Board's First Report because of the frequency with which questions are raised about working in the developing world, the Board has prepared, after consultation with the Agency for Personal Services Overseas (APSO), a short hand-out on the subject.

7.13 The fairs and symposia referred to form the core of the Board's overall career guidance programme. They enable young doctors to get at one time an overview of the training pathways and prospects in many different specialties and also provide an important forum through which the Board is able to get, at first-hand, an insight into the type of information young doctors wish to obtain. This two way flow of information helps to shape the programme for the coming year. The evaluation

forms completed by those attending have indicated, for instance, that interns and first year house officers not only wish to obtain information from hospital consultants, general practitioners and others in career posts but also generally value the opportunity to obtain information from more experienced NCHDs (e.g. registrars and senior registrars).

School-leavers

- 7.14 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. A number of changes suggested by the Board were incorporated in the Department of Labour career information leaflet "The Doctor". 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. In 1985 the Board asked the Irish Medical Organisation to prepare for its members a briefing document which would be available for doctors asked to give career guidance talks in schools. In 1986 the Board prepared a paper on medical manpower for the Institute of Guidance Counsellors so as to provide basic data and information for school leavers and their parents.

Medical Manpower

- 7.15 As stated in the Board's First Report career guidance cannot be divorced from career prospects. Career prospects are, of course, 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. While written about and spoken about a great deal Irish medical manpower is not a topic which has generated much real concerted action. It is a topic bedevilled by a myriad of confusing facts and projections. Discussions thereon must take account of its many diverse aspects such as the role of the consultant, career structures, doctor/population ratios, percentage participation and activity levels of female doctors to mention but a few. It is difficult to escape the conclusion that Irish medical manpower can provoke endless debate but little enough by way of action plans or sustained commitment, particularly in relation to the wide spectrum of medical manpower issues which have emerged in recent times. It seems to be difficult even to assemble the most basic of information - how many doctors are there in active practice in Ireland? No single agency has the task of collating what information is available; the Board has done this to some extent but clearly it is difficult, on occasions, to vouch for the accuracy of some of the figures obtained.
- 7.16 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. Its 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."

7.17 In its First Report in 1985 the Board endorsed the recommendation set out in the preceding paragraph and strongly urged that the process of looking at medical manpower issues in a planned cohesive integrated way begin. The Board went on in that report to suggest that it would have been helpful at that stage to establish a special committee or body (with representation drawn from various statutory agencies and medical schools) charged with the task of bringing forward proposals.

7.18 The Board is disappointed that it must report that the recommendations set out above have not been acted upon nor has any alternative approach been adopted and implemented.

7.19 A significant number of changes have occurred since the Council for Postgraduate Medical and Dental Education reported in 1977 which of course have an impact on the medical manpower issue now. Some of the principal changes are listed in this paragraph:-

7.19.1 The number of doctors in active whole-time medical practice has risen from 3,925 in 1976 to 5,345 in 1989 giving 15.0 doctors per 10,000 population as compared with 12.0 in 1971 and 12.4 in 1976;

7.19.2 The number of hospital consultants was stated to be 960 in 1976; as at 1 May, 1989 the approved establishment of consultant posts in the public sector was 1,100 and the number of specialists in private practice was 122 at that date;

7.19.3 The number of non-consultant hospital doctors (NCHDs) in public sector hospitals at house officer, registrar and senior registrar level rose by 500 to 1,444 in the period 1976 to 1984 which represented an increase of 52.5%; The number of such NCHDs increased by 60 in the period April, 1984 to October, 1988 but this was largely offset by a decrease of some 56 in the numbers of interns employed; it is understood that some 170 additional NCHD posts have been approved since October, 1988 to facilitate the (i) introduction of the 65 hour week for NCHDs and (ii) the revised organisational arrangements for the Accident and Emergency services in the Dublin area; the Board does not have information on the

extent to which those additional posts have been filled;

- 7.19.4 In April, 1984 there were 242 non-nationals employed as NCHDs in the public sector hospitals and this figure had risen to 418 (23% of the total) in October, 1988; the most significant difference between the 1984 and 1988 NCHD staffing figures was the increase in the number of male non-nationals employed as House Officers and the corresponding decrease in the number of Irish male House Officers - the latter number fell by 102 while the number of male non-nationals employed as House Officers rose by 96 to 204; there was also an increase of 38 (from 97 to 135) in the number of male non-nationals employed as Registrars;
- 7.19.5 During 1989 Irish hospitals have experienced a decreased candidature for NCHD posts from Irish nationals;
- 7.19.6 In the period 1975 to 1979 the number of graduates from the five Irish medical schools was 2,325, of whom about 465 were foreigners. The corresponding figures for the period 1980 to 1984 were 2, 326 and 443 respectively. In the period 1985 to 1989 the number of such graduates was 2, 165, of whom 1, 562 were from the Republic of Ireland, 105 were from Northern Ireland and 498 were from elsewhere;
- 7.19.7 The intake to UK medical schools which was around 2,150 in 1963/64 grew throughout the 1970s before stabilising at a little over 4,100 in the 1980s;
- 7.19.8 Throughout the 1980s medical unemployment has featured in a fair number of European countries, including the Netherlands, Italy, Spain, West Germany to name but a few;
- 7.19.9 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. The average intake of students from the Republic of Ireland in the years 1982 to 1989 inclusive has been 317 with actual numbers being admitted in 1988 and 1989 being 339 and 320 respectively;
- 7.19.10 The total number of undergraduates from the Republic of Ireland in the five medical schools fell each year from 1983 when it was 2,003 to 1,832 in 1988; The number rose slightly to 1,853 in 1989 and rose again in 1990 to 1,880;
- 7.19.11 In 1983 43.3% of medical undergraduates from the Republic of Ireland were female; this percentage has increased each year since then and in 1990 stands at 51.4%; 46% of Irish medical graduates in the years 1985 to 1989 inclusive were female;
- 7.19.12 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”;

- 7.19.13 The same report called 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; In a paper prepared in 1986 the Irish Medical Organisation recommended that the Irish intake to medical schools should be reduced to 260;
- 7.19.14 Changes have been introduced in the modes of entry by doctors to the General Medical Services Scheme (GMS); Only doctors who have established themselves in whole-time general practice in a particular centre prior to 1 January, 1989, (and who informed health boards accordingly at the time) will be allowed to avail themselves of an automatic right of entry to the Scheme in that centre of practice, subject to satisfying the other criteria for entry to the GMS. Therefore the last doctors who will have “right of entry” will be entitled to enter the GMS Scheme as of 31 December, 1993. Entry to the scheme under the 5 year rule will thereafter terminate. This change and the EC Directive relating to specific training for general medical practice have important implications for Irish medical manpower;
- 7.19.15 Information compiled by the ICGP shows that in 1988 at least 107 Irish graduates were in general practice vocational training schemes in Great Britain;
- 7.19.16 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’ - concerned medical education with special reference to the number of doctors and the career structure. Its best known recommendations indicated that (a) a much higher proportion of patient care should be provided by fully trained medical staff than was then the norm 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 were accepted by the British Government. The Department of Health and Social Security (in London) adopted targets for the doubling of the number of consultants in the NHS 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 was, perhaps predictably, mixed but the report 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.
- 7.19.17 1986 saw the publication in the UK of the proposals “Hospital Medical Staffing: Achieving a Balance” which related to England and Wales and there were corresponding reports in relation to Scotland and Northern Ireland. Among the recommendations in these proposals were the

following -

- a boost to the existing rate of consultant expansion, including (i) a limited period of central funding to allow the creation of additional consultant posts; (ii) the conversion to consultant of senior registrars and registrar posts identified as surplus to training requirements; (iii) a review of the regular staffing of consultant firms, to take place prior to each impending consultant retirement, with a view to converting registrar posts to consultant posts wherever this would be appropriate on service grounds;
- a scheme to allow early retirement in the interests of removing promotion blockages; and arrangements to facilitate partial retirement of consultants over 60 to release funds for new consultant appointments;
- continuation of the review of senior registrar numbers to relate the number of such posts to expected consultant-level vacancies;
- arrangements to relate the numbers of graduates of UK medical schools entering registrar posts to the number of senior registrar posts;
- a steady reduction, in some specialties, in the total number of registrar posts in the light of the number of posts required for training future consultants and the likely training requirements of overseas doctors;
- a small increase in the number of SHO posts may be required to allow for adequate breadth of training at this level;
- newly appointed consultants in the acute specialties to accept a greater direct involvement in patient care and in the direct supervision and training of their junior staff. This would be subject to the important proviso that staffing in support of consultants in acute specialties should not be reduced below a minimum number at an intermediate level of experience (the "safety net");
- local assessment of the needs of those now in the training grades who seem unlikely to make further career progress;
- a long-term aim of reducing the length of time spent in the registrar and senior registrar grades to the point at which the two grades could be combined into a single higher training grade.

The proposals also identified the bodies which would have responsibility of detailed manpower planning within this agreed framework.

After a period of consultation the British Government published its 'Plan of Action' aimed at implementing the recommendations described above including (i) measures for consultant expansion, (ii) designation of registrars

as "career" (eligible for a career in the UK) or "visiting" (overseas doctors due to return to their own country in due course) and (iii) arrangements for an overall reduction in registrar numbers and (iv) the introduction, subject to strict manpower controls, of a new non-training grade (called the Staff Grade) to provide a secure career for the small minority of doctors who do not wish or who are unable to progress to the consultant grade.

- 7.19.18 This report will return later to the Board's proposals relating to medical manpower issues which it feels should be reviewed. In the paragraphs immediately following statistical information is given in relation to medical manpower in Ireland.

MEDICAL MANPOWER IN IRELAND

7.20 General

- 7.20.1 The General Register of Medical Practitioners published by the Medical Council shows that there were 8,188 doctors who fully registered as at 1 May, 1989. About 5,590 of those were resident in Ireland and about 1,380 were over 65 years of age.

- 7.20.2 In addition to those doctors who are fully registered there are in the region of 690 other doctors in practice - those who are registered either provisionally or temporarily (viz. about 310 interns and 380 doctors from outside the EC).

7.20.3 Number of Doctors in Practice

Based on the numbers outlined in paragraphs 7.20.1 and 2 there could be up to 6,300 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 5,345 doctors in whole-time medical practice in the Republic of Ireland made up as follows: -

(a)	Doctors in the intern year	316
(b)	Hospital Doctors (non-consultants)	1,536
	- senior registrars	77
	- registrars	517
	- house officers	942
(c)	General Practice Trainees	28
(d)	Hospital Consultants	1,100
(e)	Specialists in Private Practice	122
(f)	Community Medicine	231
(g)	Defence Forces	27
(h)	General Practice	1,820
(i)	Occupational Medicine	15
(j)	Academic Medicine	90
(k)	Others	60
<hr/> TOTAL		5,345

7.21 Medical Posts in the Hospital Service

Appendix 5 shows the number of consultant posts by specialty as at 1 May, 1989 and the number of anticipated retirements to 1998. The appendix also shows the number of house officer, registrar and senior registrar posts by specialty 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.

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

7.21.2 A survey of non-consultant hospital doctor staffing as at 1 October, 1988 conducted by the Board showed that:-

- 1,815 NCHDs were employed in public sector hospitals on 1 October, 1988 (73 senior registrars, 514 registrars, 916 house

officers, 312 interns);

- 36% of all NCHDs were non-nationals, 28.4% of all registrars were non-nationals as were 24.6% 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.

Further information is given in Appendix 7.

7.22 Community Medicine

206 of the 231 doctors in community medicine identified in a 1982 survey (O'Se, L., Reilly W.B. and Hurley, M. Survey of Doctors in Community Medicine, 1 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. Other doctors working in community medicine were employed in the Department of Health, the Medico-Social Research Board and the Universities.

More up to date information on the medical staffing in community medicine should be available shortly when the report of the Working Party which has the task of defining the role of community medicine in the health services in the medium to longterm is published.

7.23 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, 1 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).

7.24 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.

7.25 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 are at least 1,820 wholetime general practitioners. At 31 December, 1988 there were 1,568 doctors participating in the General Medical Services as follows:-

Health Board	Number	Health Board	Number
Eastern	517	North-Western	97
Midland	92	South-Eastern	173
Mid-Western	135	Southern	256
North-Eastern	117	Western	181

The figure of 1,568 compares with 1,421 doctors participating in the GMS at the end of 1982.

The Working Party on the General Medical Service (August, 1984) said that there were then over 300 doctors in private practice awaiting entry to the GMS. The Board has been told by the health boards that on 1 January, 1990 251 doctors were waiting to enter the GMS under the "five year rule".

Figures published by the ICGP in 1988 indicate that there may be up to 2,210 doctors in general practice of whom some 1,960 may be in wholetime general practice.

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. It is also known that in 1988 there were 107 Irish doctors undertaking general practice vocational training in Great Britain.

7.26 Women in Irish Medicine: Some Statistics

Information gathered by the Board from various sources shows that -

- 51% of Irish medical undergraduates at 1 January, 1990 were female (the corresponding percentage in relation to the numbers of females in the pre-year and in the first and second years of the medical course was 55%),
- 46% of Irish medical graduates in the period 1985 - 1989 were female, 44% of Irish non-consultant hospital doctors on 1 October, 1988 were female,
- at 1 May, 1989 12% of Hospital Consultants were female; the percentage varied considerably between the specialties e.g. 29% and 21% of Psychiatrists and Anaesthetists, respectively were female, as were 17% of Pathologists and 16% of Paediatricians. The corresponding percentages in the other hospital specialties were much lower viz. Ophthalmology 10%, Radiology 9%, Medicine 5%, General Surgery 2% and Obstetrics/Gynaecology 1%. No female held a post of ENT Surgeon or Orthopaedic

Surgeon on 1 May, 1989,

- 23% of General Practitioners are female. 66% of doctors in community medicine in 1982 were female.

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 I) 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.

No similar Irish survey has been published since 1982. Issues related to career patterns of female doctors are, however, much discussed and surveyed in the UK. A study of the career pattern of UK women medical graduates of 1974 showed that in 1984 89% of them were employed in a vast range of specialties and of those 89% were in full-time employment, 9% in part-time employment and 2% were job-sharing. 32% had taken time off work for family commitments ranging from 1 month to 8.5 years. (Stephen PJ, Career patterns for women medical graduates 1974 - 84. Medical Education 1987, 21, 255 - 259).

A British study published in 1988 looked at the careers of the 1966, 1976 and 1981 graduates of British medical schools. 640 graduates from those three years were interviewed for the purposes of the study. Of the 640 doctors interviewed, 94 per cent were working either full-time or part-time in clinical medicine; 2 per cent were working outside clinical medicine but in a medically related occupation, less than one per cent were working both in and out of medicine, and, the rest were not working, were on maternity leave or were working outside medicine. Of those working in clinical medicine, three-quarters of all the doctors were working full-time and 19 per cent were working part-time. The figures for men and women were very different, with virtually all the men in clinical medicine working full-time, compared with just over 60% of the women. 1981 women qualifiers were much more likely to be working full-time than the 1966 and 1976 women, of whom just under 50 per cent of those working in clinical medicine were working full-time. Just over a quarter of women working part-time were in hospital medicine, just over half were in general practice, 15 per cent were in community medicine or community health and the rest were in other branches of medicine. The majority of women working part-time in medicine were not in training posts and the majority of women in training posts were not working part-time. Some ten per cent of the women GP trainees were working part-time, as were 6 per cent of the women registrars, but none of the SHOs. One-third of the women senior registrars were working part-time. The authors of the study stressed, however, that 'part-time' working was often a misnomer, since the

hours worked by many 'part-timers' in medicine far exceed those worked by full-timers outside medicine. (Allen I. Any Room at the Top? : A study of doctors and their careers. Policy Studies Institute, London. 1988, P43).

7.27 Number of Medical Graduates from Irish Medical Schools

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		
		Republic of Ireland		Northern Ireland		Other
1985	441	189	148	13	15	76
1986	440	183	138	13	5	101
1987	442	169	156	12	9	96
1988	405	149	138	7	8	103
1989	437	153	139	10	13	122

7.28 Undergraduates in Irish Medical Schools

At 1 January, 1990, there was a total of 2,781 (1,534 male and 1,247 female) undergraduates in Irish medical schools. The number in each year was as follows:-

Pre med: 455 (226 male and 229 female)
 1st Year: 516 (264 male and 252 female)
 2nd Year: 463 (261 male and 202 female)
 3rd Year: 471 (279 male and 192 female)
 4th Year: 438 (240 male and 198 female)
 5th Year: 438 (264 male and 174 female)

901 of the 2,781 students in the five medical schools were from outside the Republic of Ireland. 59 (31 male and 28 female) were from Northern Ireland and 842 (590 male and 252 female) were from elsewhere.

7.29 Concluding Remarks

7.29.1 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.

- 7.29.2 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 issues. It looked in 1980 that steps were being put in motion to go some way 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 and again in 1988 to revive the idea and indeed some progress was made towards agreeing on the objectives and framework for a medical manpower study but these have not got off the ground.
- 7.29.3 In its First Report published in 1985 the Board strongly urged that the process of looking at issues facing Irish medical manpower in a planned cohesive integrated way should then begin. The Board felt that it might have been helpful if a special committee or body with representation drawn from the various statutory agencies and medical schools were then established under an independent chairman and charged with the task of bringing forward proposals. This recommendation was not acted upon.
- 7.29.4 There is no disagreement on the need to look at medical manpower issues. The Department of Health in its 1986 Consultative Statement on Health Policy 'Health - The Wider Dimensions' acknowledged that there is an urgent need to strengthen the manpower planning capacity in the health services. The 1989 Report of the Commission on Health Funding recommended that there should be a comprehensive review of medical manpower requirements of all hospitals. Other bodies including Comhairle na nOspideal and the Irish Medical Organisation have also pointed to the need to review medical manpower.
- 7.29.5 Medical manpower policies are central to the Board's work. During the course of its deliberations on the many issues which come before it for consideration the Board has identified the following matters relating to medical manpower as requiring study and review
- an imbalance exists between the number of NCHD posts and career opportunities,
 - there is a need to consider the total organisation of the medical career structure with particular regard to the balances and ratios which should ideally exist between career posts and training positions; it is recognised that a single uniform agreement covering all specialties may be unlikely to produce a totally satisfactory structure; different approaches may be called for in relation to a number of specialties and there must be sufficient flexibility to take

account of this,

- there is a need to recognise that the numbers working and/or required in a number of specialties are too small to provide permanent career outlets to all the NCHDs working within them; a balanced approach is needed in this regard to seek to provide training in the specialty for those who aspire to a career in that specialty, to provide experience in a specialty for NCHDs aspiring to a career in a related specialty or pursuing general professional training and posts within those specialties can also be utilised to provide training for non nationals,
- the potential benefits of hospital rationalisation should not be overlooked in addressing issues related to postgraduate training,
- greater endeavours to promote the introduction of rotational arrangements at house officer/registrar levels on a wider scale than has applied hitherto may be justified but taking care so as to ensure that the quality of training is not diluted,
- there may be a case for an improved system of regulating NCHD complements at house officer and registrar level,
- the decrease being experienced in candidature for posts at house officer level which is fuelled to some extent by greater opportunities to obtain posts abroad allied to a perception that insufficient career opportunities are available in this country on completion of training,
- the implications both for training and for medical personnel policies generally of the 65 hour week for NCHDs,
- is there scope and/or need for an intermediate level career grade in this country along the lines recently introduced in the UK?
- the development of vocational training for general practice,
- consideration of the career patterns of female graduates, the development of part-time training, job sharing etc.,
- the need to provide appropriate facilities within hospitals for postgraduate training and for medical and clinical audit,
- other issues to be addressed would include matters relating to the numbers of non nationals employed (e.g. the numbers involved, the clear services need for them, the nature of the training they obtain).

7.29.6 In submitting its views in November, 1989 to the Department of Health on the Report of the Commission on Health Funding the Board bore the issues listed in paragraph 7.29.5 particularly in mind, welcomed the Commission's comments and recommendations relating to manpower planning and said

that a comprehensive review of medical manpower embracing the hospital service and relating also to general practice and community medicine should be commenced straight away. The Board suggested that the following draft terms of reference would be appropriate for such a review -

"To undertake a comprehensive review of medical manpower requirements and in so doing

(i) to have regard to

- the teaching, management and training responsibilities of medical personnel,
- the implications both for training and for medical personnel policies generally of the 65 hour week for NCHDs,
- the need to develop vocational training for general practice,
- the career patterns of female graduates,
- the implications of (a) the EC Directives permitting the free movement of doctors and (b) high unemployment among doctors in some EC Member States,
- the pattern of migration of Irish medical graduates,
- the need to provide appropriate facilities for postgraduate training and for medical and clinical audit, and

(ii) to consider

- the balance which should exist between NCHD posts and career opportunities bearing in mind the desirability of part of training being undertaken abroad,
- whether there is scope and/or need for an intermediate level career grade,
- whether there is a case for an improved system of regulating NCHD complements at house officer and registrar level,
- whether opportunities to provide clinical attachments (in hospitals) for general practitioners should be developed."

In the Board's view it would also be worthwhile for a survey to be undertaken in relation to the career aspirations and destinations of a cohort of Irish medical graduates from the 1980s. Such a survey would provide

valuable information relating not only to the career aspirations but also to the early career patterns of Irish medical graduates. Such a survey could be undertaken either as part of or simultaneously with the fundamental review of medical manpower favoured by the Board.

- 7.29.7 It is the Board's firm conviction that a thorough review of Irish medical manpower should be undertaken now. In the past the Board has perceived goodwill towards addressing this issue but such goodwill was not translated into a sustained commitment to action. The issues while regarded as important tended to be set aside by the pressures of day to day problems. To permit this to continue to happen would inevitably lead to major difficulties and accumulating problems. An initiative should be taken now. As stated by the Board on a previous occasion 'medical manpower issues are not amenable to quick resolution'. The medical school output to mid 1995 has already been determined; any review of career structures will of necessity take time to develop and take further time to implement. The Board strongly urges that no further time be allowed to elapse before an appropriately constituted body is given the task of urgently reviewing Irish medical manpower needs.

CHAPTER 8

The Immediate Future

- 8.1 The main 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. The report has been concerned mainly with the five year period to 31 May, 1990 but has also drawn attention to some of the activities undertaken by the Board in the period before 1985. The Report would 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 are defined by statute. They include promotion of the development of postgraduate medical and dental education, the co-ordination of such developments, the provision of advice on all matters, including financial matters relating to such development and co-ordination and the provision of career guidance. In its First Report in May, 1985 the Board foresaw that in the period immediately ahead health agencies would continue to strive to provide services against a background of severe financial constraint. The Board's First Report stressed the importance of health agencies not overlooking the needs of postgraduate education, including continuing education, when preparing their estimates and budgets. The Board strongly recommended that each health agency involved in postgraduate medical and dental education should have a specific budget for this purpose. The Board in this report repeats and reaffirms that strong recommendation. It is to be hoped that the improvements which have occurred in the national economy will be such as to ensure that the finances available to health agencies will maintain their real purchasing powers and that, indeed, some growth may be possible. As stated earlier in this report not only is postgraduate medical and dental education essential but the need for appropriate funding is inescapable. All health agencies should be particularly mindful of this when preparing their estimates and adopting their budgets.

Monospecialist Training/Multidisciplinary Needs

- 8.3 In its First Report the Board commented at some length on the issue of monospecialist training and multidisciplinary needs. This issue arises in the Irish context from the need to keep under review the training of consultant staff of all disciplines in order to satisfy the service needs of the Irish health services. Concerns have been expressed by some hospital managements that current training schemes are geared to specialisation within disciplines as against overall general training. The Board has previously said that 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. The responsibility for staffing our hospitals rests primarily with the employing authorities. They therefore have the task of clearly identifying the nature of the workload of individual hospitals and the organisation of their staffing complements to meet this workload. Training bodies should then in response to such information see to it that their training

programmes fully take into account the needs identified by hospital authorities. The Board would not wish to suggest that this is an area for quick and easy solutions; on the contrary it is one which is likely to involve fairly constant communication and interaction between employing authorities and training bodies. Any indepth look at medical manpower issues in this country must have regard to this topic. The role that increased rotations within training programmes could play in this matter should not be overlooked.

8.4 General Practice

The present Board has devoted considerable attention and time to issues relating to general practice. The Board's activities in relation to this specialty have concentrated on vocational training and continuing education. There is a consensus that structured vocational training for general practice is in urgent need of expansion. A framework as to how such expansion could be co-ordinated on a national level has been submitted to the Department of Health and the Board would urge that final decisions in relation thereto should not be delayed any further.

In Chapter 3 of this Report the activities undertaken by the Board in relation to continuing education for general practitioners are described in some detail. The Board has adopted proposals which envisage a national network of GPCME schemes. In the past five years considerable progress was made towards implementing those proposals. Nearly half the national network is now in place. The Board would hope that the necessary funding will be forthcoming during the lifetime of the next Board so as to enable the network to be completed.

8.5 Dentistry

The need to provide a structure for the promotion and development of continuing education for dentists has been a particular priority with the Board. The Board's four Regional Dental Committees have played a key role in this regard. The further development of these regional dental committees will form an important part of the work programme of the incoming Board. The incoming Board will also be conscious, no doubt, that the services of the existing four Regional Dental Committees encompass about half of the dentists in the country. A priority therefore will be to build on the regional committees and to provide a structure for the development and co-ordination of continuing dental education for those dentists not covered by those committees - in other words to not only develop existing services but extend them to dentists in the Eastern part of the country.

The question as to whether vocational training for general dental practice should be introduced will no doubt be addressed in the coming years. Issues related to Dental Manpower will also have to be kept under review - while the Board does not have a primary responsibility in this area it will continue to have a lively ongoing interest in the subject.

8.6 Career Guidance

The Board will continue to keep under review its career guidance programme with a view to achieving maximum effectiveness. The Board's annual programmes based on Dublin, Cork and Galway appear to be successful in providing information

to young doctors. There is a need to consider how best to provide information to doctors working in other centres - undoubtedly some such doctors travel to the existing programmes but this may not be sufficient in itself; on the other hand experience has shown that when career guidance fairs have been organised in other centres they have not always been well attended. The Board also needs to keep under review how best to develop a career guidance programme for dentists.

8.7 Medical Manpower

The Board is convinced that there is a need for a fundamental and thorough review of Irish medical manpower. It is further convinced that the commencement of this review should not be long delayed. As outlined in Chapter 7 it has indicated the draft terms of reference which it feels any such review should have and it commends them to the Department of Health.

8.8 Continuing Education

Continuing education is necessary for all doctors and dentists. The Board has devoted considerable time and resources to the development of networks for the provision of continuing medical education for general practitioners and for the co-ordination and development of continuing dental education. As already stated the Board looks forward to being in a position to provide the necessary funding to extend these networks so as to provide a full national coverage.

Continuing medical education, outside of the GPCME schemes, is much less structured. The level of funding provided therefor is also a matter of some concern. The professional training bodies should address the issues of structure and organisation. The employing authorities must see to it that their staffs are facilitated to avail of continuing education and they must budget therefor.

8.9 Doctors and Dentists in the Management Process and in Resource Utilisation

There can be little doubt that the role of the health professionals in the management process will receive a great deal of attention over the next number of years. This of course is a very broad issue but one aspect thereof relates to training. All phases of doctors' and dentists' training must take account of the role they will be expected to play in the management process. The Board's remit relates to the co-ordination and development of programmed and continuing education and training. Such education and training must help equip doctors and dentists with the knowledge and skills they will require to enable them to fulfill their management role to its full potential. Training of doctors and dentists for a management role is relatively underdeveloped at present. This deficit must be addressed and rectified. It is hoped that the Symposium which the Board is holding in May, 1990 will serve as a stimulus to the development and implementation of policies aimed at meeting doctors' and dentists' training needs in this area.

8.10 Other Issues

In the period immediately ahead we are likely to see an increased emphasis on the development and implementation of medical audit. Some training bodies already insist and many more are likely to insist that audit is systematically organised and

integrated with the training process.

The Postgraduate Medical and Dental Board is keen to see an improvement in the system of recruiting non consultant hospital doctors. It believes that the proposals which it has put forward in relation to the introduction of a Matching Scheme would serve greatly to streamline and improve the present less than satisfactory position.

Training at general professional level in a number of specialties, particularly in the Medical specialties, is much less structured than in others. While this may appear to avoid rigidity and permit flexibility it can also be questioned whether such unstructured or self-structured arrangements really facilitate the training process. There is no doubt that such arrangements can make career guidance and manpower planning more difficult. They can also contribute to uncertainties on the part of trainees on the composition of their individual training programmes and on the direction of their careers. In many instances the training/experience being gained is left more to chance and determined by the nature of the posts obtained every six or 12 months rather than being determined by a personal training programme. Training programmes must of necessity be flexible in their structures to take account of the training needs of trainees. However, questions can be raised as to whether the best interests of Irish medicine and Irish trainees are served by arrangements which can generate so much uncertainty.

In the remaining years of this decade many developments relating to medical (and probably dental) broadcasting may be expected. British medical television is already operational and the Board is aware of efforts being made to extend its service to Irish doctors and to develop therefrom a service specifically geared to Irish doctors. Developments in medical broadcasting will not be confined to these islands alone. Several European initiatives to utilise satellites are currently planned - information in relation to one of these (the Delta Project) is given in Chapter 3; another initiative in medical broadcasting has been the allocation of 104 hours of broadcasting time per annum by the European Space Agency to EuroTransMed, a medical education organisation that is arranging the transmission by satellite of undergraduate and postgraduate programmes. The Board is maintaining contact with these developments and provides information, as it becomes available, to the professional training bodies in this country.

8.11 Concluding Remarks

The role of the Postgraduate Medical and Dental Board is 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 seeks to promote, develop and co-ordinate it. To help it carry out its functions the Board is dependent on the action, the co-operation and the efforts of many other bodies and persons - including training bodies and hospitals, employing authorities, individual doctors and dentists. The Board is appreciative of the help and co-operation which it has received. There are other statutory bodies whose functions relate to or impact on postgraduate education for example Comhairle na nOspideal, the Medical Council, the Dental Council. The Board's working relationships with these bodies are satisfactory and the Board looks forward to continuing to work with them in the future with the overall objective of contributing to the development of manpower and training policies geared to bring Irish

medicine and dentistry to the 21st century.

The Board concluded its First Report by expressing appreciation of the sympathetic manner in which its requests for financial assistance for its own activities had been heard in the Department of Health and expressing the hope that this would continue to be the case. The Board is very happy to be able to record that its hopes in this regard were largely fulfilled. It saw quite substantial increases in its financial allocation during the period 1985 to 1988. While a setback did occur in 1989 the Board is confident that 1990 will see the commencement of a return to the earlier trend. It is the Board's hope that its activities and plans will continue to have the active and financial support of the Minister for Health and his Department.

Recognition of Training Posts

Appendix 1

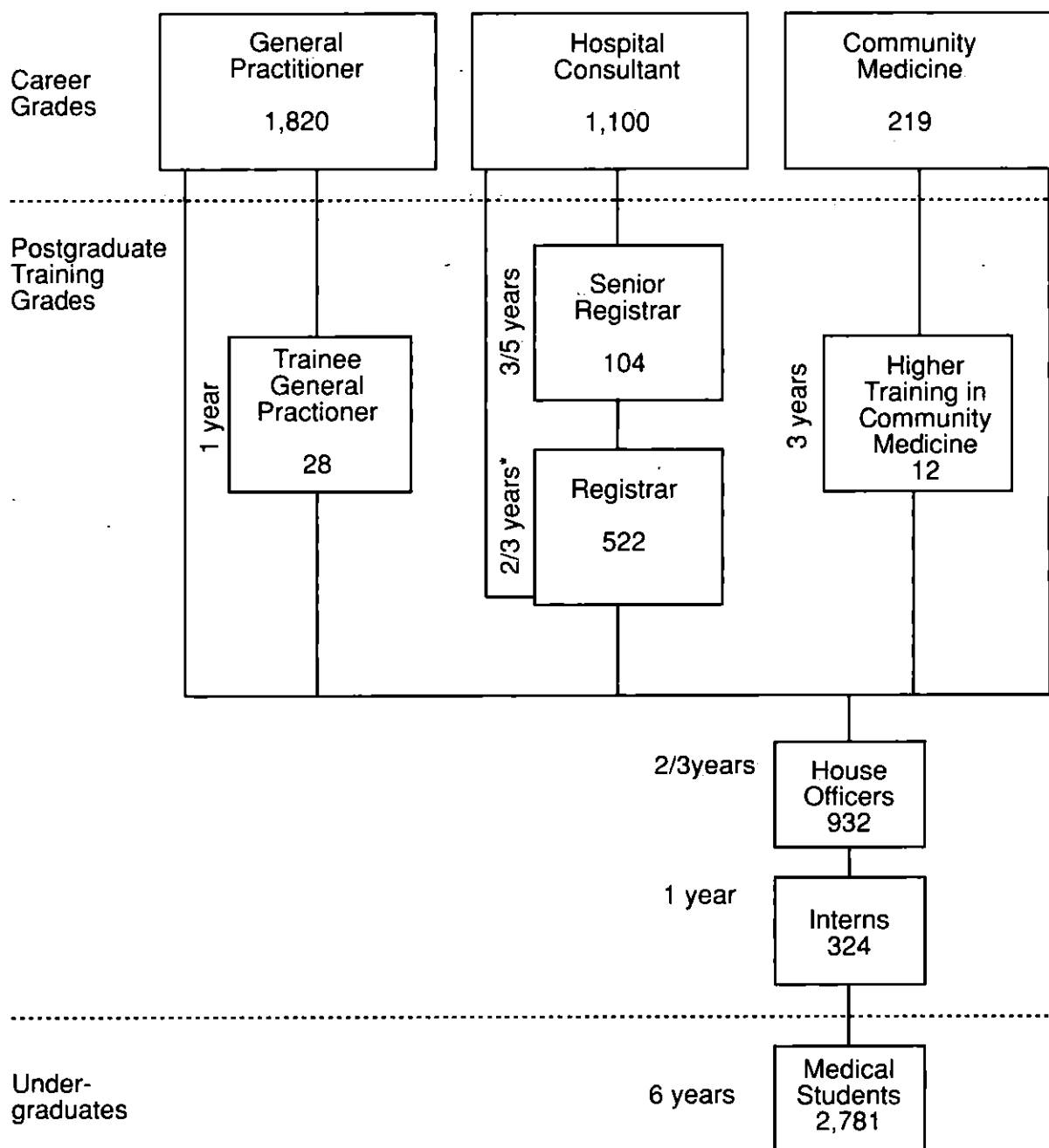
Details of the bodies responsible for the recognition of posts in training programmes are set out below.

(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 Post-graduate 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; **(d) Dentistry:** The Faculty of Dentistry of the RCSI recognises posts for general professional training and the Joint Committee recognises posts for higher specialist training.

THE PRINCIPAL CAREER STRUCTURES

**Notes:**

1. The figures shown for the establishment of each grade are the latest published for the grades shown.
2. The length of time spent in individual grades varies as between specialties.
3. This chart does not deal with (a) careers in academic medicine, (b) occupational medicine, (c) hospital specialists and other hospital doctors working exclusively in the private sector.

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

Training at Senior Registrar Level - The Position on 1 February, 1990

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	3 (3)
Orthopaedics	8	4	7 (5)
Cardio-Thoracic	2	4	2 (-)
General	18	4	17 (17)
Neuro	1	4	1 (1)
Paediatric	1	4	1 (1)
Plastic	2	4	1 (1)
Urology	4	4	4 (4)
Medical Group of Specialties			
General Internal Medicine	15	4	12 (4)
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	—
Respiratory	3	4	1 (-)
Rheumatology/Rehabilitation	3	4	—
Haematology	3	4	—
Anaesthesia	22	3	22 (22)
Obstetrics/Gynaecology	10	3	5 (4)
General Psychiatry	13	4	10 (5)
Child Psychiatry	9	4	7 (6)
Mental Handicap	2	4	1 (1)
Radiology	9	2	not yet decided
Accident & Emergency	1	4	1 (-)
TOTAL	151		104 (77)

** "approved" means approved by Comhairle na nOspideal.

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

Anaesthetics:	Dr. S.M. Hart, Regional Hospital, Wilton, Cork Dr. P. Keane, University College Hospital, Galway Dr. K. Moore, Our Lady's Hospital for Sick Children, Crumlin, Dublin 12
General Practice:	Dr. O. Clarke, Dublin Regional Vocational Training Scheme for General Practice, Corrigan House, Fenian Street, Dublin 2 Dr. H. Comber, Vocational Training Scheme for General Practice, University College, Donovan's Road, Cork Dr. P. Money, Drumcliffe Family Practice, Drumcliffe, Co. Sligo Dr. C.S. Macnamara, Chatsfort, Newtown, Waterford Dr. G. McGuire, General Practitioner Training Scheme, c/o University College Hospital, Galway Professor W. Shannon, Department of General Practice, RCSI, 84/85 Harcourt Street, Dublin 2 Dr. J.P.R. Stewart, Ballintemple, Falcarragh, Co. Donegal Dr. M. Griffin, "Dromlinn", Monaleen Road, Castletroy, Co. Limerick Dr. G. Kidney, Medicentre, Tullamore, Co. Offaly
Medicine:	Professor C.F. McCarthy, University College Hospital, Galway
General Professional Training:	Dr. B. Ferris, Regional Hospital, Wilton, Cork Professor J.S. Doyle, Beaumont Hospital, Beaumont, Dublin 9 Dr. G. Burke, Regional Hospital, Dooradoyle, Limerick Dr. B. Callaghan, General Hospital, Letterkenny 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. M. Hynes, EHB Community Care Area 8, Cromcastle Road, Coolock, Dublin 5 Dr. C. Foley-Nolan, Southern Health Board, Abbeycourt House, George's Quay, Cork Dr. E. McHalé, Western Health Board, Galway Community Care Department, Newcastle Road, Galway
Dermatology:	Dr. S. O'Loughlin, Mater Hospital, Eccles Street, Dublin 7
Gastroenterology:	Professor 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:	Professor D. Coakley, St. James's Hospital, Dublin 8
Haematology:	Professor 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:	Dr. H. Monaghan, Our Lady's Hospital for Sick Children, Crumlin, Dublin 12 Dr. W.A. Gorman, National Maternity Hospital, Holles Street, Dublin 2 Dr. J. McKiernan, Regional Hospital, Wilton, Cork
Rheumatology	Dr. Ciaran Barry, 9 Upper Fitzwilliam Street, Dublin 2
Obstetrics/ Gynaecology:	Dr. J. Murphy, National Maternity Hospital, Dublin 2 Professor D. Jenkins, Erinville Hospital, Western Road, Cork Professor E. O'Dwyer, University College Hospital, Galway Dr. H. Lamki, Royal Maternity Hospital, Grosvenor Road, Belfast
Pathology:	Professor C.T. Doyle, Regional Hospital, Wilton, Cork Dr. M. Farrell, Beaumont Hospital, PO Box 1297, Beaumont, Dublin 9 Professor J. Flynn, University College Hospital, Galway Dr. S. Kirrane, Mater Hospital, Eccles Street, Dublin 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, University College Hospital, Galway Dr. A.G. Carroll, Department of Child Psychiatry, University College 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. M. O'Neill, Department of Radiology, Regional Hospital, Wilton, Cork Dr. N. Murphy, Department of Radiology, University College Hospital, Galway Dr. J.A. O'Dwyer, Department of Radiology, Beaumont Hospital, PO Box 1297, Beaumont, Dublin 9 Dr. G. Hurley, Department of Radiology, Meath Hospital, Heytesbury Street, Dublin 8
General Surgery:	Mr. P. Keeling, Department of Surgery, University College Hospital, Galway Mr. J. Kelly, South Infirmary and Victoria Hospitals, Cork Mr. J. Hyland, Department of Surgery, St. Vincent's Hospital, Elm Park, Dublin 4 Mr. F. Lennon, Our Lady of Lourdes Hospital, Drogheda, Co. Louth
Accident & Emergency:	Mr. P. O'Connor, Accident and Emergency Consultant, Mater Hospital, Dublin 7
Cardiothoracic Surgery:	Mr. M. Neligan, Blackrock Clinic, Rock Road, Blackrock, Co. Dublin
Neurosurgery:	Mr. J. Phillips, Beaumont Hospital, Dublin 9
Ophthalmology:	Professor L. Collum, Royal Victoria Eye and Ear Hospital, Adelaide Road, Dublin 2
Otolaryngology:	Mr. M. Walsh, Suite 15, Blackrock Clinic, Rock Road, Blackrock, Co. Dublin
Orthopaedic Surgery:	Mr. F. McManus, Suite 8, Mater Private Hospital, Eccles Street, Dublin 7
Plastic & Reconstructive Surgery	Mr. D. Lawlor, Mater Private Hospital, Eccles Street, Dublin 7
Urological Surgery:	Professor J. Fitzpatrick, Mater Private Hospital, Eccles Street, Dublin 7

PANEL OF CAREER GUIDANCE ADVISORS IN DENTISTRY

Child Dental Health: L.P. Convery, TCD
D. O'Mullane, UCC

Community Dental Health: M.H. Hobdell, TCD
D. O'Mullane, UCC

General Practice: C.A. Aherne, UCC
B. Harrington, TCD

Oral Surgery: H.J. Barry, TCD
C. O'Brien, UCC

Oral Medicine: B. McCartan, TCD
J.G. Russell, UCC

Orthodontics: V. Morris, TCD
M. Hegarty, UCC

Restorative Dentistry:
(comprising Conservative
Dentistry, Periodontology
and Prosthetic Dentistry) B.E. Barrett, UCC
L.A. Buckley, UCC
F. Houston, TCD
D.B. Shanley, TCD

Appendix 5

Consultants (Position at 1 May, 1989)	Anaes	ENT Surg.	Obs/ Gynae	Oph Surg.	Ortho Surg.	Paeds	Path.	Phys- icians	Psych	Radi- ology	Surg- eons	Total for all Spec.
1 Establishment (1/5/89)	163	27	83	32	46	56	85	188	183	93	144	1100
2 Vacancies	14	4	1	1	2	5	3	11	16	5	8	70
3 No. of retirals by end 1993	15	3	8	4	3	5	11	21	24	4	9	107
4 No. of retirals 1994 to 1998	14	2	11	3	4	4	14	15	32	6	13	118
NCHDs												
5 House Officer Posts (1988)	61	15	86	20	44	94	27	264	116	10	143	931.5
6 Registrar Posts (1988)	38	13	31.5	8	32	26	23	120	125.5	18	83	522
7 Senior Registrars filled (establishment) (1990)	22 (22)	3 (3)	4 (5)	1 (1)	5 (7)	-	-	6 (21)	12 (18)	-	24 (26)	77 (104)
8 Annual intake into General Professional Training	23	3	25	3/4	-	-	8	410	25	4	23	
9 Approximate No. in General Professional Training	73	9	75	9	-	-	40	900	85	20	70	

Footnotes:

(1) Radiotherapists are included with physicians. (2) In this table surgeons exclude obstetrician/gynaecologists and surgeons in ophthalmology, orthopaedics and ENT. (3) The total of Senior Registrars includes one post in Accident and Emergency. (4) The totals for House Officers and Registrars include 51.5 and 4 posts respectively 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.

**DISTRIBUTION BY SPECIALTY OF REGISTRAR AND HOUSE OFFICER
COMPLEMENT AS AT 1 OCTOBER, 1988**

Speciality	Registrars	House Officers
Anaesthetics	38	61
Cardiology	14	13
Communicable Diseases	-	8
Dermatology	2	5
Endocrinology and Diabetes Mellitus	5	12
Gastroenterology	9	16
General (Internal) Medicine	45	118.5
Geriatrics	12	28
Renal Medicine (Nephrology)	5	5.5
Neurology	3	13.5
Paediatrics	26	93
Radiotherapy	3.5	8
Oncology	1	2
Respiratory Medicine	10	20
Rheumatology (Physical Medicine)/ Rehabilitation	8	11.5
Other Medicine	2.5	3
Obstetrics/Gynaecology	31.5	86
Neonatology	-	1
Chemical Pathology	1	-
Clinical Immunology	-	1
Microbiology	2	5
Morbid Anatomy/Histopathology	14	9
Haematology	5	11
Pathology	1	1
General Psychiatry	103.5	112
Child and Adolescent Psychiatry	17	1
Mental Handicap	1	3
Forensic Psychiatry	4	-
Diagnostic Radiology	18	10
General Surgery	60	122.5
Casualty/Accident & Emergency	4	51.5
Neurological Surgery	4	5
Ophthalmology	8	20
Orthopaedic Surgery	32	44
Otolaryngology	13	15
Paediatric Surgery	2	-
Plastic Surgery	3	2
Thoracic Surgery	6	6
Urology	8	6.5
Vascular Surgery	-	1

Notes:

1. Approved complement means the complement authorised by the Department of Health.
2. The totals for registrars and house officers in psychiatry are overstated and understated respectively. This arises because some employing authorities classify all NCHD posts in psychiatry as "registrars/house officers" with the mix at any one time varying depending on the qualifications and/or experience of the post holders.
3. Information in relation to senior registrars is given in Appendix 3.

Survey of NCHDs Employed at 1 October, 1988

- 1 The following statement shows the numbers of NCHDs employed on 1 October, 1988 in the public sector:-

Grade	Appr Compl (a)	Numbers employed						
		Nationals		Non-Nationals		Total		
		M	F.	M	F.	M.	F.	T.
Senior Registrars (b)	79	53	15.5	5	-	58	15.5	73.5
Registrars	522	222.75	145.25	135	11	357.75	156.25	514
House Officers	931.5	370.5	319.5	204	22	574.5	341.5	916
Interns	324	141	130	28	13	169	143	312
Totals	1856.5	963	610.25	372	46	1159.25	656.25	1815.5

- (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 also been approved by Comhairle na nOspideal and which have been funded either specifically or by the 'conversion' of some other NCHD post.
- (c) The figures above do not include the 28 third-year trainee posts in the general practice vocational training schemes.
- (d) The survey showed an approved complement of 79 Senior Registrars with 73.5 in post. Comhairle na nOspideal had at 1 October, 1988 approved 101 senior registrar posts but many of these have not been activated due in the main to lack of funding and also employing authorities in some instances "revert" post(s) to registrar grading if the Senior Registrar position(s) is vacant and not being utilised, for the time being, in the higher training programme(s).

2 Male/Female Ratios

2.1 General

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

	Nationals		Non-Nationals		Totals	
	M.	F.	M.	F.	M.	F.
Senior Registrars	77	23	100	-	79	21
Registrars	61	39	92	8	70	30
House Officers	54	46	90	10	63	37
Interns	52	48	68	32	54	46
Totals	56	44	89	11	64	36

2.2 Senior Registrars

23% of Irish nationals employed as Senior Registrars were female. 87% (5.5 of 6) of Irish nationals employed as Senior Registrars in General Psychiatry were female. 1 of the 13 Senior Registrars in General Surgery is a female. All 17 Senior Registrars in the other surgical specialties are male.

2.3 Registrars

64% of the Irish nationals employed as Registrars in Histopathology and Morbid Anatomy were female. The corresponding percentages in Paediatrics, General Psychiatry, Child and Adolescent Psychiatry, Obstetrics and Gynaecology, General Internal Medicine, General Surgery were 62%, 54%, 53%, 53%, 44% and 14% respectively.

No female Irish nationals were employed as Registrars in the specialties of otolaryngology, urology and orthopaedic surgery.

2.4 House Officers

The majority of Irish nationals employed as House Officers by the Eastern, South-Eastern, Southern and Western Health Boards were female.

3 Numbers of Non-Nationals employed

3.1 The survey shows a total of 418 non-nationals employed as NCHDs at 1 October, 1988. This figure, which represents 23.02% of the total, was made up as follows:-

Senior Registrars	5	
Registrars	146	(28.4% of all Registrars)
House Officers	226	(24.6% of all House Officers)
Interns	41	(13.14% of all interns)
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Total	418	(23 . 02 %)

3.2 Non-Nationals employed as Registrars

(a) A number of health boards were very dependent at 1 October, 1988 on non-nationals for their registrar staffing:-

Midland	54 . 5% of Registrars were non-nationals (6 out of 11)
Mid-Western	72 . 7% of Registrars were non-nationals (16 out of 22)
North-Western	81% of Registrars were non-nationals (17 out of 21)

(b) 53% of all Registrars in General Surgery were non-nationals.

50% of all Registrars in Otolaryngology were non-nationals.

51% of all Registrars in Paediatrics were non-nationals.

Non-nationals comprised 83% of the registrars in the numerically small surgical specialty of thoracic surgery.

3.3 Non-Nationals employed as House Officers

(a) A number of health boards were very dependent at 1 October, 1988 on non-nationals for their house officer staffing:-

Midland	47.7% of House Officers were non-nationals (21 out of 44)
North-Eastern	54.0% of House Officers were non-nationals (20 out of 37)
South-Eastern	45.4% of House Officers were non-nationals (30 out of 66)

- (b) 65% of all House Officers in General Surgery were non-nationals as were 83% of all House Officers in Orthopaedic Surgery and 50% of all House Officers in General Psychiatry.

Very high percentages of the house officers in the numerically small surgical specialties (of neurological surgery, urology, plastic surgery, cardiac surgery) were non-nationals.

4. Distribution by Specialty of registrar and house officer complement

	Registrars	House Officers	Total
Anaesthetics	38	61	99
Medicine	120	264	384
Paediatrics	26	94	120
Pathology	27	23	50
Psychiatry	125.5	116	241.5
Radiology	18	10	28
A & E & Casualty	4	51.5	55.5
Surgery (all specialties)	136	222	358
Obstetrics Gynaecology	31.5	86	117.5
Totals	522	931.5	1453.5

Notes

- (i) The totals for registrars and house officers in psychiatry are overstated and understated respectively. This arises because some employing authorities classify all NCHD posts in psychiatry as "registrars/house officers" with the mix at any one time varying depending on the qualifications and/or experience of the post holders.
- (ii) See Appendix 6 for a more detailed breakdown of the house officer and registrar complement by specialty.

5 Private Hospitals

At 1 October, 1988 33 NCHDs were employed in 8 private hospitals comprising 3 registrars, 26 house officers and 4 interns. Most of the registrars and house officers concerned work in General Medicine and/or provide cover in all disciplines.

Source: Survey conducted by Postgraduate Medical and Dental Board.

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