OUTLINE OF THE FUTURE HOSPITAL SYSTEM

REPORT OF THE CONSULTATIVE COUNCIL ON THE GENERAL HOSPITAL SERVICES

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CONTENTS

PRELIMINARY

I. Terms of Reference

The Minister for Health, Mr. Seán Flanagan, T.D., acting in accordance with powers given to him under Section 98 of the Health Act, 1947 appointed in November, 1967 a Consultative Council with the following terms of reference—

> To examine the position in regard to general hospital in-patient and out-patient services in the State and to report in outline on the future organisation, extent and location of these services taking into account the changing pattern of demand, the impact of developing specialisation and the introduction of new techniques so as to secure, with due regard to the national resources, that the public is provided in the most effective way with the best possible services.

II. Membership

The following members were appointed to the Council :—

Professor Patrick FitzGerald, M.D., M.Ch., M.Sc., F.R.C.S.I., F.A.C.S., Senior Professor of Surgery, University College, Dublin; Surgeon, St. Vincent's Hospital, Dublin (Chairman).

Senator Bryan G. Alton, M.D., F.R.C.P.I., Physician, Mater Misericordiae Hospital, Dublin.

Mr. Patrick Bresnihan, M.D., M.Ch., F.R.C.S.I., County Surgeon, Castlebar.

Dr. Dermot Collins, M.D., M.R.C.P., County Physician, Sligo.

Dr. Henry E. Counihan, M.D., Physician, St. Laurence's Hospital, Dublin.

Professor W. G. Fegan, M.Ch., F.R.C.S.I., Professor of Surgery, Trinity College, Dublin; Surgeon, Sir Patrick Dun's Hospital, Dublin.

Mr. Colm Galvin, M.Ch., F.R.C.S. (Eng.), County Surgeon, Tralee.

Professor Peter B. Gatenby, M.D., F.R.C.P.I., F.R.C.P. (Lond.), F.T.C.D., Professor of Medicine, Trinity College, Dublin; Physician, Meath Hospital, Dublin.

Professor William Kearney, M.D., M.A.O., F.R.C.O.G., Professor of Obstetrics and Gynaecology, University College, Cork; Obstetrician/Gynaecologist, Erinville Hospital, Cork.

Professor John Kennedy, M.Sc., M.D., M.R.C.P.I., Professor of Pathology, University College, Galway; Pathologist, Regional Hospital, Galway.

Professor William A. L. MacGowan, F.R.C.S.I., F.A.C.S., Professor of Surgery, Royal College of Surgeons in Ireland; Surgeon, St. Laurence's Hospital, Dublin.

Dr. John Nash, M.Sc., M.D., M.R.C.P., Physician Superintendent, Regional Hospital, Limerick.

Professor Seán O'Beirn, M.Ch., F.R.C.S.I., Professor of Surgery, Unversity College, Galway; Surgeon, Regional Hospital, Galway.

Dr. James St. L. O'Dea, M.B., D.P.H., Resident Medical Superintendent, St. Kevin's Hospital, Dublin.

Professor D. K. O'Donovan, M.D., Ph.D., F.R.C.P. (Lond.), Senior Professor of Medicine, University College, Dublin; Physician St. Vincent's Hospital, Dublin.

Professor William O'Dwyer, M.D., Associate Professor of Medicine, Royal College of Surgeons in Ireland; Physician, Jervis Street Hospital, Dublin.

Professor Eoin O'Malley, M.Ch., F.R.C.S.I., Professor of Surgery, University College, Dublin; Surgeon, Mater Hospital, Dublin.

Professor Denis J. O'Sullivan, M.D., F.R.C.P. (Lond.), Professor of Medicine, University College, Cork; Physician, St. Finbarr's Hospital, Cork.

III. Secretariat

Mr. Joseph A. Robins, B.A., B.Comm., D.P.A., Department of Health, was appointed Secretary to the Board and Mr. Shaun Trant, B.A., A.I.S., Department of Health, was appointed Assistant Secretary. Mr. Tomás Ó Donnagáin of the Department also assisted in the work of the Council.

IV. Meetings

The Council first met on 20th November, 1967 and terminated its discussions on 16th June, 1968. The plenary Council met on eighteen occasions, including five meetings of two or three days duration on each occasion. In addition five sub-committees were set up which met on a total of twenty-five occasions.

PART ONE

THE PRESENT GENERAL HOSPITAL SYSTEM AND THE PRINCIPLES ON WHICH IT MIGHT BE DEVELOPED

CHAPTER ONE

INTRODUCTION

Development of Voluntary and Local Authority Hospitals

1.1 The Irish general hospital system is a two-fold one. Approximately half of the hospitals, usually referred to as voluntary are, to place them in order of historical precedence, owned by lay boards or by religious orders. The others, usually of more recent development, are owned by public authorities. There is nothing unique about this dichotomy in the hospital system. In many other countries this pattern in the organisation of hospital services also developed with the growing participation by the State in a social activity which for centuries had been regarded as exclusively that of private charity.

1.2 The Irish voluntary hospital movement had its origins in the early decades of the 18th century and, because of the penal restrictions of the period on religious communities, was initially entirely lay in character. Philanthropic individuals, moved by the conditions of the sick poor, voluntarily took on themselves the task of establishing and running hospitals and raising money for them. It was a form of charity to the public not available in Ireland since the closure of the monasteries following the Reformation. On the other hand, in Britain, under Elizabethan legislation, a system of rate-supported public parochial assistance, including provision for the poor infirm, had been devised, but it had not been extended to Ireland.

1.3 The development of the Irish voluntary hospital was almost entirely confined to the city areas, particularly to Dublin. The movement depended largely for its support on the commercial and professional classes, an element not significantly represented in rural areas. Many of the hospitals had a short career, because of lack of continued financial support, but some of the earliest voluntary hospitals have survived to the present day. In Dublin, the Charitable Infirmary, Jervis Street; Dr. Steevens' Hospital; Mercer's Hospital; the Rotunda Maternity Hospital; the Royal Hospital for Incurables and the Meath Hospital all have early 18th century origins, and some of them were the earliest hospitals of their type in the world. The Dublin House of Industry, which eventually included in its complex of buildings the Richmond, Whitworth and Hardwicke Hospitals, started developing in 1773 and now forms St. Laurence's Hospital. The North Infirmary and the South Infirmary, Cork, also date from the same period as do, among others, the County and City Infirmary, Waterford.

1.4 During the first half of the 19th century the voluntary hospital movement was still the main force in providing for the sick poor. In Dublin, Sir Patrick Dun's Hospital, the Coombe Maternity Hospital, the Adelaide Hospital, the Royal City of Dublin Hospital, the Royal Victoria Eye and Ear Hospital and the National Children's Hospital, Harcourt Street came into existence. Barrington's Hospital was opened in Limerick. A significant influence on voluntary hospital development was the growth of more liberal political attitudes and the lifting of restrictions on the Catholic community, thus allowing the foundation of a number of new Irish Orders of Religious dedicated to the care of the sick poor. The Irish Sisters of Charity founded St. Vincent's Hospital, Dublin, in 1834. The Sisters of Mercy opened the Mercy Hospital in Cork in 1857 and the Mater Misericordiae Hospital in Dublin in 1861. A great expansion of these, and other Orders, took place from then on, resulting in a most important contribution to the Irish hospital provision, among other examples of the charitable actions of these Orders. This is manifest in the lists of hospitals enumerated later in this report.

1.5 During the last one hundred years, rate supported institutions, owned and operated by local authorities, have opened in all counties. They were originally particularly associated with the indigent and are largely rural, or county town, in distribution. The voluntary hospitals, both religious and lay, due to their position mainly in Dublin and Cork, became associated over the years with the Medical Schools and on them has devolved the main responsibility for the clinical education of the medical student and young doctor. Thus, the majority of them can also be referred to as voluntary teaching hospitals. On the other hand, the local authority hospitals were not developed in this direction and continue, in general, to be non-teaching hospitals. This is mainly because of their position away from university centres, but also because their support has been through public funds, strictly allocated for service, often in a niggardly fashion. There are, however, two notable exceptions—the Regional Hospital in Galway and St. Finbarr's Hospital in Cork. Significantly, perhaps, both of these local authority teaching hospitals are close to the corresponding university college. As the State came to concern itself more and more with its sick and needy citizens, the impetus of voluntary charity slowed down. In any event, increasing taxation to meet the rapidly expanding public services hit hard those sections of the community on whom the voluntary hospital had largely depended. Contributions dwindled and during the 1920's many of the Irish voluntary hospitals were in an extremely difficult financial position. It was these circumstances which gave rise to the establishment of the Irish Hospitals Sweepstakes and to the creation of a source of funds which was to make possible radical improvements in both the voluntary and local authority hospital systems. To date Irish hospitals have benefited from these funds to the extent of over £62,000,000.

1.6 Prior to the establishment of the workhouse system under the Poor Relief (Ireland) Act, 1838, the Government had made little provision for the sick poor. An entirely inadequate system of county infirmaries, partly dependent on voluntary subscriptions, had been established by an Act of 1765, and subsequent enactments provided for fever hospitals and lunatic asylums. The workhouses were designed primarily as places where the destitute could receive food and shelter in the harshest and most deterring surroundings. While some accommodation was provided in them for the sick, the Government initially opposed any suggestion that they should be planned or fitted out as hospitals, for the principles on which the early workhouses were established aimed to discourage the pauper, sick or well, from entering them. However, since in most areas, and particularly in rural districts, there was no other institution to care for them, the sick poor generally were prepared to accept from the workhouses the modicum of care it had to offer them. In 1862 the Government, recognising the role which the workhouses were being forced to take, made legislative changes which, in effect, gave these institutions something of the character of hospitals. Rural Ireland became largely dependent on these centres and this remained the position until after British withdrawal from the country.

1.7 Subsequent to 1922, the newly established Irish Government introduced measures [Local Government (Temporary Provisions) Act, 1923] to abolish, in name at least, the poor law and county infirmary systems. The workhouses and the infirmaries were closed as such and their existing administrations abolished. A hospital system based on what were referred to as " County Schemes " was introduced. In nearly every county a central medical and surgical hospital, called the County Hospital, was established. These were one-surgeon, one-physician institutions. Most counties were also assigned a County Home and one or more District Hospitals. The main function of the former was to provide shelter for the destitute and of the latter to make available a non-specialist medical service. The medical staff provided for the District Hospital was a single, part-time, Medical Officer practising otherwise in the area as a family doctor and usually holding the post of local dispensary doctor as well.

1.8 In nearly every instance the new institutions were based on a former workhouse or infirmary, for it would have been impossible to find the funds to undertake new building. Most of the original hospitals have since been replaced by new buildings, with the assistance of funds derived from the Irish Hospitals Sweepstakes, but there has been no alteration in the organisation of local authority hospitals since the county system was initiated, apart from the building of a number of hospitals and sanatoria providing services on a regional basis.

CHAPTER TWO

THE PRESENT GENERAL HOSPITAL SYSTEM

2.1 The pattern of the present system of Irish hospitals is one of a large number of small institutions scattered throughout the country (See Map 1). With a few exceptions the voluntary hospitals are concentrated in the city areas, so that it may be said that, while city patients obtain their hospital services mainly from voluntary hospitals, the rural community are more likely to be treated in a local health authority hospital. However, largely due to the more elastic methods of staffing employed by the voluntary hospitals, permitting greater specialisation, many country patients, suffering from the more complicated disease processes, are sent on to one of these voluntary hospitals for treatment (see also paragraph 4.2). In examining the present structure of these services, we have included, however briefly, in our consideration the specialised hospitals, namely, the maternity, children's, ophthalmic, cancer, orthopaedic, fever and tuberculosis hospitals, since we consider that they may properly be regarded as falling within the ambit of the general hospital system.

THE VOLUNTARY HOSPITAL

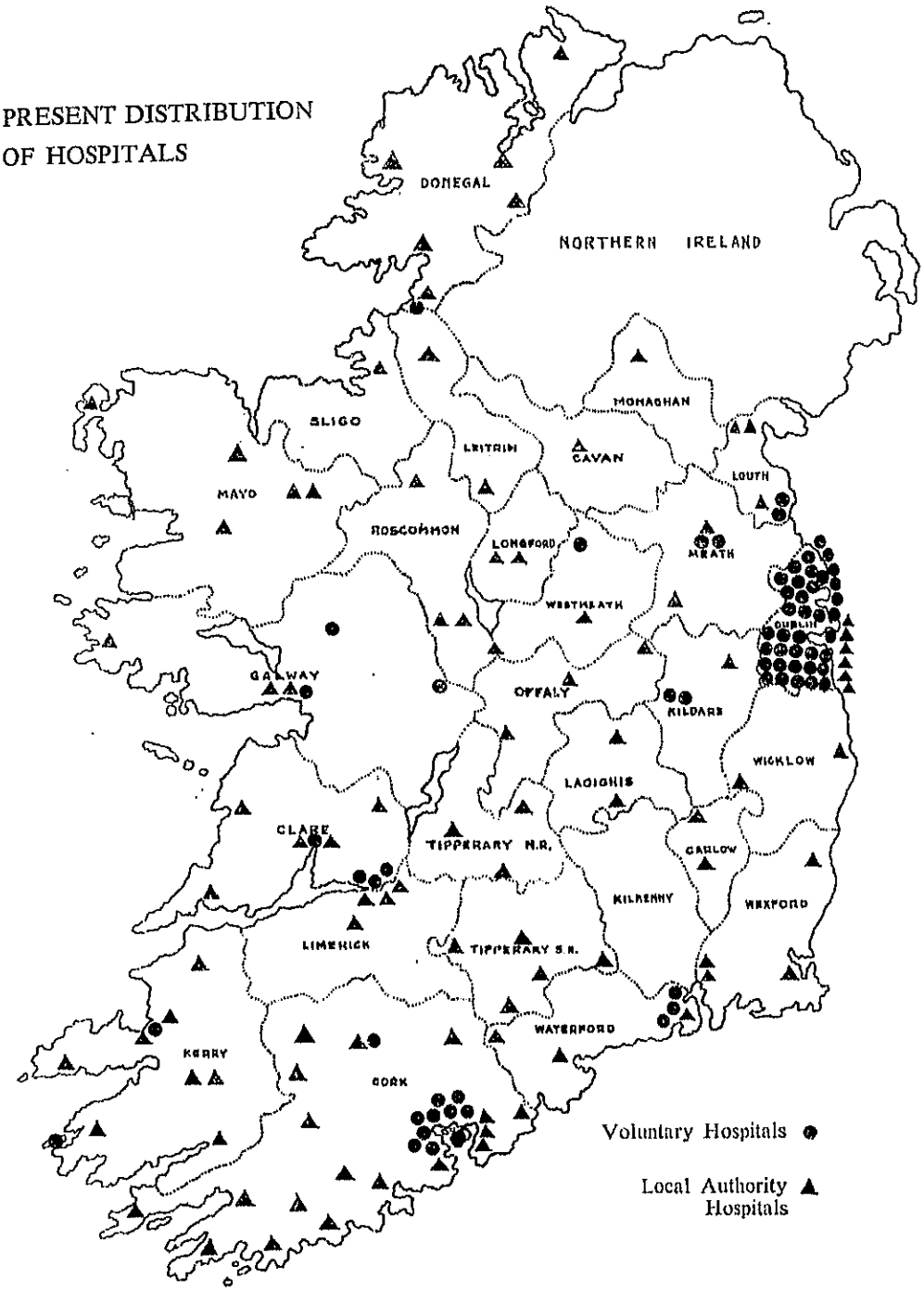
2.2 The voluntary hospitals are now, as in the past, mainly located in Dublin, Cork and Limerick cities. Most of them are public hospitals but a few of them are private in character. In the former category the majority of the patients pay little or none of their expenses. The management authorities of the hospitals are varied. Some are owned and operated by religious orders, notably the Irish Sisters of Charity, the Sisters of Mercy, the Sisters of Bon Secours and the Medical Missionaries of Mary. Others are incorporated by charter or statute and are operated by lay Boards of Governors who, generally speaking, are elected from amongst the voluntary subscribers to the hospital. A few hospitals, such as the North Infirmary and South Infirmary, Cork, were formerly County Infirmaries and the composition of their Boards, which includes local authority representation, is regulated by early statutes. The constitution of the management authorities of the Meath Hospital (Dublin), and St. Laurence's Hospital (Dublin), is governed by more recent legislation.[1]

2.3 Most of these hospitals now depend on public funds for all but a relatively small proportion of their income. With the exception of the private hospitals, they participate in the provision of services for those entitled to them under the Health Acts and are paid certain fixed capitation rates by the health authorities. Many of them also

[1]Meath Hospital Act (5 of 1951); St. Laurence's Hospital Act (3 of 1943).

MAP ONE

PRESENT DISTRIBUTION OF HOSPITALS



have deficits in their annual operational costs met by a grant paid by the Minister for Health from the Hospitals Trust Fund. Where capital expenditure is concerned most of the public voluntary hospitals are also largely dependent on grants from the Hospitals Trust Fund. The private voluntary hospitals do not participate fully in the provision of services for Health Act patients and do not obtain grants from the Hospitals Trust Fund. Nevertheless, they provide a service for a significant number of patients and must be taken into consideration in reviewing our hospital needs.

2.4 The majority of the voluntary hospitals are small institutions of less than 150 beds and only three of them, the Mater Misericordiae Hospital (Dublin), St. Laurence's and Our Lady's Hospital for Sick Children (Dublin) have over 300 beds. (The new St. Vincent's Hospital (Dublin) will, however, have about 450 beds). While nearly all the hospitals have benefited from the Hospitals Trust Fund and have, at least, some modern features, many of them are still mainly accommodated in old buildings, some of eighteenth century origin, completely unsuited to the requirements of a modern hospital service. It has long been accepted that St. Laurence's Hospital requires urgent replacement but various difficulties have led to its repeated postponement. Plans for the replacement of the Federated Dublin Voluntary Hospital Group (Sir Patrick Dun's, Mercers, Meath, Adelaide, Royal City of Dublin, Dr. Steevens' and the National Children's Hospitals) by one large unified hospital have also been under consideration during the last few years.

2.5 Most of the consultant medical staffs of the voluntary public hospitals are unsalaried and are appointed on the traditional basis of having a specified number of beds allocated to them. Naturally, this cannot occur if the specialist is non-clinical, such as a pathologist. Under such circumstances, methods of payment for public service have been negotiated with the paying authority by the groups of specialists concerned. Where private patients are concerned, the consultants are free to arrange fees and are paid directly by the patients, but such patients are rarely (and usually only for special reasons) accommodated in the wards of public voluntary hospitals. The great majority of private patients attend the private voluntary hospitals, or the private wing of the public voluntary hospital, if such exists. Consultants rarely have an allocation of private beds; these beds are applied for by the consultant when he has a private patient to treat and are granted by the owners of the hospital as occasion demands. Public patients comprise about 90 per cent of the population; therefore a remarkably large part of the time of most voluntary hospital consultants is spent in the treatment of patients in respect of whom relatively little payment ensues. Since the enactment of the Health Act, 1953, a method of remunerating consultants for the treatment of public patients is in operation whereby the daily capitation rate paid by health authorities for eligible patients includes a small sum which is allocated to a "pool" for distribution among the consultants con-

cerned. In addition, consultants attached to the voluntary hospitals are paid fees on a sessional basis by the health authorities for providing out-patient services for eligible patients. Consultants on the staffs of teaching hospitals may receive portion of their remuneration from the medical schools concerned. This is small except for the rare full-time clinical teachers.

2.6 The Dublin voluntary hospitals, which include those devoted to general, obstetrical and specialised services, number about thirty (including a few private hospitals). They represent a particularly important segment of the Irish hospital system. Since the institutions of the Dublin Health Authority provide only a very limited acute hospital service, the population of the Dublin area is served in the main by the voluntary hospitals. In addition, as previously mentioned, a substantial number of provincial patients come to Dublin for treatment and normally about 30 per cent of all Dublin voluntary hospital beds are occupied by such patients. Between them, the Dublin voluntary hospitals provide a full range of medical and surgical specialties. Some particularly specialised units are providing a service on a national basis. Another important feature of the Dublin voluntary hospitals is that the majority of them are teaching hospitals associated with at least one of the three Dublin Medical Schools.

2.7 In Cork City, too, the voluntary hospital contribution to the local hospital service is an important one. It includes five general hospitals, a maternity hospital and an eye, ear and throat hospital. Most of them are teaching hospitals associated with the Medical School of University College, Cork. In Limerick City, the two general hospitals and the maternity hospital under voluntary control provide services for a significant number of patients.

THE LOCAL HEALTH AUTHORITY HOSPITAL

2.8 The local health authority for most areas is the County Council, but in the Dublin, Cork, Limerick and Waterford areas the health services are administered by special joint health authorities with responsibility for both the city and county in each instance. Each joint authority is comprised of elected members of the local County and County Borough Councils. The current expenditure of all health authorities is met partly from local rates and partly by a grant from central funds, which at present is equivalent to at least 50 per cent of the total expenditure of each health authority. Capital expenditure is met by borrowing, or by grants from the Hospitals Trust Fund.

2.9 The main feature of the health authority hospital system is the *County Hospital* of which there is one in most counties. It provides a general medical, surgical and maternity service for the area. All have less than 200 beds and generally they range between 100-150

beds. Most of them are of modern construction having been built during the last thirty years. In a few areas, however, notably in Wexford and Tralee, the existing hospitals are old and plans for their replacement are under consideration.

2.10 The consultant staff of the County Hospital is, in most instances, comprised of the County Surgeon and County Physician with the part-time services of a radiologist and an anaesthetist. The County Surgeon normally has the assistance of a surgical registrar and one or more house surgeons. Medical registrars are exceptional appointments and the County Physician's supporting staff is usually comprised of one or more house physicians. There is also an obstetrician-gynaecologist on the staff of a number of hospitals (Castlebar, Letterkenny, Sligo, Waterford and Wexford) but in the remaining County Hospitals the obstetrical work is done by the County Physician. The system of remuneration for local authority consultants is rather complex. Some receive a relatively small salary for part-time posts and derive most of their earnings from private practice. Others, whose private practice is limited by the terms of their appointment, receive a higher salary for a virtually wholetime service. There is a third group, whose incomes derive solely from their wholetime local authority employment, who have no private practice.

2.11 In some of the main centres of population there is a number of *Regional Hospitals and other large general hospitals* operated by the health authorities. These hospitals have more consultant staff and provide a wider range of services than the County Hospitals. They include the Regional General Hospitals in Galway (577 beds) and Limerick (336 beds), St. Kevin's Hospital, Dublin (400 acute care beds approximately) and St. Finbarr's Hospital, Cork (368 acute care beds). The two Regional Hospitals have not fully developed a regional catchment and their services are in the main availed of only by local patients. Both hospitals have been built since the last war. Galway Regional Hospital is the main teaching hospital associated with the Medical School of University College, Galway, and Limerick Regional Hospital provides some training facilities for the medical school of University College, Cork. St. Finbarr's Hospital, Cork is closely associated with the Cork Medical School.

2.12 Another feature of the health authority hospital service is the *District Hospital.* There is at least one in most counties. All are small institutions and most of them range in size between 20 and 40 beds. They have the part-time services of a general practitioner who is the Medical Officer to the hospital. Normally there is no other medical staff associated with the hospital and the service given is limited to medical and maternity cases requiring non-specialised care. In a few instances, however, District Hospitals are visited as a regular feature by consultants in medicine and obstetrics.

In practice, many beds in District Hospitals are occupied by long-stay elderly patients and this is a matter which shall receive our attention later in this report. The standard of accommodation in most of the hospitals is good.

2.13 In addition to the general hospital institutions mentioned in the foregoing paragraphs, there is a number of hospitals of a specialised nature under the control of health authorities. These include *Regional Sanatoria* in Dublin, Cork and Galway, *Regional Orthopaedic Hospitals* in Cork, Kilcreene (Kilkenny), Croom (Limerick) and Navan, and a *Regional Maternity Hospital* in Limerick. There are two large *Fever Hospitals* in Dublin, viz. Cherry Orchard (282 beds) and Clonskeagh (149 beds), and there are seven smaller fever hospitals in various parts of the country.

DEFECTS IN THE PRESENT HOSPITAL SYSTEM

2.14 **There are altogether 169 separate hospitals providing acute medical, surgical and maternity services. Most of them are inadequately staffed and equipped. In County Hospitals, the single consultants in surgery and medicine are isolated from colleagues in their fields. Many maternity patients throughout the country have not convenient access to the services of a consultant obstetrician. Inadequate operating theatre, out-patient, laboratory and radiological facilities are keeping patients in hospital longer than necessary. Teaching standards for our medical students and nurses are falling behind as our hospitals fail to adapt themselves to the rapid advances of modern medicine. The older hospital buildings are unsuitable for re-modelling while the majority of the modern ones were planned on too rigid and too restricted a scale to permit satisfactory conversion. We realise that available public funds are limited, but even if there were no limitations on financial resources it would clearly be unrealistic and a waste of money to attempt to develop so many hospitals to desirable standards of staffing and accommodation. As we shall show later, the requirements of a modern hospital service have become so complex that we can only meet them by a radical re-organisation of our hospital system involving, *inter alia*, a considerable reduction in the number of centres providing acute treatment.**

2.15 **Another significant defect in the present hospital system is the lack of co-ordination between the various hospital authorities and the absence of a planned organisation of services. Twenty-seven different health authorities operate their own health authority hospitals and, although they are subject to the general supervision of the Minister for Health, they remain largely independent of each other. Where the voluntary hospitals are concerned, the management authorities are autonomous and independent of each other. In practice, the fact that voluntary hospitals are largely dependent for their resources on public funds has given the Minister for Health a certain degree of indirect control over them, but it has not prevented**

unnecessary duplication of some services and the growth of divisive and competitive tendencies amongst them. This has hindered the efficient development of specialisation at advanced level. Some of the voluntary hospitals have, however, accepted the need for closer association. In Dublin, the association of seven teaching hospitals as the Federated Dublin Voluntary Hospitals has been an important development. More recently, six Cork Hospitals have taken more limited steps in the same direction. However, the need remains to achieve on a broader basis a planned and co-ordinated hospital organisation embracing both public authority and voluntary hospitals, while, at the same time, preserving and spreading the best features of the voluntary hospital. It is a matter which has received our special attention and is the subject of recommendation later in this Report (paragraph 4.2).

CHAPTER THREE

GENERAL PRINCIPLES FOR FUTURE PLANNING

INTRODUCTORY

3.1 The advance of medical science during the past few decades has been remarkable. This advance has been on a broad front. Contrary to popular conception, the pattern is not a series of isolated spectacular leaps, but rather a steady progress maintained by ceaseless research activity in many different disciplines and by the gradually accumulating knowledge of clinical experience. Scientists who study normal life processes and those who study disorders of living matter make their fundamental contribution. Clinicians—i.e. doctors who deal directly with patients—learn more and more about disease and its control from their own experience and that of their colleagues all over the world. The pharmaceutical industry provides an endless array of new and powerful drugs. The engineering scientists have transformed whole sections of medical practice—e.g. in diagnostic and therapeutic radiology. By the provision of specialised measuring equipment they have made possible the development of increasingly refined surgical techniques, such as those utilised in cardiovascular surgery, to mention one of many recent and impending developments. **These advances depend on many factors, but two in particular are outstanding; firstly, the recognition that help must be sought from many different scientific disciplines, which must be organised to work closely with each other in the medical interest; secondly, the acknowledgment that clinical specialisation is necessary if the specialist is to acquire sufficient familiarity with a particular medical problem to enable him not only to identify the problem, but also to find solutions and apply them skilfully.**

3.2 Wealthy countries are able to support hospitals comprising many large specialised units associated with a wide range of research activity. Most new medical knowledge comes from such centres. In a small country with limited resources organisation on this scale would be impracticable. We must keep our priorities right. Our first duty is to make high level hospital medical care available to the people, but if at the same time we can add even a small quantum to the pool of new knowledge, so much the better. **We must, however, emphasise straight away that even a relatively unambitious hospital service which aims only at giving high standard care must be organised on the pattern accepted and established in all developed countries.** Modern medicine is a complex activity and the trend is to greater complexity. Thirty years ago many surgeons were practised in all branches of their art; most operations were conducted by the surgeon, assisted by a general practitioner and a part-time anaesthetist. To-day

many operations involve not only two or more surgeons specialising in a narrow field, but also an anaesthetist specialising in a branch of anaesthesia; the group will be supported by a specialist physician and a radiologist trained in special techniques; laboratory personnel such as pathologists, biochemists and haematologists may be indispensable; and the support of specialised nurses, physiotherapists, radiographers, technicians and other ancillary personnel may be likewise essential. Only a large institution can provide such a service. Equally complex arrangements are necessary for the management of many serious medical cases. While it is true that the majority of hospital patients will not require such complicated care, it is also true that the medical and surgical treatment of most illness which requires investigation and treatment in hospital is restricted in quality if laboratory and x-ray services and a fair range of specialist consultant advice are not immediately and at all times available.

3.3 **In their present form few of our general hospitals are in a position to give this service. Fewer still, if any, are in a position to cope with the coming advances. As we have pointed out in earlier paragraphs, our hospitals are too many, too small and too independent of each other. The available resources are too thinly spread.**

3.4 Emphasising the need for an urgent review of our hospital system is the ever increasing demand on its services. Despite improvement in social conditions and better standards of living, we have here, as elsewhere, the remarkable phenomenon of an annual growth of 2 per cent to 5 per cent in the numbers being admitted to hospital. **In Ireland during 1966 one in every ten of the population spent a period in hospital.** This trend probably reflects the consequences of increasing State paternalism as well as growing public confidence in the benefits of hospital care.

3.5 **We are satisfied that the present structure of our hospital organisation is outmoded and is now a hindrance to good medicine, good teaching and economic operation. We believe that if it is to be adapted to meet fully the requirements of modern medicine this can be achieved only by radical changes, involving a departure from many long established concepts in regard to organisation, staffing and operation of hospitals.** In the following paragraphs we set out the principles by which we feel this transformation can be brought about. We are conscious of the fact that controversy may arise from some of our recommendations, particularly those which will lead to the change of function of hospitals in a number of areas throughout the country. We must emphasise at this juncture that some of the criticisms we are now making are not being voiced for the first time. As long ago as 1928 a Government Commission investigating the provision for the sick poor commented—

" We are not in sympathy with the attempt to preserve in small

towns, district or cottage hospitals on the plea that the distances to the central hospital are too great."[1]

And in their first report in 1936 the members of the Hospitals Commission were clearly opposed to the concept of the small county hospital and were particularly critical of the fact that the surgical services in them were dependent on one surgeon. They reported—

"The grouping of three or four counties together for hospital purposes, in suitable centres, would enable not only better and more up-to-date central and special services to be provided but would enable a more complete hospital medical staff to be employed, at less cost to the ratepayers of such grouped counties than the restricted services and personnel that one county can at present afford." [2]

In the intervening thirty or forty years since these criticisms were first voiced we believe that their wisdom has become manifest. With the rapid advance of medicine the need for more comprehensive hospital medical staffing has become a matter of urgency and is the subject of recommendations later in this Report.

BASIC RECOMMENDATIONS

3.6 Our basic recommendations are as follows :

(i) The hospital system should be re-organised into three regions.

(ii) The regions should be based on the medical teaching centres, namely, Dublin, Cork and Galway. Our detailed proposals about the various regions are set out in Chapters 8-10.

(iii) The organisation and administration of the hospital service should be put on a new basis involving the creation of a central professional body to be called the Consultants Establishment Board as well as administrative Regional Hospital Boards and Hospital Management Committees. These proposals are detailed in Chapter 4.

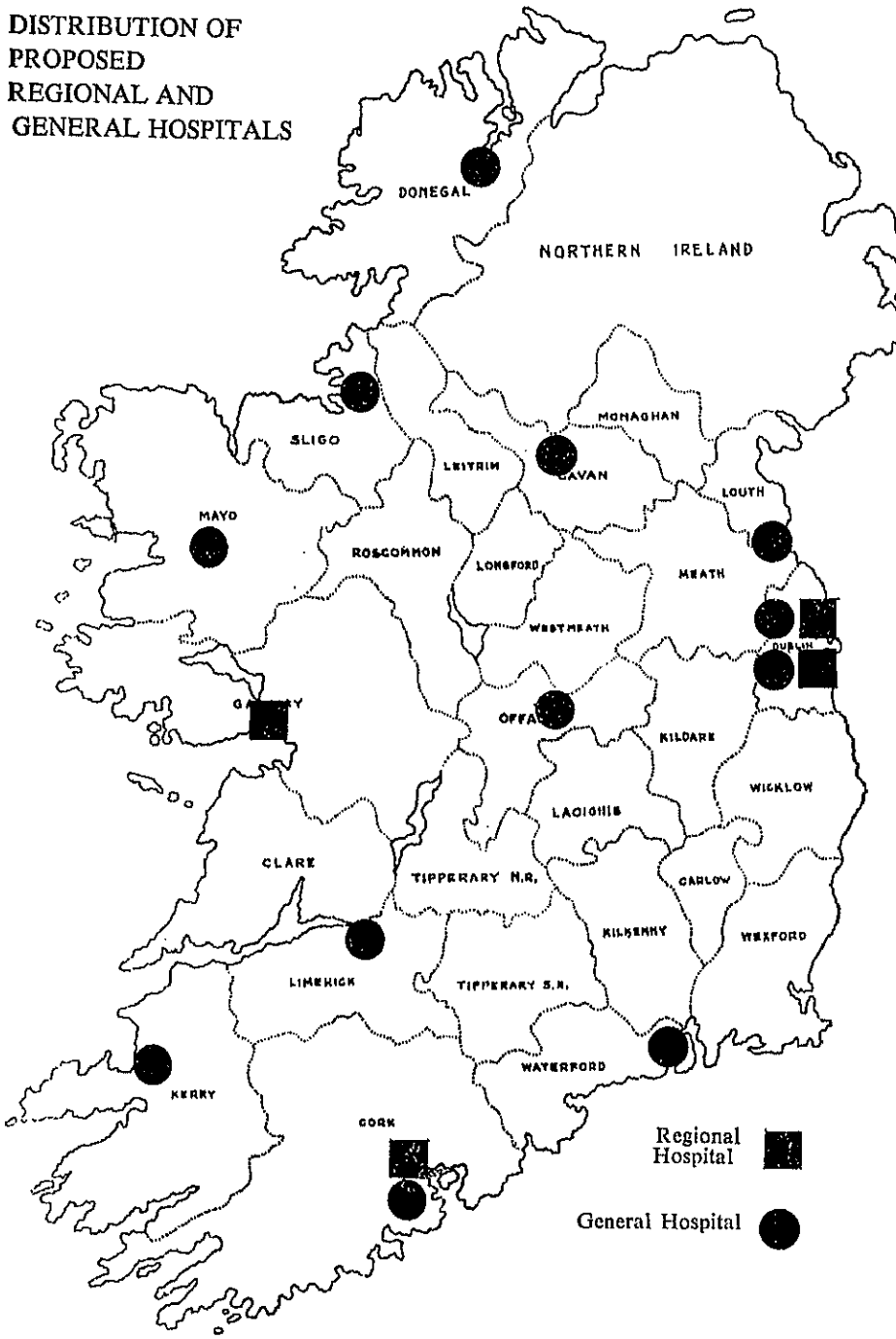
(iv) There should be two kinds of acute care hospital (a) the Regional Hospital and (b) the General Hospital. In addition there should be associated with these hospitals a system of Community Health Centres and District Nursing Homes based on former County and District Hospitals.

[1]Report of the Commission on the Relief of the Sick and Destitute Poor, including the Insane Poor. (1928, Stationery Office, Dublin, p.19).

[2]The Hospitals Commission. First General Report, 1936. (Stationery Office, 1936.)

MAP TWO

DISTRIBUTION OF PROPOSED REGIONAL AND GENERAL HOSPITALS



(v) In each region there should be close links between the above institutions and the long-stay hospitals as well as with the general practitioners and social services.

THE GENERAL HOSPITAL

3.7 The chief hospital of the region will be the *Regional Hospital* located in the regional centre. However, as the *General Hospital* is basic to the re-organised hospital system, we shall describe it first.

3.8 **We consider that the small hospital of less than 200 beds with one surgeon and one physician is no longer capable of adequately meeting public needs. While in some instances there will be special local factors to justify having a smaller hospital, we recommend that the broad policy should be to establish General Hospitals of not less than 300 beds.** These hospitals would serve the needs of a population of at least 120,000. They might have considerably more than 300 beds in the urban and more densely populated centres. The General Hospital will cater for the major proportion of relatively short-stay illness in an area and will usually develop from a group of existing smaller general hospitals. Its basic services would be general medicine, general surgery, obstetrics, gynaecology, pathology and radiology. Some of these hospitals would also provide services for ear, nose and throat conditions, ophthalmology, orthopaedics, paediatrics and psychiatry. We would emphasise, however, that in describing a hospital in terms of its bed complement we do so only in order to give some concrete idea of the kind of service it should provide. More important than actual bed numbers are the size of staff and the service they can organise. These must be related to population needs and to current medical practice. Unfortunately, at this time, we have no better way of indicating hospital size than in traditional terms of bed numbers.

3.9 In recommending that the General Hospital should, as far as possible, have not less than 300 beds, we are motivated by two principles: firstly, the provision of better hospital care to the patient, and secondly by the economic factor. In addition, a unit of this size is necessary for the training of nurses.

3.10 Within limits, which are impossible for us to exceed in this small country, the bigger the population served by a hospital the more comprehensive the service that can be given. The bigger hospital can cater for a wide range of different medical demands without having to send the patient further. On the other hand, the small hospital must concentrate on bare essentials; certain important services may have to be abandoned, or, alternatively, provided inefficiently and at very high cost owing to the lack of enough patients to ensure maximum use of apparatus or personnel. We should not forget that even if money were available to provide specialised apparatus and personnel at the highest level, a small population would be

insufficient to maintain expertise. There is, therefore, a lower limit below which hospital size becomes inefficient economically and less than satisfactory medically. This is recognised in all well developed countries. The recent Todd Report[3] makes the point that the future basic unit in the British Hospital Service will be a District General Hospital of not less than 800 beds.

3.11 After much deliberation on the needs of this country, we consider 300 beds to be the minimal viable size for our hospitals. A hospital of this size, serving a population of about 120,000 people, can carry properly set-up and well-used laboratory and radiological services, with sufficient work load to justify the appointment of two radiologists and two pathologists. For the same reason, there will be enough work for three consultant physicians and surgeons, and the provision of well equipped operating theatres and of intensive care units will be justified. The staff of highly qualified clinicians will have available laboratory, radiological and other ancillary services of a standard which will allow work of a high order. Staffed at this level with three medical and three surgical consultants, some degree of agreed specialisation becomes possible, and fewer patients need be sent on to bigger centres for specialised treatment. The same arguments favour the appointment of two obstetrician-gynaecologists and three anaesthetists to a hospital of this size. With the above arrangement, the pitfalls of the one-man department are avoided.

3.12 **Small, understaffed and incompletely equipped hospitals cannot treat patients as safely as larger more comprehensive units. In the more specialized reaches of medicine, and particularly of surgery, where technical ability is so vital, this is clearly recognised by all doctors.** What is, perhaps, not so clear is that the same specialisation has advantages in the day to day practice of medicine and surgery. Specialisation can to an important degree take place in a hospital with three general surgeons, provided they agree to develop certain aspects of general surgery as a particular interest. Obviously, no such division of work can take place in a hospital staffed by single physicians or surgeons. **There are important statistics suggesting the validity of the above remarks by indicating that the mortality and morbidity of even relatively common conditions such as acute appendicitis declines as the hospital size (and thus the staff) increases.**[4] The more technically difficult operations present this in a more marked form, particularly if the condition is somewhat rare, when lack of day-to-day practice may have a telling effect on the outcome. If the best interest of the patients is to be the paramount factor,

[3]Report of the Royal Commission on Medical Education, 1965-68. HMSO, London 1968.

[4]Leader—*The Lancet* 1. 199, 1967. Milnes-Walker, R., *Ann. Roy. Coll. Surg. Eng.* *42* 161-2 1968.

there is no doubt that the concept of the multiple staff hospital must be accepted.

3.13 **There is therefore a very strong case to be made in favour of larger hospitals, more specialisation, and more recognition of the fact that the relatively small population of this country must very definitely restrict the number of specialised units developed for rare conditions.**

3.14 For the young doctor wishing to gain experience in hospital, it is far more satisfying intellectually to work where there are several clinicians and busy pathology and radiology departments; the opportunities for seeing a variety of work, for discussion and for organised teaching are much greater than in the small institution. Furthermore, most young doctors taking continued hospital positions beyond the statutory intern year do so with the intention of specialising later, while many of the bodies controlling the examinations which give entry to the specialties insist that training will be recognised only if received in large hospitals such as we describe. To ensure suitable medical staff at the assistant level it is therefore necessary that our hospitals be not less than minimal size. The same principle applies in nursing as further detailed in paragraph 3.20.

3.15 Paramedical staff are also much easier to get in the bigger hospital. It is notoriously difficult to persuade radiographers, physiotherapists and laboratory technicians to work in small hospitals—a problem which is bound to increase with the years.

3.16 From the economic point of view, apart from the better use of capital, there is the added advantage that three physicians or three surgeons working in one hospital with the proper background services and good junior help can deal with much more than three times the number of patients any one of them could handle working on his own in a small hospital.

3.17 Another advantage of the bigger hospital is the practicability of providing a 24-hour service at all levels all the year round. If a consultant takes a holiday, attends a conference, or falls ill, the whole service is not jeopardised or at least rendered haphazard, as it is at present. The bigger establishment of consultants will also allow for the development of out-patient work on a larger scale, including the provision of out-patient services at a distance from the hospital. Less tangible, but none the less real, is the increased professional expertise that results from constant association with colleagues at senior and junior level, because this ensures that the consultant is aware of all important new advances.

3.18 In the light of hospital developments in Britain and throughout Europe, where 600-800 bed units are considered optimum size for economy and efficiency, many may question a modest recommend-

ation of 300 bed units for this country. However, we have been faced with the problem of a small population widely spread in many areas and also with the actual presence of a multiplicity of small general hospitals. Consideration of these two factors lead us somewhat reluctantly to modify our recommendations regarding hospital size below that which is customary. We are now satisfied that, when all the circumstances at issue are taken into account, units of 300 beds in a well integrated national service are best suited to the special circumstances of Ireland. In such a unit, an efficient and varied general hospital service can develop. It is only in very exceptional circumstances that the existence of a smaller unit should be countenanced.

3.19 Having regard to the foregoing considerations, we recommend that the minimum consultant staffing of the General Hospital should be

2 Pathologists
2 Radiologists
3 Physicians
3 Surgeons
2 Obstetrician-Gynaecologists
3 Anaesthetists.

Ideally, we consider that the physicians, surgeons and obstetrician-gynaecologists might be responsible for 30 to 35 beds each but the actual allocation of beds per consultant is a matter that will have to be determined by local factors in each instance.

3.20 Apart from the reasons which we have put forward above in support of the concept of the minimum 300 bed hospital, there is another important consideration to which we must draw attention. **If our student nurses are to receive training in the wider range of nursing skills and techniques now required of the trained nurse, they can only receive it in a hospital providing a fairly comprehensive service.** It is of interest that the General Nursing Council for England and Wales considers that smaller hospitals are incapable of providing adequate nurse training facilities and the Council is now insisting that nurse training schools be restricted to hospitals with at least 300 beds and an average daily bed occupancy of 240. It is difficult to criticise this view, which inevitably raises the question of the future recognition of Irish nursing qualifications in Britain and underlines the urgency of organising our hospitals in larger units.

3.21 The arrangements we recommend in Chapter 4 will bring each Regional Hospital and its associated General Hospitals within the same administration. It is important that there should also be close medical liaison between them. Consultants in some specialties might, as a normal feature, undertake sessions in both a Regional and a General Hospital. We recommend that the General Hospital form part of

the teaching complex and have some part in teaching functions both at under-graduate and post-graduate level.

3.22 We regard it as of particular importance that there should be a close relationship between the General Hospital staff and the general practitioners of the area. General practitioners should be encouraged to take an active interest in their local hospital. A lecture theatre, a common room and a medical library should be provided in each hospital, which should be a common meeting ground for the hospital staff and the general practitioners. We deal more fully with the role of general practitioners in paragraphs 3.47 to 3.49.

THE REGIONAL HOSPITAL

3.23 **The Regional Hospital will be located at the regional centre and will have two components. On the one hand, it will provide the same general service in its particular area as above described for a General Hospital; on the other hand, it will provide specialist services for the wider regional area containing perhaps two or more General Hospitals.** The specialist departments of the Regional Hospital must be big and active if they are to be viable. Generally, this means that each such department must be staffed by at least two consultants with an appropriate number of beds. We have already referred to the need for certain minimum staffing levels in General Hospitals and the considerations mentioned apply equally in the Regional Hospital context. The region must also contain sufficient patients to provide full and active employment for the specialised staff of any unit established at the Regional Hospital.

3.24 In dividing the country into regions to meet this requirement we are faced with the situation that our population is only 2.9 millions and that in many parts of the country it is thinly spread. It is of interest that our total population is smaller than that of the average hospital region under the National Health Service in England and Wales where there are fifteen regions of which nine have populations over 3 millions. Looking at the problem with a cold medical eye we considered the possibility that the whole country might, therefore, be treated as one region with a concentration of all specialties. We came to the conclusion, however, that the personal nature of the service provided in medicine makes desirable the avoidance of extreme centralisation. Countries such as Scotland, with a similar population structure to our own, are administering their hospital services in regions about the size we propose. Furthermore, there is a tendency for the population to orientate towards Dublin, Cork and Galway cities and this fact, allied with the location of medical schools in these cities, is a strong stimulus to the formation of regions based on them. **Accordingly, we recommend that the country be divided into three regions served by Regional Hospitals**

based on the cities of Dublin, Cork and Galway. Because of the extent of the population to be served we consider that there should be two Regional Hospital centres in Dublin under a single regional authority. The two centres in Dublin should consist of hospital groups or complexes rather than of single institutions, because of the present pattern of hospital organisation in the city. One regional complex should be located in the north and the other in the southern part of the city.

3.25 In delineating the areas comprising each region we recommend, in the interests of the convenience of patients, that existing county demarcation lines be disregarded. It must be emphasised that the regions are envisaged as administrative units devised for the efficient integration of hospital services kept as close to the people as efficiency allows. **While the patients of a regional area will normally wish to be treated therein, a patient who wishes to be treated in a region other than that in which he resides must be allowed the right to such individual choice.** These regions are described in greater detail in Chapters 8-10.

3.26 Each Regional Hospital is placed in a city where there is one or more medical schools. This has patent advantages. The diversity of clinical work done in such hospitals is ideal for student teaching and will thus ensure the provision of well trained doctors for our medical service. The prospect of academic attachment will help attract the best available specialists and make easier the provision of high quality assistance at trainee level. The presence of the basic science departments of the medical school will greatly encourage the development of laboratory work of high standard in the hospital and again ease staffing problems. Co-operation between hospital and medical school lays the foundation for research activity, which, in turn, greatly improves the quality of the medicine practised. This co-operation keeps medical personnel in touch with new developments and makes the introduction of new procedures and techniques practicable. The Regional Hospital complexes, including the two in Dublin, must have complete scientific facilities for teaching and research, preferably with the relevant scientific units of the university and/or medical schools of the region in close proximity. In the case of a Regional Hospital complex which is not in the immediate neighbourhood of the university, we recommend that relevant university scientific units should also be developed on those hospital sites.

3.27 As already stated, a General Hospital should, as far as possible comprise a minimum of about 300 beds depending on the population it serves. Such a number of beds would also form the nucleus of the Regional Hospital. To cover the regional specialties at least another 300 beds would be necessary. Thus, depending on the population to be served, a Regional Hospital, or hospital complex, would have at least 600 beds but the number could be as high as 1,000 or more.

3.28 The Regional Hospital and associated medical school would be the medical centre for the region. On this centre would devolve the provision of all medical care of a more specialised kind, and also the duty of organising postgraduate education for the medical personnel of the area. There must, however, also be co-operation between the Regional Hospitals themselves. Since we have a small population, the needs of the whole country in some particularly specialised branch of medicine can only be effectively and economically served by the establishment of a single major unit. In such cases, this would be attached to one Regional Hospital and would serve the whole country. In less complex specialties, the major unit would still be associated with a single Regional Hospital but smaller units, co-ordinated with the main one, might be attached to other hospitals. We make, in Chapter 6, proposals about the manner in which we consider the various specialties should be distributed.

3.29 We recommend that serious consideration be given to the development of some major units in conjunction with the Medical Schools of Cork and Galway. We make this recommendation in order to maintain the highest standards in the relevant regions and to ensure that medical personnel of the best quality would be attracted to these areas. The decision to advise on the development of such units would rest with the Consultants Establishment Board.

THE FUTURE ROLE OF THE DISTRICT HOSPITALS

3.30 There are altogether fifty-three District Hospitals providing a total of 1,925 beds. As we have already stated, the medical staffing of these hospitals is limited to the part-time services of a Medical Officer. Some of the hospitals are busy, acute care centres for routine medical and maternity cases. Generally speaking, however, the extent to which District Hospitals are being used for patients in need of acute care is declining. As the following table illustrates, these hospitals are dealing with a small and reducing share of the total number of patients being treated in hospital.

Year	Percentage of all hospital patients treated in district and cottage hospitals
1953	18
1957	15
1960	13
1962	12
1964	11
1966	10

3.31 An indication that the trend in District Hospitals is towards the treatment of long-stay patients rather than those requiring acute care is that while the average duration of stay of patients in acute hospitals shows a continuous downward movement, it is increasing in the medical units of the District Hospitals, as shown in the following table :

Year	Average Duration of Stay (days) of Patients in Medical Units of District Hospitals
1960	20.3
1962	21.2
1964	22.4
1966	24.5

3.32 Certain District Hospitals appear to be largely used for chronically ill long-stay patients and available statistics suggest that there is also a significant number of this category of patient in many of the remaining hospitals. Detailed figures showing the occupancy of these hospitals during 1966 are given in Appendix A.

3.33 **We do not consider it desirable that in the re-organised hospital system District Hospitals should continue to have a role in the provision of acute care hospital services.** It would appear to us that a number of these institutions could be closed, but this is a matter which will require a study of the medical and social factors in each instance. In arriving at a decision on a particular hospital cognisance should be taken of bed occupancy, average duration of stay, the number of patients per bed per annum, the maternity and geriatric function of a hospital, and the role of the hospital in providing a service to an isolated community. **We recommend however that most of the District Hospitals should become District Nursing Homes staffed by general practitioners from the area.** The Homes would provide a service for normal maternity patients and for medical patients of the type that would usually be treated in their own homes by general practitioners if the circumstances of the patient were suitable. The need for expert nursing may also tip the balance in favour of admitting the patient to the District Nursing Home. The Homes would, in addition, provide accommodation for convalescent patients from the main hospital centres and also for some geriatric patients.

3.34 The District Nursing Home, or Homes, would be closely associated with the main hospital centre for the area and would be under the administrative control of the Management Committee of the main hospital. Where they have maternity units they should be visited fortnightly by an obstetrician who should conduct ante-natal clinics and, in consultation with the general practitioners concerned, decide which patients should be treated at the main hospital centre. Where other patients are concerned, a consultant from the main hospital should attend for a ward round at least once a fortnight. If desirable, out-patient clinics might be conducted by him also. It would be advisable to limit the duration of stay of patients, other than geriatric patients, to three weeks, but in certain circumstances, a more prolonged stay could be arranged after consultation with the appropriate consultant. Surgery in the District Nursing Home should be limited to procedures normally carried out by an individual general practitioner alone.

3.35 All District Nursing Homes must have facilities for emergency resuscitation and this should be supplemented by an efficient ambulance service to ensure, where necessary, that the patient can be quickly taken to the main hospital centre. We consider it particularly important that all general practitioners in areas removed from the main hospitals should be trained in the application of resuscitation techniques. In this connection it is desirable that there should be a rota system in operation amongst doctors using the District Nursing Home to ensure that there is coverage to deal with emergencies.

3.36 General practitioners using a Home might select one of their number to act, for a period to be determined, as medical officer in charge of the day-to-day management of the Home. Where there is already a permanent Medical Officer in charge of a District Hospital he might, while the character of the institution is changing, have the option of continuing in charge for the normal term of office or otherwise be suitably compensated should he resign from it.

3.37 All general practitioners granted access to a District Nursing Home should possess certain minimum qualifications or experience. Where there is a maternity unit associated with the Home we would recommend that general practitioners responsible for the care of patients in it should have adequate post-graduate experience in obstetrics. A suitable system of remuneration would have to be devised for general practitioners participating in the services of the District Nursing Homes.

THE FUTURE ROLE OF FORMER COUNTY HOSPITALS

3.38 Elsewhere in this report we deal with the transitional period during which certain County Hospitals will cease to provide an acute medical service and their present work will be integrated in the hospital designated to become the local General Hospital. When full integration has been achieved the role of the County Hospitals ceasing to exist as such must be defined. **We consider that these hospitals should become** *Community Health Centres* **providing in-patient services similar to that already suggested for the District Nursing Homes, but backed by somewhat increased diagnostic facilities and a more comprehensive consultant out-patient organisation.** The diagnostic facilities should include an x-ray department staffed by a radiographer, where a radiologist would attend once a week. Existing small laboratories in the County Hospitals have proved very helpful to their staffs, but have not always been available to family doctors. They would become so under the above plan. This type of laboratory service, providing essential day-to-day needs, should be included in all Community Health Centres and would be carried on under the general direction of the consultant staff of the main hospital laboratory. More elaborate investigations will be forwarded to the laboratory at the appropriate main hospital centre.

3.39 The role of these centres in the care of long stay geriatric patients should be a particularly important one. Such patients, who will have been previously assessed and, if necessary, treated in the main hospital, will have the additional advantage of continued advisory supervision by consultants from the General or Regional Hospital for the area. A particular merit in basing geriatric care on Community Health Centres and District Nursing Homes is that these patients will thus receive care in their own community rather than in a distant centre removed from their friends and relations.

3.40 The establishment of Community Health Centres presents another opportunity to bring general practitioners into the hospital service and we would envisage their association with these former County Hospitals as similar to that already recommended for District Nursing Homes.

OUT-PATIENT SERVICES

3.41 **We consider that there should be increasing emphasis on out-patient care.** As the number of persons seeking hospital treatment continues to grow and as the cost of maintaining a patient in a hospital bed rises, it becomes increasingly important to ensure that only those for whom hospital admission is unavoidable are occupying hospital beds. Indeed, this is not primarily a question of economics. Medically and socially it is more beneficial and less irksome to a patient to receive treatment without having to suffer the full incapacitation of being confined to a hospital bed. Active persons should not lightly be made bed-fast patients. Yet at present a significant number of patients enter hospital who could adequately be provided for by a well developed out-patient service. Even where it is necessary to admit a patient to hospital, it should be possible in many instances to carry out necessary investigations at out-patient level before he is admitted, thus reducing his stay in hospital. His admission can then be timed to ensure that there is no delay in his treatment. A well-developed out-patient service will also facilitate the timely discharge of patients for whom follow-up treatment and supervision is possible at out-patient level.

3.42 The major out-patient departments will, naturally, be located at the Regional and General Hospitals. We consider, however, that in other areas out-patient services should be made easily accessible to the communities served by the main hospitals and we have accordingly recommended in paragraphs 3.34 and 3.38 that the Community Health Centres and District Nursing Homes should, *inter alia*, be used as out-patient centres served by consultants from the main hospitals. This arrangement will avoid much of the longer travelling and other inconveniences for patients which would be caused if these services were to be made available only at the hospitals. However, the more highly specialised the out-patient service, the less it can be reduplicated. In such circumstances, travel by the patient becomes unavoidable

3.43 The staffing and other facilities provided in out-patient departments generally should be such as to ensure that patients requiring investigation can have it carried out as early as possible—often on the day of the visit. In this context, we consider it most important to emphasise that the medical staffs of these departments should be provided with full secretarial assistance so that there is no delay in the collection and tabulation of data, in making additional appointments and in issuing patients' reports to the referring doctor. **At present the lack of adequate secretarial assistance is the greatest single defect in the hospital out-patient departments.**

3.44 For the efficient use of an out-patient department there must be a good transport system. Córas Iompair Éireann should be asked to investigate the possibility of providing transport facilities. Where patients have no private transport available to them and are unfit for normal bus travel, some form of organised transport will be necessary. Such auxiliary transport should be controlled by the hospital. (See pars. 7.30 to 7.37). For ambulant patients who come long distances, or who need out-patient investigation which cannot be completed in a day, overnight hostel accommodation should be provided. This is frequently a better arrangement than admitting each patient to an acute care hospital bed for investigation. Such hostels might also be used for the accommodation of patients requiring rehabilitation after injury or illness.

3.45 As so many factors are involved in the development of out-patient departments and services, we recommend that a committee of the various interested parties, medical, lay and architectural should be set up to study in full (1) the type of out-patient department to be provided; (2) its staffing at all levels; (3) its structure and siting; and (4) to make an analysis of the present out-patient services. In the meanwhile, the present out-patient services should be expanded where possible and sanction should be granted more readily for new out-patient sessions which are deemed necessary in the interest of patients and services.

3.46 **Conscious of the supreme importance of out-patient diagnostic services in future hospital development, we recommend that the provision of these services at the new General and Regional Hospitals should be proceeded with as soon as possible. It should not await the completion of comprehensive in-patient accommodation in these hospitals.**

THE ROLE OF THE GENERAL PRACTITIONER

3.47 **There is clearly a need for exploring the relationship between the hospital service and the general practitioner.** Comprehensive details of any scheme aimed at developing this relationship would have to be worked out in consultation with bodies representing both services, but in the foregoing paragraphs we have outlined some ways in which the family doctors could be associated with the Community

Health Centres and the District Nursing Homes. Further consideration should be given to the relationships of the general practitioners to the Regional and General Hospitals. These hospitals might in future provide the general practitioner of the locality with access to diagnostic facilities, and they might also provide a focus of contact and continuing education for general practitioners in the area by such means as libraries, conferences and open-ward rounds. In the light of the changing pattern of medical practice, the association of the general practitioner and the General Hospital is a matter requiring continuous review by consultants and general practitioners. General practitioners could also make an important contribution to medical teaching and discussion. By thinking in terms of total medical care of a population, rather than in terms of a hospital or a general practitioner service we will make progress towards the close integration of both services.

3.48 Possibilities for domiciliary consultations should be made available to general practitioners. These would rarely be necessary with an adequate out-patient service, but their need could be envisaged in certain circumstances.

3.49 Doctors in general practice and hospital consultants are generally overworked and lack adequate secretarial and other ancillary assistance and staffing. Both have an essential role to play in the care of the patients. Every effort should therefore be made to facilitate communication in the best interests of the community as a whole.

Implementation of Recommendations

3.50 In later chapters we suggest in a number of specific instances the manner in which our recommendations might be implemented. We also indicate what we regard as the priority requirements of each region. There are, however, some general comments which we wish to make on these matters. The conversion of our present hospital system into the one envisaged in this Report will involve many radical changes. It is desirable that these should follow a careful schedule, rather than proceed in a series of abrupt steps which could easily disorganise the working structure. A date for completion must be settled as, otherwise, the inevitable multitude of small delays may well result in the entire project being slowed down, perhaps to the point of indefinite postponement. **We are of opinion that all the major changes outlined in this Report should be accomplished by the year 1980.**

3.51 Our recommendations give rise to very important issues for the various voluntary hospital authorities, particularly those in the city areas. If the Minister, for his part, is prepared to accept these recommendations we would suggest that he urgently request the hospitals concerned to form joint negotiating committees represen-

tative of their authorities and their medical staffs. These committees must in a stated period report to the Minister on the manner in which the proposals relating to their hospitals might be implemented.

3.52 **If the hospital authorities concerned are prepared to participate in the re-organised system of Dublin hospitals envisaged by us, we strongly recommend that the development of the two main hospital centres in Dublin together with the building of a new Cork Regional Hospital, should take priority over other capital projects arising from our report.** These three projects are not simply of local significance, but are of national importance. The well-being of our medical services and of medical education in this country demands that they be pushed ahead simultaneously and without delay. Furthermore, the rapidly increasing cost of hospital building suggests that it would be to our economic advantage quickly to undertake this work.

3.53 **We consider that another priority in implementing our recommendations and an essential pre-requisite to the creation of a co-ordinated hospital system is the unification of the consultant pool into one nationwide organisation.** To help achieve this the Consultants Establishment Board (the role of which we describe in the next chapter) should be set up immediately. Initially the Board might be appointed on a provisional basis, since it cannot be constituted in the manner recommended by us until the Regional Hospital Boards (see also next chapter) have been created. The provisional Consultants Establishment Board would, in the interim period, be empowered to supervise consultant appointments to hospitals proposing to participate in the regionalised service. Appointments made without the provisional Board's approval would have to be re-advertised when the regional system is put into operation.

3.54 We visualise that in the provincial areas the process of developing the selected General Hospital centres and of orientating the public towards them will, of necessity, be a gradual one. In the interim, the fact that the status of a hospital is to be changed to a Community Health Centre should not be used as an argument to deny these hospitals essential equipment which can be moved later to the main centre.

3.55 Our proposals envisage a reduction in the amount of acute—and more expensive—hospital bed accommodation. **This can only be achieved by the speedy development of those services, both inside and outside the hospital system, which will minimize the occupation of acute beds by social problems or long-stay patients or by patients who might be treated on an out-patient basis.** This must be a high priority objective requiring the closest co-operation between various public and voluntary authorities.

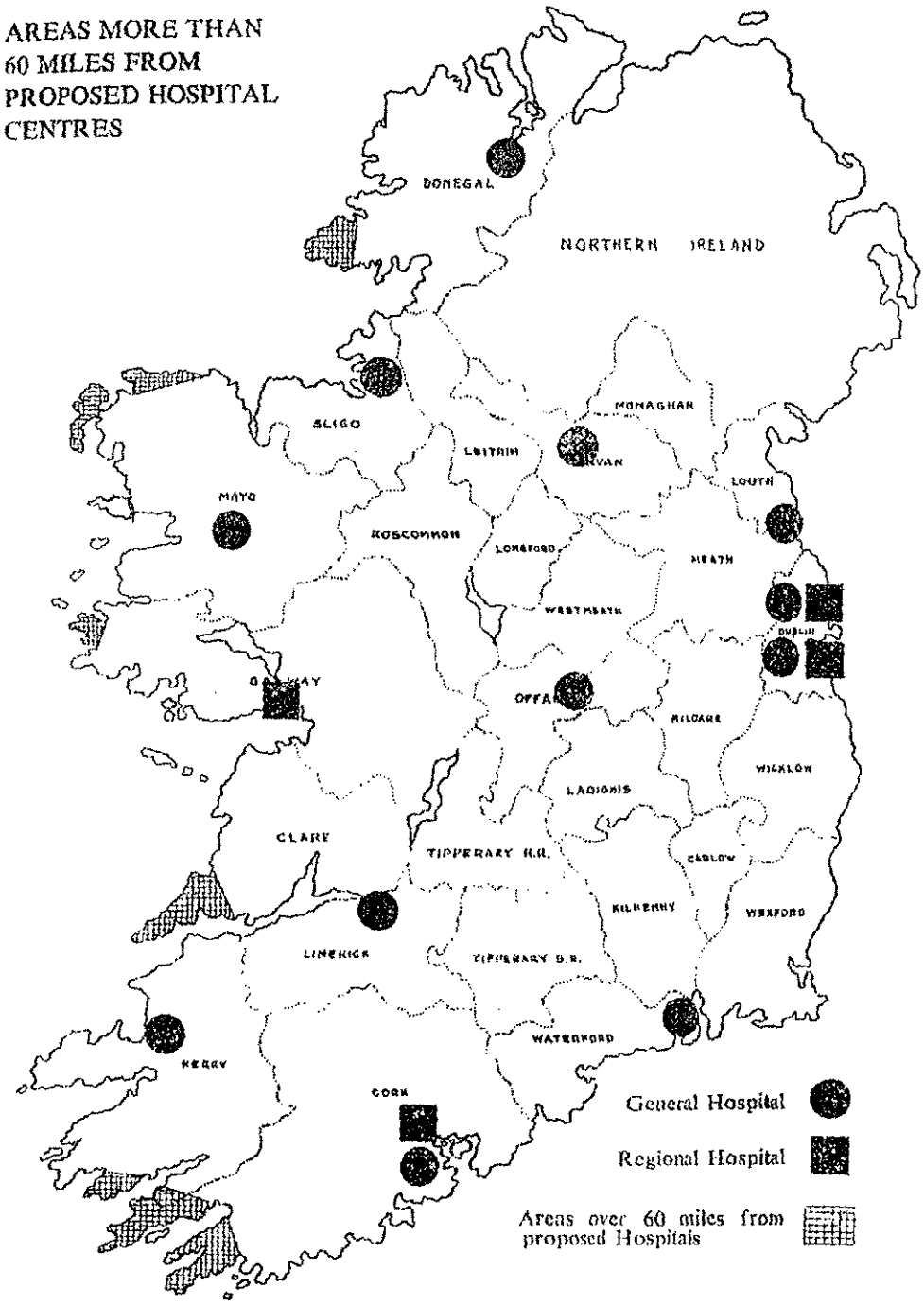
3.56 The full implementation of our plan for a revised hospital system will necessarily involve heavy capital expenditure. It follows, too, that the creation of a well-staffed, well-equipped, modern hospital organisation demands a large amount of revenue so that it can be operated and maintained at the highest standard. With the decline in the resources of the Hospitals Trust Fund we are conscious that the financial requirements of our hospitals have become more dependent on taxation. In this situation there is a danger that the competing demands of other sectors of the public services may tend to reduce below what is desirable the amount of finance provided for the health services and for the hospital services in particular. **We would urge that it be adopted as a matter of public policy that the financing of the development and operation of our hospital services be accorded a high priority, and that our annual expenditure on these services should compare favourably with that of other advanced countries.**

GENERAL COMMENTS

3.57 We have outlined what we believe should be the basic pattern of the Irish hospital service. In making these recommendations we have been activated by the knowledge that good medical care at hospital level demands reasonable centralisation. **The principles which have guided us have long been accepted in international medicine; they are recognised in all developed countries and as a council we had no difficulty in unanimously agreeing to them.** We are conscious, however, that the existing hospital organisation in Ireland has become so much a part of the community life of the country that the introduction of radical changes will raise serious objections in many quarters.

3.58 In the first place, some may object that the reduction in the number of hospitals will expose patients suffering from acute medical problems to long and stressful journeys before reaching expert care. This is an objection which is easily over-stated. There are many acute cases which should be admitted to hospital urgently—but in the vast majority the urgency is a matter of hours rather than of minutes. No hospital service can be planned to deal with the latter. Reasonable care of this type of problem (e.g. acute asphyxia, severe haemorrhage, cardiac arrest) must always, in the first instance, depend on well trained general practitioners in the city as well as the country. High standard first aid services located in all the smaller peripheral institutions, such as the suggested Community Health Centres and District Nursing Homes, would provide the necessary service at local level. When it becomes necessary to move the patient, well equipped and staffed ambulances can safely convey seriously ill patients the necessary distances to the proposed hospital centres. If, at the end of the journey, they reach a big hospital with a good range of specialist advice and well equipped laboratories and x-ray departments providing a comprehensive 24-hour service, they are far better

MAP THREE


AREAS MORE THAN
60 MILES FROM
PROPOSED HOSPITAL
CENTRES
DONEGAL
NORTHERN IRELAND
SLIGO
MONAGHAN
LEITRIM
CAVAN
LOUTH
MAYO
ROSCOMMON
LONGFORD
MEATH
WESTMEATH
DUBLIN
GALWAY
OFFALY
KILDARE
WICKLOW
LAOIGHIS
CLARE
TIPPERARY N.R.
CARLOW
KILKENNY
WEXFORD
LIMERICK
TIPPERARY S.R.
WATERFORD
KERRY
CORK
General Hospital
Regional Hospital
Areas over 60 miles from proposed Hospitals

off than if they had made a shorter journey to a small hospital with minimal staff and marginal laboratory and x-ray facilities. Even with the reduced number of hospitals now advocated, few areas of the Republic would be more than 60 miles from a hospital (see map 3). We estimate that the total population more than 60 miles from a hospital is of the order of 25,000 people, all of whom would have, closer at hand, the special emergency arrangements we have recommended for the Community Health Centres and the District Nursing Homes.

3.59 With very few exceptions our proposals will not involve more than one hour's driving in excess of that required in the existing hospital situation. This would be true even with present available ambulance facilities. These facilities will be greatly improved if our special recommendations on the future of ambulance services are accepted. The country is small; the number of hospitals could be reduced even further than we have suggested if the problem of maximal safe distance was the only consideration. **In making these assertions we are, of course, taking for granted the provision of an entirely satisfactory ambulance service including the development of the flying squad. We have, later in this report (pars. 7.28 to 7.35), made recommendations aimed at ensuring that there will be an efficient and reliable ambulance service. We cannot over-emphasise the important role of this service in the re-organised hospital system.**

3.59A A second major objection to our proposals will naturally be made by many members of the public on the grounds of convenience. Nobody likes going into hospital as a patient but if this is necessary the nearer the hospital is to his home the more acceptable it is. The patient remains near his family and friends who can visit without making long journeys. The more centralised the hospital services the further visitors from peripheral areas will have to travel. This is undoubtedly true—but it is part of the price that must be paid for higher standards of hospital treatment. It will be possible to alleviate the inconvenience to a real extent by making use of vacated County Hospitals and of District Hospitals, in the manner we have suggested, for convalescence and for long-stay care, thus minimising the length of time that a patient need remain at a longer distance from his home. Moreover, the setting up of out-patient diagnostic services, and of in-patient services for normal maternity and for minor medical illness in these same areas, will, in many instances, avoid the need for travelling to the main hospital centre.

3.60 The existing County Hospitals have, in nearly all cases, attracted to themselves a very real local loyalty and pride. Many of them are new buildings bearing solid witness to the triumph of a new generation over an old and alien workhouse system. Moreover, the hospitals have enjoyed the services of well qualified, over-worked County Surgeons and County Physicians, who have established their worth in their local communities. Again, a County Hospital is a

source of real economic benefit to a town—it gives employment and is an amenity. This, however, would be offset by the continued use of the building as a Community Health Centre. It is evident that the modification of any County Hospital is bound to arouse some sentimental regrets, perhaps even bitter opposition. Likewise, the city voluntary hospitals have their own traditions, loyalties and treasured autonomy. In asking them to sacrifice a measure of their independence we do so only in the knowledge that there is no other way in which our hospital services can be brought to modern standards. The longer the necessary modifications are delayed, the more difficult it will become to make the appropriate re-adjustments.

3.61 Our proposals involve the eventual modification in the usage of many newly built hospitals. This may seem extravagant. The extravagance, however, was incurred during the last few decades when these multiple small hospitals were built. In ceasing to retain a number of them we are cutting our losses. Fortunately, the buildings can still be of value for the other purposes that we have recommended. Apart from modifying the function of some newly built hospitals our proposals require the expansion of others. New building will be necessary over the next twelve years (much of it already approved). This, at least, will be done as part of a logical national plan with a view to long term medical efficiency at the most economical level.

3.62 Since the implementation of our recommendations in regard to buildings may take some time, we would urge that there is a medical necessity for the continued general maintenance and essential temporary improvement of hospitals scheduled for replacement or extension.

3.63 **The selection of the most appropriate centres for expansion has not been a simple matter and, indeed, where the Eastern region is concerned, has been especially difficult. We should, therefore, like to emphasise that while the centres nominated by us appear to be the most suitable, having regard to the areas and populations to be served, further and more detailed investigation than we have been able to undertake might indicate different locations. On the other hand, the general pattern of regionalisation which we have recommended is based on the inter-relationship between medical principles, social necessity and geographical facts. It is an unanimous recommendation and we have no hesitation in stating that a larger number of regions would be medically disastrous.**

3.64 Re-organisation of the hospital service along the lines laid down in the report will ensure that every patient who needs hospital treatment will get it in modern accommodation providing services of the highest standard. This streamlining will result in a reduction of the number of acute hospital beds. Part of the accommodation at present being used for acute hospital purposes will be freed to accommodate geriatric and other cases, many of whom are now in

out-moded and unsatisfactory accommodation. Much of this county home type accommodation can then be closed. The reduction in the number of acute hospital beds will be made possible by more suitable patient selection, more efficient bed utilisation, better out-patient services, improved transport services and the provision of hostel accommodation.

3.65 In the chapters that follow we attempt to show, in greater detail, how the principles outlined in this chapter should be implemented. There is considerable room for legitimate difference of opinion at this level and many of the decisions were reached only after considerable debate. By nature of our origin as a consultative council rather than a commission, and owing to the praiseworthy insistence of the Minister on a quick report, we have been unable to hear any formal witnesses or study every aspect in absolute detail. We believe, however, that the proposals we make in this Report have a general validity confirmed by the unanimity of our findings on a subject notoriously liable to produce divergent opinions.

CHAPTER FOUR

ADMINISTRATION

4.1 The radical changes we have recommended in the organisation of the hospital services require equally drastic changes in their administration. The Government has already, in its White Paper on the Health Services published in January, 1966, recognised that the future development of the health services necessarily involves their separation from the present local authority system and the creation of a new administrative machinery. We fully agree that this is necessary. **We regard it as essential that future developments in the hospital service should give precedence to the broad community interest rather than to purely local pressures and loyalties. To achieve this the new bodies to which responsibility will be transferred should, we consider, be broadly based geographically and should include appropriate technical representation, including substantial representation from the medical profession in general and from the consultant staffs of the hospitals in particular.**

Administrative Features of the Voluntary Hospitals

4.2 **We cannot emphasise too strongly the importance and urgency of successfully co-ordinating the activities of the voluntary hospitals and the health authority hospitals.** The various bodies, the establishment of which we recommend in the following paragraphs will, we hope, help to bring this about. The voluntary hospitals are now almost entirely financed from public sources and are, in essence, an important part of the national hospital service. Their independent status, in the absence of effective machinery for co-ordination, has been a basic factor in a tendency to reduplicate services excessively. Changes are, of course, necessary but certain tangible advantages must be preserved. Their traditional freedoms, their ready adaptability to changing demands and their ability to increase staff rapidly as the need arises, have been very advantageous to medical progress in the country. Most important of all, the participation of voluntary hospital medical staff in matters of hospital policy and administration has been stimulating to the management and has, undoubtedly, been to the advantage of the service. **These, among other characteristics of the system, represent something of considerable value which should continue to be availed of in the future.**

In the following paragraphs we describe the manner in which we envisage that voluntary and local authority hospitals might be brought into close association with each other.

Department of Health

4.3 The Department of Health would continue to be the central authority responsible for broad policy and legislation concerning the

hospital services. It would also exercise financial control over the Regional Hospital Boards and the Consultants Establishment Board (referred to later).

Standing Educational Committee

4.4 In the past, it has not been clear to hospital authorities where the dividing line is drawn between the Department of Health and the Department of Education in regard to matters concerning medical education in the hospitals. **We consider that examination of the proposals relating to buildings, equipment and staff required for medical teaching purposes would be facilitated by a close liaison between the two Departments in the form of a permanent Standing Committee.** This question is considered fully in the Report of the Commission on Higher Education.[1]

CONSULTANTS ESTABLISHMENT BOARD

4.5 **It is essential to secure a rational and co-ordinated distribution of specialised services throughout the country. To ensure this we recommend the creation of an authority to be called the Consultants Establishment Board.**

4.6 **The primary function of the Consultants Establishment Board should be to co-ordinate consultant appointments and to approve the creation of necessary new consultant posts.** Normally, new posts would be proposed by the Hospital Management Committees and be submitted through the Regional Boards, but these proposals might originate with the Regional Boards. In certain circumstances, it would be desirable for the Consultants Establishment Board itself to take the initiative. All new consultant posts would have to have the prior approval of the Establishment Board. Posts already created and being refilled following death, resignation or retirement would also be subject to review. Where consultants are appointed to posts without the Establishment Board's approval, the Regional Board should not be responsible for their remuneration. Temporary consultant posts of duration greater than six months would require the approval of the Establishment Board.

4.7 The Board will be appointed by the Minister for Health. We recommend that it be representative of the Department of Health, the Regional Hospital Boards, the Universities, the Medical Schools, the Irish Medical Association and the Medical Union. In carrying out its duties the Board will rely largely on the advice and knowledge of its technical members and, consequently, we recommend that at least two-thirds of the members be medical practitioners.

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[1]Report of Commission on Higher Education, 1960-67. Stationery Office, 1967.

4.8 We suggest that the Board might be comprised as follows :

Department of Health One medical and one lay representative

Southern Regional Hospital Board, *Western Regional Hospital Board* — Two medical and one lay representative each

Eastern Regional Hospital Board[2] — Four medical and two lay representatives

University Medical Faculties and Medical School of the Royal College of Surgeons in Ireland[3] — One representative of the medical teaching staff from each

Royal College of Physicians of Ireland One representative

Irish Medical Association, *Medical Union* — One medical representative each

Minister for Health Three persons of his choice.

The representatives of the medical teaching staffs should be hospital consultants. We have suggested that the Eastern Regional Hospital Board be given higher representation than the other regions because of the greater concentration of hospital services in that area.

4.9 Members should be appointed to the Board for a period of three years. One third of the membership should retire at the end of each year but they would be eligible for re-appointment.

4.10 In addition to its primary functions of co-ordinating consultant appointments, the Board would lay down qualifications and the broad scope of duties for such posts and would aim to ensure that conditions for all consultants were equivalent. In this connection, we consider that all consultant appointments should be on a notional sessional basis. The Consultants Establishment Board would, in the case of each new post created, determine the number of sessions appropriate to the post. In determining the number of sessions, the Board would be influenced by the routine work load for the post, by the amount of research which the post carried, by private practice and by exceptional demands likely to be made on the consultant's time.

4.11 The sessional rates payable to all categories of consultant should be similar and should be determined from time to time by an independent tribunal. The rates should be on an incremental scale basis which would take account of a consultant's age and experience. It should be open to the Consultants Establishment Board to recommend that certain posts carry additional remuneration. Where a number of consultants in the same speciality are attached to a hospital department, one of them should have admini-

[2]Equally divided between North Eastern and South Eastern areas.
[3]In the event of a merger of the Dublin universities there shall be two representatives from the medical school of the unified body.

strative responsibility for the department and should be paid some additional remuneration for these duties.

4.12 **All existing hospital consultants would be approved and invited to enter into contracts with the Regional Board on terms which would take into consideration their present contracts, or terms of appointment, either formal or implied, without detriment to the position of any existing consultants.** Where a consultant, at present remunerated in whole or in part for services to Health Act patients, does not wish to accept a contract, or is unable through infirmity to meet the requirements of the Board, he should be compensated. The compensation terms, unless agreed, should be subject to arbitration by a judicial tribunal. Consultants whose present terms do not compel them to retire at 65 years may, if they so wish, retire at that age and would then be entitled to adequate retirement benefits the terms of which should be laid down by an independent tribunal. All future appointees must retire at 65 years and be adequately pensioned.

4.13 **All new consultant appointments should be advertised and should be subject to open competition.** An appointment system should be devised preserving the best features of the present Local Appointments Commission to ensure objectivity. The selection boards would be set up by the Consultants Establishment Board and would have representation, from the Board (not necessarily by members), from the Regional Hospital Board and from the Hospital Management Committee concerned. The interests of the hospital concerned would be protected by the presence on the selection board of its representation. There would be an independent Chairman and external assessors would be employed. Where consultant posts in teaching hospitals are being filled the selection board must also have representation on it from the appropriate medical school. For full-time university posts, special arrangements should be devised. Where teaching duties occupy a large part of a consultant's time the apportionment of his time would be negotiated between the Board and the medical school. The selected candidate would, in all instances, be recommended to the Regional Hospital Board.

4.14 As we envisage them, the duties of the Consultants Establishment Board might be summarised as follows:—

(i) To co-ordinate consultant appointments and to approve the creation of necessary new appointments.

(ii) To review any existing consultant post when a vacancy occurs.

(iii) To lay down qualifications and the broad scope of duties for consultant posts and to devise equivalent conditions for all consultants as far as possible, while taking into account the population characteristics and the geography of each region.

(iv) To establish a system for the selection of candidates for vacant consultant posts.

(v) To initiate, when considered desirable, proposals for the development or improvement of a particular specialist service.

(vi) To ensure an even distribution of specialties throughout the regions, as far as the spread of population and the incidence of disease allows.

(vii) To ensure integration of the specialist services of the various regions, where necessary by the creation of inter-regional specialist sub-committees.

(viii) To determine the establishment of senior registrars, taking into account the estimated need of the country as a whole for future consultants in that specialty.

(ix) With the co-operation of the teaching bodies and the Regional Hospital Boards, to integrate the training arrangements suitable for future specialists.

(x) To control the number of senior para-medical appointments (such as biochemists) in the hospital service.

(xi) When requested, or on their own initiative, to advise the Minister for Health on matters relating to the organisation and operation of hospital and specialist services throughout the country.

(xii) To correlate information relating to the hospital services of this and other countries and, from time to time, to write reports of such services.

4.15 The Consultants Establishment Board would be financed by central funds and by the Hospitals Trust Fund.

REGIONAL HOSPITAL BOARDS

4.16 **Regional Hospital Boards should be established with responsibility for the general policy and supervision of the hospital services in their regions. The Boards would have as much independence as was practicable and would be financed on a block grant negotiated with the Department of Health. We are of opinion that the cost, complexity, and importance of the hospital service require a separate regional administration, but we would emphasise that, in the interests of economy and the efficiency of the health services generally, it should be closely linked with the authority or authorities responsible for other health services in the region and that, as far as possible, senior trained medical and lay administration staffs should be shared.**

4.17 The Boards would be appointed by the Minister for Health after consultations with the teaching bodies and teaching hospitals in the area, with medical and nursing organisations, with local interests, and with the medical staffs and management committees of the hospitals concerned. The number of medical nominees from all organisations should form 40 per cent of the total membership of the Boards. **It is particularly important that the authorities of the Regional and General Hospitals have direct representation on the Boards through representatives of their Management Committees.** The term of appointment might be for three years with one-third of the members retiring annually, but eligible for re-appointment.

4.18 Ownership of all local authority hospitals in the area should be transferred to the Regional Hospital Boards. Voluntary hospitals in each region should be invited to enter into contractual arrangements with the Regional Board under which they would agree to participate in a planned hospital service and to co-ordinate their activities with those hospitals owned by the Board. Voluntary hospitals wishing to vest themselves in the Board would be permitted to do so.

4.19 Consultants attached to the hospitals participating in the hospital service would hold their contracts with the Board and receive their remuneration from it.*

4.20 The Regional Boards would exercise general budgetary control over Hospital Management Committees.

4.21 The Boards will require highly trained senior Administrative Officers, both medical and lay.

HOSPITAL MANAGEMENT COMMITTEES

4.22 **We consider that Hospital Management Committees should be established which would manage individual hospitals or groups of hospitals including the associated Community Health Centres and District Nursing Homes.** The Committees would be appointing and employing authorities for all staff other than consultants, senior registrars and senior para-medical staff, but would act in accordance with the general recommendations of the Regional Boards in regard to the numbers and conditions of appointment of these staffs. The Regional Hospital Board should apportion each hospital management committee with an appropriate block grant, out of which the Committee would manage the day to day expenses of the hospital.

4.23 **In voluntary hospitals, the lay board or religious community or combinations of these, as the case may be, would be, as at present, the management authority.**

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* Dr. H. E. Counihan considers that all consultants should have their contracts with the Consultants Establishment Board.

In the case of hospitals owned by the Regional Board, the Board would appoint Management Committees which would be representative of local public and philanthropic interests and of the medical staffs. It is desirable that teaching hospitals owned by the Regional Boards should have direct representation on their Management Committees from the medical school concerned.

Administration of Hospitals

4.24 **We consider that the Management Committee of each Regional and General Hospital should eventually employ a highly trained and experienced Administrator.** While it is of paramount importance that he should be highly trained and experienced, we consider that it would be of some advantage if he were a medical practitioner.

4.25 We recommend that each Hospital Management Committee should have the assistance and advice of a Medical Committee and a Nursing Committee. These committees should be representative of the nursing and medical staffs. For the purpose of developing the Regional Hospital complexes, it will, as recommended elsewhere in this report, be necessary to formulate co-ordinating committees to integrate the activities of the various hospitals and hospital units within these complexes.

Hospitals Commission

4.26 **The future role of the Hospitals Commission must necessarily be influenced by the proposed changes in the organisation and administration of the hospital system. We feel that its functions must be redefined in the light of these changes.** In its new role, it might be particularly concerned with the application of work study techniques to the hospital services, the study of hospital design, and the collection, processing and publication of statistics relating to hospital in-patient and out-patient care. It is important that the work of the Commission should be closely co-ordinated with that of the other administrative elements of the re-organised hospital system and we consider that this might best be achieved by basing the membership of the Commission on selected members of the Consultants Establishment Board.

CHAPTER FIVE

BED REQUIREMENTS

Total Hospital Provision of Acute Care Beds

5.1 The number of beds at present in use in our acute care hospitals may be summarised as follows :—

Voluntary Public Hospitals:		
12 general hospitals (teaching)	2,654	beds
11 general hospitals (non-teaching)	1,243	,,
6 cottage hospitals	174	,,
5 maternity hospitals	820	,,
4 children's hospitals	735	,,
1 infant's hospital	100	,,
2 cancer hospitals	152	,,
2 eye, ear and throat hospitals	194	,,
4 orthopaedic hospitals	627	,,
1 rehabilitation hospital	115	,,
1 sanatorium containing	227	tuberculosis beds
	80	beds for non-T.B. chest cases
	110	mental handicap beds
Voluntary Private Hospitals		
11 general hospitals	1,147	beds
1 maternity hospital	26	,,
Local Authority Hospitals		
4 major general hospitals (3 teaching)	2,603	beds
1 major maternity hospital	107	,,
24 county hospitals	3,307	,,
4 orthopaedic hospitals	484	,,
4 large sanatoria (or former sanatoria) now catering for a number of different categories of patient and containing	748	tuberculosis beds
	168	orthopaedic beds
	331	medical and surgical
	778	geriatric beds
	241	mental beds
3 other sanatoria	191	tuberculosis beds
	30	geriatric beds
53 district hospitals	1,925	beds
9 fever hospitals	709	,,
Other		
1 State-controlled cancer hospital	147	beds
5 military and Garda hospitals	667	,,

The total number of institutions is 169 and the total beds provided in them is 20,840.

5.2 All of these institutions fit the World Health Organisation definition of "hospitals", i.e. "establishments permanently staffed

by at least one physician which offer in-patient accommodation and provide medical and nursing care ".[1] It must be pointed out that this definition is a minimal concept, designed to include undeveloped countries and is used here for purposes of statistical comparison only. There are, in addition, a number of small nursing homes, maternity homes and homes for children which, although not strictly classifiable as hospitals, do help to take some of the load imposed on the hospital service. In total, there are about 80 such homes with a total of about 1,100 beds.

COMPARISON WITH OTHER COUNTRIES

5.3 **The total of about 21,000 hospital beds represents 7.2 beds per 1,000 of the population.** This ratio is compared in the following table with corresponding figures for a number of other countries. These figures are based on hospital bed numbers published by the World Health Organisation[2] and on population figures published by the United Nations.[3] This table includes figures for all hospitals with the exception of mental hospitals and hospitals for chronic diseases and convalescence.

Country	Year to which figures relate	Beds per 1,000 population
Sweden	1964	7·8
Luxembourg	1964	7·3
Ireland	1965/66	7·2
France	1963	6·9
Denmark	1964	6.6
Norway	1964	6·6
Switzerland	1964	6·2
Finland	1964	6·0
Scotland	1964	5·7
Northern Ireland	1964	5·5
Netherlands	1961/62	5·3
Belgium	1962	5·2
United States	1964	4·9
England & Wales	1964	4·3

5.4 While these figures are carefully compiled by government agencies, there can be no guarantee as to exact comparability and they must be interpreted critically. This arises mainly from possible differences in the criteria applied in the compilation of the statistics. Nevertheless, Ireland's position towards the head of the table emerges fairly clearly. The most significant feature is the considerable difference between the Irish figures and the figures for England and Scotland as well as those for some of the Northern European countries.

[1] World Health Statistics Annual, 1963 Vol. III World Health Organisation Geneva 1967.

[2] *Ibid.*

[3] Demographic Year Book, 1966, United Nations, New York, 1967.

5.5 **It is not possible to attribute our relatively high provision of hospital beds to any specific reason.** It is likely that there are many factors involved which are complex and inter-related and which are grounded both in our social characteristics and in the development of our present local authority hospital organisation from the 19th century poor law system. It is possible to speculate on the various social, demographic and other factors involved but there is a clear need for more objective information on which reliable conclusions could be based. We feel that field research, on the lines of Corridan's investigation[4] of the relationship between living alone and admission to a mental hospital, would help to clarify this question.

5.6 **Irrespective of what considerations have led up to our present relatively high provision of hospital beds, we are satisfied that this situation tends to be perpetuated by the nature of the hospital system which has evolved.** The wide diffusion of hospital services in a multiplicity of small minimally staffed and equipped institutions militates against full effectiveness and requires considerably more beds than would be necessary in a better structured service. It has, in fact, been demonstrated in a recent study[5] that the throughput of patients in our acute hospitals compares unfavourably with that of some other countries. The Irish figure of short-term patients treated annually per bed was 16, compared with 19 for Sweden, 22 for England and Wales and 30 for the United States. This consideration has had an important influence on our approach to the task assigned to us by the Minister for Health. **While our primary concern is, of course, the creation of a hospital system in which the patient can most fully benefit from the skills and knowledge of modern medicine, we consider that an efficient hospital service in the medical sense is also an efficient service in the economic sense.** Consequently we feel that our recommendations must lead not only to an improved hospital service but to a wiser and more fruitful expenditure of public funds.

Acute Care Beds More Closely Defined

5.7 The summary given above, amounting to a total of about 21,000 beds in 169 hospitals, includes all hospitals and beds which are now associated with the acute hospital service. But many of these beds cannot properly be described as acute. Such, for example, are beds being used for long-stay tuberculosis patients or for the care of chronic sick and geriatric patients. In the re-organised service which is visualised in this report it is assumed that adequate provision will be made for supporting services such as domiciliary care, convalescent homes and homes required for geriatric and welfare patients for social reasons. In this way, all the effort of the acute hospitals can be concentrated on the investigation and treatment of acute conditions in

[4]John P. Corridan. A Comparison of Geriatric Patients in a County Home and a Mental Hospital. *Journal of the Irish Medical Association*, Vol. LX, No. 366.
[5]B. Herlihy and S. Trant. Economic Significance of Falling. Duration of Stay in Acute Hospitals. *Journal of the Irish Medical Association*, Vol. LX, No. 363.

the most prompt and efficient manner possible. This may involve a physical separation, while maintaining a close association, between the acute hospital and these supporting services. In order to establish our starting position, it is necessary to estimate the number of beds now in use which can strictly be classed as acute. Unfortunately, quantitative information about the hospital patients is not available in sufficient detail to permit this to be done to a fine degree of accuracy, but certain modifications can be made to the gross figure of 21,000 beds to make it conform more closely to the description "acute". These modifications come under the following broad headings.

(a) The known chronically ill patient element of certain large hospitals such as St. Kevin's Hospital and the regional sanatoria totalling about 2,000 beds, can be excluded.

(b) A number of district and cottage hospitals which are used largely for the care of chronic sick and long-stay patients and containing something less than 800 beds can also be excluded.

(c) A number of small fever hospitals which are now little occupied for cases of infectious disease and which have a total of about 100 beds can also be left out of the reckoning.

(d) The findings of Bourke and Coughlan[6] in their investigation of patients in the Dublin general hospitals can be used to help in estimating the proportion of beds in the general hospitals which do not comply with the definition "acute". These beds are estimated at over 1,700.

(e) Tuberculosis beds in sanatoria, amounting to about 1,200 are not counted.

(f) The military and Garda hospitals with a total of 667 beds make a very limited contribution to the overall hospital needs of the community and can be largely excluded.

5.8 **These modifications result in a net figure of about 14,000 beds representing a ratio of 4.9 beds per 1,000 of the population.** About half of these beds are in voluntary hospitals.

PLANNING GUIDE: ESTIMATED RATIOS IN PARTICULAR CATEGORIES

5.9 As we have shown in the preceding paragraphs, the number of hospital beds which are now being used strictly as acute care beds is of the order of 14,000 or 4.9 per 1,000 of the population. We are satisfied that, if the hospital services were re-organised on the lines visualised in this report, a better and more efficient service could be provided in an even further reduced number of acute care beds. As explained earlier in this report, this reduction will be made possible

[6]Geoffrey J. Bourke and J. A. Coughlan. Dublin General Hospital and Geriatric Study. Dublin 1967.

by a greater concentration of the hospitals to enable them to be better staffed and better equipped, and by the development of better transport and of more comprehensive out-patient facilities to take much of the work of investigation and treatment which can appropriately be done at this level. We have considered this question at length and, while we are satisfied that the existing bed provision can and should be reduced, we do not think it possible, due to the lack of precise information on the use of Irish hospitals, to give the exact level at which our bed provision should lie. In England a number of surveys have been carried out into the use of hospitals and the demand for medical care. Surveys undertaken for the Nuffield Provincial Hospitals Trust at Northampton[7] and Norwich and by the Oxford Regional Hospital Board at Reading[8] suggested a need for about 2 acute beds per 1,000 of the population while a Trust study in Barrow-in-Furness[9] put the bed requirement at 2.9 acute beds per 1,000 population. These figures covered all normal requirements of medicine, surgery and obstetrics but excluded the more specialised work such as radiotherapy, plastic surgery and neurosurgery. Based on these surveys and on the results of the Annual Hospital In-Patient Enquiry conducted by the British Ministry of Health[10] a ratio of 3.3 acute* beds per 1,000 of the population (plus 0.58 for maternity) has been adopted as the target figure in the Hospital Plan for England and Wales.[11] An almost similar ratio (3.4 acute; 0.69 maternity) has been adopted in the Hospital Plans for Scotland[12] and for Northern Ireland.[13]

5.10 We feel (and in this we do not think that we are in any way at variance with the British planners) that there is no single figure which represents the optimum bed/population ratio to the exclusion of all others. It is a mercurial quantity which varies in both time and place, and is influenced by, among many other things, local levels of morbidity, the structure and distribution of the population, by the supporting services available, by a variety of social considera-

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[7]Studies in the Functions and Design of Hospitals. "The Report of an Investigation sponsored by the Nuffield Provincial Hospitals Trust and the University of Bristol." Oxford University Press 1955.

[8]A. Barr. The Population served by a Hospital Group. *Lancet*, 1957, ii, 1105–1108.

[9]G. Forsyth and R.F.L. Logan. "The Demand for Medical Care. A Study of the Case-Load in the Barrow and Furness Group of Hospitals." Oxford University Press 1960.

[10]Reports on Hospital In-Patient Enquiry 1956-57 onwards. Ministry of Health and General Register Office. H.M.S.O. London.

*Acute beds are defined in the Hospital Plan for England and Wales as beds for general medicine, paediatrics, infectious diseases, dermatology, neurology, cardiology, physical medicine, venereal diseases, general surgery, ear, nose and throat cases, traumatic and orthopaedic surgery, ophthalmology, radiotherapy, urology, plastic surgery, thoracic surgery, dentistry, neurosurgery, gynaecology and diseases of the chest; also pre-convalescent beds.

[11]A Hospital Plan for England and Wales, H.M.S.O. London 1962.

[12]Hospital Plan for Scotland. H.M.S.O. Edinburgh. 1962.

[13]Hospital Plan for Northern Ireland 1966-75. H.M.S.O. Belfast 1966.

tions and, perhaps most of all, by changes over time in the pattern of disease and in the techniques in use in medicine. **We are strongly of opinion that the actual number of beds to be provided is of less importance than having the services properly developed, adequately staffed and properly located.** Architectural planning should therefore allow for flexibility so that beds can be added as required or have their function altered to meet changing demands. This would be facilitated by the use of modular and prefabricated units where possible. Bearing in mind these reservations about the value of fixed planning targets, it is necessary, nevertheless, to adopt some standards which can be used as guidelines in broadly determining the sizes of the hospitals required. It must be emphasised that these guides are valid only on the understanding that adequate supporting services, such as long-stay beds and facilities for domiciliary care, are available.

5.11 The Scottish Home and Health Department has made available to us a breakdown of the 3.4 ratio being used in Scotland. Because of demographic and other similarities between Ireland and Scotland, and because we have no reason to believe that there is any significant difference in the pattern of illness in the two countries, we consider that the Scottish planning ratios, amended by us in certain aspects to bring them more into line with the known requirements of this country, could be used for this purpose. We have broadly classified the beds under community beds (those which should be provided in all General Hospitals); regional specialities (those which would normally be available in each region, mainly in the Regional Hospital with some auxiliary units in the General Hospitals) and highly specialised units which would be based on only one or two centres.

5.12 **We estimate our total acute bed requirements as 4.15 per 1,000 population calculated as follows:**

Nature of Beds	Beds per 1,000 Population	Corresponding Scottish Figures
Community Beds		
General Medicine ..	0·8	0·8
General Surgery ..	0·8	0·8
Obstetrics	0·8	0·69
Gynaecology	0·3	0·3
Total ..	2·7	
Regional Specialties		
Orthopaedics	0·33	0·33
Ophthalmology	0·06	0·06
E.N.T.	0·08	0·08
Infectious Diseases ..	0·1	0·3
Urology	0·08	0·08
Paediatrics	0·3	0·1
Total ..	0·95	

5.13 The figure of 0.3 beds for paediatrics represents, in our view, the maximum number of beds required for this specialty as numbers of children will continue to be dealt with by general surgeons and physicians and other specialists. In arriving at a requirement of 0.8 beds per 1,000 of the population for obstetrics, we took account of the present birth rate of 21.1 per 1,000 population. We also had regard to the fact that at present over 90 per cent of all confinements take place in a hospital or nursing home and we consider that future planning should be based on the assumption that the number of domiciliary births will become insignificant. While this estimate may be taken as an overall guide to our maternity bed requirements, local variations will arise depending largely on the structure of the population. In addition to the beds listed in paragraph 5.12, provision must be made for highly specialised units. These include the services necessary for the care of rare or difficult conditions, which require elaborate staffing or highly expensive equipment. In other words, units which should not be reduplicated too readily. Examples of such are cardiac surgery, neurosurgery and radiotherapy, but the pattern tends to change with advances in medicine. We estimate that an overall bed requirement of 0.5 beds per 1,000 population should suffice, thus giving a total bed requirement of 4.15 beds per 1,000 population.

SUMMARY OF MAIN CONCLUSIONS AND RECOMMENDATIONS

GENERAL PRINCIPLES (CHAPTER 3)

1. If the hospital system is to be adapted to meet fully the requirements of modern medicine this can be achieved only by radical changes, involving a departure from many long-established concepts in regard to organisation, staffing and operation.

2. The hospital system should be re-organised into three regions based on the medical teaching centres, namely, Dublin, Cork and Galway. These regions are administrative. Patients may choose to be treated in a region other than that in which they reside.

3. There should be two kinds of acute care hospitals (a) the Regional Hospital and (b) the General Hospital. Associated with these hospitals would be a system of Community Health Centres and District Nursing Homes.

4. The administration of the hospital service should be put on a new basis by the creation of a central Consultants Establishment Board, Regional Hospital Boards and Hospital Management Committees.

The Regional Hospital

5. The Regional Hospitals would be located at the regional centres. They would provide the same routine service in their particular areas as a General Hospital, but would also provide certain specialised services for a broader regional area.

6. Each Regional Hospital should be based on a medical school and should be closely associated with the General Hospitals of its area. The medical staff might work in both types of hospital. These hospitals would also be closely linked with intermediate and long-stay institutions.

The General Hospital

7. The General Hospital should, ideally, have not less than 300 beds and serve a population of at least 120,000. It would cater for the major proportion of relatively short-stay illness in an area and might develop from a group of existing smaller general hospitals. A certain minimum consultant staffing is recommended.

The Community Health Centre

8. County Hospitals not selected for development as General Hospitals should become Community Health Centres providing in-patient services (similar to those of the District Nursing Homes) but giving comprehensive consultant out-patient services supported by improved diagnostic facilities.

The District Nursing Home

9. Most of the District Hospitals should become District Nursing Homes, staffed by general practitioners, providing services for routine maternity cases, convalescent and geriatric cases and for medical cases, who, if their domestic circumstances permitted, could be treated in their own homes.

10. All District Nursing Homes should have facilities for emergency resuscitation supplemented by an efficient ambulance service.

Out-Patient Services

11. There should be increased emphasis on out-patient care. The main out-patient departments would be at the Regional and General Hospitals but out-patient clinics should, where necessary, also be held at the Community Health Centres and District Nursing Homes, in order to make the services as easily accessible as possible.

Role of the General Practitioner

12. General practitioners should be closely associated with the Community Health Centres and District Nursing Homes. Consideration should be given to the position of the general practitioners in relation to the Regional and General Hospitals.

ADMINISTRATION (CHAPTER 4)

13. Further developments in the hospital service should give precedence to the broad community interest rather than to purely local pressures and loyalties. The new administrative bodies should, therefore, be broadly based geographically and should include substantial representation from the medical profession.

14. It is important and urgent to co-ordinate the activities of the voluntary hospitals and the local authority hospitals and the proposed new bodies are devised to help achieve this aim.

Department of Health

15. The Department of Health would continue to be responsible for broad policy, legislation and finance concerning the health services.

Consultants Establishment Board

16. It is recommended that a Consultants Establishment Board be instituted, with the primary function of co-ordinating consultant appointments. The Board would have functions in relation to the creation and approval of posts, the laying down of conditions and qualifications, the selection of candidates and the standardisation of records. It should have power to report to the Minister on matters necessary for the improvement of medical services to the community.

17. All existing hospital consultants should be approved by the Consultants Establishment Board. A retirement age of 65 is recommended. Pensions would be payable.

Regional Hospital Boards
18. Regional Hospital Boards should be established with responsibility for the general policy and supervision of the hospital services in their regions. The Boards would be appointed by the Minister for Health after consultation with certain interests as outlined.

19. The Boards should have as much independence as practicable and should be financed on block grants negotiated with the Department of Health.

Hospital Management Committees
20. Hospital Management Committees should be maintained if in existence, or established where necessary to manage individual hospitals or groups of hospitals and associated institutions.

Administration of Hospitals
21. Each Management Committee should employ highly trained and experienced administrators.

Hospitals Commission
22. The future functions of the Hospitals Commission should relate to the application of work study techniques to the hospital service, the study of hospital design, and the collection and processing of hospital statistics. A proposed relationship between the Hospitals Commission and the Consultants Establishment Board is outlined.

BED REQUIREMENTS (CHAPTER 5)
23. The adoption of a provision of 4.15 acute care beds per 1,000 of the population is recommended as the standard to be adopted for future planning.

SPECIALIST SERVICES (CHAPTER 6)
24. The growth in specialisation requires the employment of an increasing number of highly trained doctors and supporting staff. It is important that the various specialised units should have an adequate number of patients.

25. Some specialties, dealing with rarer conditions and a relatively small number of patients, can function efficiently only if concentrated at one or two Regional Hospitals. Other specialties might be represented at all Regional Hospitals and many General Hospitals.

26. Isolated highly specialised hospitals are undesirable and their staffs should be co-ordinated and associated with the main Regional and General Hospital centres in preparation for complete integration.

Geriatric Services
27. It is urgently necessary that special provision should be made for the needs of geriatric patients. As far as possible, the elderly patient should be cared for in his own home; if admission to an institution is necessary he should initially be investigated, and perhaps

treated, in a Regional or General Hospital. Recommendations have been made to ensure the best possible intermediate and long-stay accommodation.

Tuberculosis Services
29. Patients suffering from pulmonary tuberculosis should, in future, be cared for in separate wards of general hospitals.

Fever Hospital Services
29A. Fever hospitals should cease to exist as separate entities. Isolation units should be associated with Regional and General Hospitals.

Surgical, Medical and Supporting Specialties
30. Recommendations are made as to the manner in which surgical, medical and supporting specialties should be organised and distributed amongst the main hospital centres.

OTHER CONSIDERATIONS (CHAPTER 7)
Medical Research
31. The importance of medical research is emphasised. Hospital authorities should ensure that adequate facilities are available.

Medical Records
32. Each hospital should have a central records office. Record systems should be standardised. Eventually the creation of a national system of records, involving the use of computers, is envisaged.

Ambulance Services
33. The proposed redistribution of acute care hospitals necessitates improving the ambulance service to the highest level of efficiency. A central Ambulance Board should be established to advise on the various medical and technical aspects of organising this service.

THE WESTERN REGION (CHAPTER 8)
34. The Western Region should be based on Galway City and should consist of Counties Galway, Mayo, Roscommon, Donegal, Sligo and parts of Leitrim, Cavan and Clare.

Location of Hospitals
35. The Regional Hospital should be based on the existing Regional General Hospital and the Western Regional Sanatorium. General Hospitals should be located at Castlebar, Sligo and Letterkenny.

THE SOUTHERN REGION (CHAPTER 9)
36. The Southern Region should be based on Cork City and should consist of Counties Cork, Kerry, Limerick, most of Tipperary and Clare and part of Waterford.

Location of Hospitals
37. A new Regional Hospital should be built in Cork City. Subsequently a General Hospital should be established in that city, based

on the present federated voluntary hospitals. There should be a large General Hospital with some specialist services in Limerick and a General Hospital of viable size in Tralee.

Limerick City Hospitals

38. The voluntary hospitals and local authority hospitals in Limerick City should be integrated in one centre.

THE EASTERN REGION (CHAPTER 10)

39. The Eastern Region should be based on Dublin City and should include all of Leinster, County Monaghan and parts of Counties Cavan, Leitrim, Waterford and Tipperary.

Regional Hospitals

40. Two major Regional Hospital groups should be developed in Dublin. One should probably be on the site of the present Mater Misericordiae Hospital and should involve associating that hospital with a new hospital to accommodate the specialised services provided in the existing St. Laurence's and Jervis Street Hospitals. The other Regional Hospital group should be developed near the new St. Vincent's Hospital on the Elm Park site. This should accommodate all the major specialised units and some of the general beds of the Federated Dublin Voluntary Hospitals.

General Hospitals in Dublin

41. General Hospitals should be based on the present James Connolly Memorial Hospital (Blanchardstown) and on the present St. Kevin's Hospital site. In each instance, an association of the staffs of several existing hospitals would be involved.

General Hospitals Outside Dublin

42. Outside Dublin, General Hospitals should be established at Waterford, Tullamore, Cavan and Drogheda.

IMPLEMENTATION OF RECOMMENDATIONS

43. All the major changes outlined in this report should be accomplished by the year 1980.

44. An urgent priority in implementing the recommendations is the establishment of the Consultants Establishment Board.

45. The two main hospital centres in Dublin, together with the building of a new Cork Regional Hospital, should take priority over other capital projects recommended in this Report.

46. The process of developing the General Hospital centres in the provincial areas will be somewhat more gradual. During the transitional stage, consultants from the re-graded County Hospitals must be associated with the main centres.

PART TWO

SPECIFIC RECOMMENDATIONS

CHAPTER SIX

SPECIALIST SERVICES

The Growth of Specialties

6.1 Medical knowledge is growing so rapidly that increased specialisation is inevitable and essential if the members of the medical profession are to give their patients the best management and treatment. It is, for example, no longer possible for a physician to be experienced adequately and informed fully in all the sub-divisions of advanced medicine. Neither can a surgeon offer the best service in every branch of surgery. For many years the clinical specialists in hospitals have been physicians, surgeons, obstetricians, gynaecologists, paediatricians, ear, nose and throat specialists, eye specialists, psychiatrists and geriatricians. They are supported by radiologists, anaesthetists and pathologists. In all advanced countries these traditional posts have given way, in many instances, to further subdivisions. In Ireland, considerable progress has taken place in this direction, but it needs substantial backing if it is to function properly.

6.2 In medicine there are many sub-specialties. These include neurology, dermatology, infectious diseases, respiratory diseases, cardiology, gastro-enterology, nephrology, endocrinology, metabolic diseases, clinical haematology, rheumatology, physical medicine, oncology and clinical pharmacology. Most physicians maintain a broad interest in medicine and manage a fairly wide variety of medical conditions, but specialise in one of the sub-specialties. Some physicians specialise completely. In either case, the specialised work is ideally carried out in a special department of a general hospital where all the particular needs of the specialty are supplied, and where doctors in that specialty may work together. Apart from the provision of an in-patient ward, or an out-patient unit, specially trained nursing and technical staff are essential. Accommodation must be provided also for equipment for laboratory work particular to the specialty concerned.

6.3 A similar situation exists in surgery. Some surgeons deal with all general surgical problems, but well defined surgical specialties have developed and have become increasingly important. These are orthopaedics, plastic and maxillo-facial surgery, neurosurgery, thoracic surgery, urological surgery, cardiac surgery and vascular surgery. In the future there is likely to be increased specialised work dealing with organ transplantation. An additional stimulus to specialisation in surgery is the difficulty in attaining skill in the less common operations, unless the cases are concentrated (see para. 3.12).

6.4 The traditional division between medicine and surgery is diminishing, and the modern tendency is for special units to be

formed in which physicians, surgeons and others work together as a team to treat disorders of a particular system. This pattern developed many years ago between neurologists and neurosurgeons. Now units of this type have also developed in such specialties as cardiology, gastroenterology and nephro-urology. The success of such combined units is facilitated by having one of the physicians or surgeons designated to be chairman or director.

6.5 The use of radioactive isotopes in diagnosis has led to the relatively new specialty of nuclear medicine. These techniques have been used especially in haematology, endocrinology and metabolic diseases. Scanning techniques have been developed for diagnosis and are applicable in most of the other specialties. Special departments of nuclear medicine are established features in major hospital centres in other countries.

6.6 Pathology, too, is a rapidly expanding subject and it is now impossible for a hospital pathologist to cover all its branches. This subject has been clearly divided into the four main branches of histopathology, bacteriology, haematology and biochemistry, together with certain sub-divisions such as cytology, immunopathology, virology, serology and blood transfusion. It is now usual for a large hospital to be served by at least one consultant in each of the major disciplines.

6.7 The increasing complexity, elaborate equipment, and time-consuming nature of diagnostic radiology, have led to the emergence of specialised aspects such as neuro-radiology and angiography. Further sub-divisions are likely to develop where clinical work becomes increasingly specialised. Radiotherapy has been a major specialty for many years and is an essential part of units for cancer therapy.

Consequences of Specialisation

6.8 **The effect of this growth in specialisation is to require the employment of an increasing number of highly trained doctors and supporting specialist staff.** Clearly, this must mean a marked rise in the financial expenditure of a hospital service. In order to use these expensively trained personnel economically and to the best advantage, it is essential that the hospital organisation be efficient in making the specialists available to the patients and also available to other consultants with the minimum of travelling. **It is important therefore to group these specialised units in a hospital which is sufficiently large and reasonably adjacent to a large population so that there is an adequate flow of patients to be served.** Not only does such an arrangement enable the specialist to utilise his time fully and efficiently, but it also ensures that the special units will see a sufficient number of patients of a particular type so that the staff concerned will maintain and improve their knowledge and skill. Such special units should be staffed by at least two specialists. This facilitates consultations and affords opportunities for the development of special

skills by each. Furthermore, it ensures that the work of the unit continues when one specialist is absent.

6.9 Obviously all the specialists mentioned in the preceding paragraphs cannot be placed in every hospital. Some major specialties, dealing with rarer conditions and thus with a relatively small number of patients, need, at the same time, continuously to maintain expensive and highly trained medical teams and costly equipment. Such units can only remain viable if they serve a very large population. We consider that these specialties should be concentrated in only one or two Regional Hospitals. Other specialties, not, perhaps, requiring very elaborate staff and facilities and which, at any rate, are in much demand because the disease processes involved are fairly common, should be represented at all Regional Hospitals. The General Hospital should contain the basic specialties. The exact allocation of specialised services to a particular hospital and their staffing and bed requirements would, of course, be influenced by medical developments and by the needs of the area concerned. In later paragraphs we outline the manner in which we consider the various specialties might be distributed and staffed.

6.10 **We are strongly of the view that isolated highly specialised hospitals such as cancer hospitals and eye hospitals are undesirable, and we consider that special units provided in the main hospital centres would be to the mutual advantage of the patient, the doctor and the economy.** We consider it of extreme importance that the staffs of these hospitals should, as soon as possible, be co-ordinated and associated with those of the main hospital centres, in preparation for the eventual physical placement of the specialised hospitals upon the sites proposed.

NEUROLOGICAL SURGERY AND MEDICINE

6.11 We recommend that there should be one large and one small centre for this specialty in Dublin and that there should also be a small centre in Cork. The two Dublin units should form a combined neurosurgical service with common staff which, initially, would be of the order of four neurosurgeons and three neurologists. We consider that the provision of a neurosurgical unit in Galway Regional Hospital would be justified if the volume of work arising in the area were proven to be sufficient. In the meantime a medical neurological service should be established in Galway. The unit in Cork should be staffed by one neurosurgeon and one neurologist. A second neurosurgeon could be appointed to the Cork centre if the volume of work there justified it. The large Dublin centre should be developed up to accepted international standards and the Cork unit should be established without delay.

VASCULAR SURGERY

6.12 We recommend that this specialty be organised on a regional basis with one centre each in Cork and Galway and two in Dublin.

One of the Dublin centres will be located on the North side of the city and the other on the South. We are satisfied that the size of the population in the Eastern region makes it necessary to provide two centres to give an adequate service.

6.13 In order to provide an efficient and safe service, we consider it necessary that a surgeon be engaged at least half-time on this particular specialty. We feel that the Cork and Galway Regional centres should, initially, be able to produce sufficient work to engage one consultant surgeon on this basis.

6.14 Each centre will require to be adequately staffed at the registrar level and to have the help of a cardio-vascular physician, a radiologist, a haematologist and suitably trained technicians.

THORACIC SURGERY AND MEDICINE

6.15 As there is a close link between this specialty and cardiac surgery we recommend that facilities for both should be continued in the Regional Centres.

6.16 We suggest that there is adequate justification for the retention of chest surgery in the Regional Hospitals in Dublin, Cork and Galway, primarily because of its central importance in relation to the development of other branches of specialised medicine and surgery, but also because of the increasing number of chest injuries arriving at our hospitals due to road traffic accidents. We recommend, however, that lung surgery ceases to be performed at Ardkeen Hospital, Waterford.

6.17 We recommend that each Regional Hospital should have a respiratory service which should be staffed by a physician and a surgeon with experience in thoracic work. Respiratory function assessment facilities must also be provided.

CARDIAC MEDICINE AND SURGERY

6.18 For open heart surgery a centre would require to have a certain minimum of cases if standards are to be maintained. We consider that in order to function at optimum level a major unit would need to cater for at least 6-8 cases per week and such closed cardiac cases as are likely to need attention.

6.19 We consider that such a unit should be staffed by four surgeons, at least one of whom should be full-time in this specialty. The medical staffing should be of the order of three cardiologists, one of whom would be wholetime. The advice of a haematologist should be readily available, together with that of a radiologist having the necessary equipment. A unit of 50 to 60 beds, covering both medical and surgical aspects, would be appropriate.

6.20 While we recognise the fact that a special problem exists in

relation to heart conditions in the very young, we consider it desirable that all open heart cases, including children, be dealt with in the same unit. A separate unit for children, although partially justified on the grounds of special medical nursing and special equipment, is considered inadvisable. Having regard to the accommodation now available, we recommend that a children's section (to deal with the problems of the very young, i.e. under four years of age) of the major unit in Dublin continue to operate in Our Lady's Hospital, Crumlin on the understanding that there must be a common staff covering both. As building becomes available, both these sections must be combined in the one hospital.

6.21 We recommend that the major cardiac unit be developed at the North Dublin Regional complex. Further open heart units might later be developed at the Regional Hospitals in South Dublin, in Cork and in Galway, if the major unit is working to full capacity and the population demands of the other regions clearly indicate that additional units are needed.

6.22 As much of the equipment and staff of the above four specialties is complementary, we consider it very desirable that all four should be linked with each other in the same hospital or complex of hospitals. We appreciate that this may not be an immediately practicable proposition.

PLASTIC SURGERY AND FACIO-MAXILLARY SURGERY

6.23 Because of the close connection between these two specialties they are being considered jointly. We recommend that a major unit, incorporating both specialties, be developed in Dublin based on the existing unit there. As this unit is at present in Dr. Steevens' Hospital, it should be moved with other specialised units of the Federated Hospitals to the South Dublin Regional Hospital complex. Facio-maxillary surgery should conveniently be associated with the same regional area, as also the proposed Dublin Dental Hospital.

6.24 A plastic and facio-maxillary unit should also be set up in the Cork Regional Hospital. Because of the highly specialised nature of certain aspects of this work, we consider that the volume of work arising in the regions might not be sufficient to maintain expertise in the rarer conditions in both units, and that the number of these cases would only be sufficient to keep one team fully skilled in certain procedures, and we recommend that these should be dealt with in a single centre. Co-operation between units might be fostered by the Consultants Establishment Board.

NEPHRO-UROLOGY

6.25 We recommend that there should be one large adequately staffed centre for nephrology, dialysis and renal transplantation situated in the North Dublin Regional Centre, while the South Dublin Centre should be particularly developed in regard to the urological

aspects of this specialty. Nephro-urology, including haemo-dialysis, should be carried out in each region. We consider that renal transplantation should, for the present, be done in the main centre, but in the light of future developments it may be advisable to extend facilities for this work to the other regional centres. The regional dialysis facilities must, however, be part of an integrated service under the Consultants Establishment Board.

TRANSPLANTATION SURGERY

6.26 We consider that, in general, transplants will only develop in connection with the clinical specialty to which they are related. We are opposed to a special centre where all kinds of transplants would be done. In relation to the general problem of transplantation, we feel that further advances in this field will depend to a large extent on further developments in medical research. These developments must be closely integrated with clinical activity.

OBSTETRICS

6.27 There are special problems associated with obstetrics in Ireland. Our relatively late marrying age, particularly in rural areas, gives rise to the problems arising from the not infrequent obstetrical difficulties of the elderly mother of a first child. As sterilisation and therapeutic abortion are not practised here, and as contraception is considerably less common than elsewhere, there are many mothers of large families and these also are more at risk with regard to obstetrical complications. In addition, mothers suffering from serious constitutional diseases continue to have children and each succeeding pregnancy carries an increasing risk to the mother and the infant.

6.28 Our arrangements for specialist obstetrical cover are somewhat inadequate. Two-thirds of the country's obstetricians reside in Dublin with the result that in many areas outside Dublin consultant physicians may have to practise obstetrics also. Too many at risk patients are delivered outside maternity hospitals and without specialist care.

6.29 As less than 10 per cent of maternity patients are delivered in their own homes, we have based our estimate of maternity bed requirements on the assumption that the number of domiciliary confinements will become insignificant, and that nearly all confinements will take place in hospitals or district nursing homes. It is inevitable that the small private maternity home will ultimately disappear. On the other hand, there would appear to be a future for the large, well equipped, properly staffed and efficiently run private maternity unit.

6.30 Ideally, there should be obstetrical and gynaecological units in all the General and Regional Hospitals throughout the country and two obstetrician/gynaecologists should be appointed to each General Hospital of 300 beds. They would be in charge of a total of, approximately, 50 maternity and 25 gynaecological beds and would, in addi-

tion, hold antenatal and gynaecological clinics in nearby towns. All maternity patients utilising these clinics should be referred by general practitioners for screening. All abnormal, or potentially abnormal, cases could then be selected for delivery in the obstetrical units. The normal cases would be delivered under the care of their own family doctors in the local Community Health Centre or District Nursing Homes (present county and district hospitals). Consultant cover should be provided for these local centres and obstetrical "flying squads" should be available for the occasional emergencies.

PAEDIATRICS

6.31 A paediatric service should be provided in all Regional and General Hospitals. In considering the bed requirements of the regions we found that the relatively high proportion of children in the Irish population makes it difficult to make accurate comparisons with other countries where, in any event, there is a considerable variation in the ratio of beds provided. A further complicating factor is the difficulty of defining what exactly is included under the term "paediatrics".

6.32 We decided, in Chapter 5, that a ratio of 0.3 beds per 1,000 population should be adopted as a guide to the requirements of specialised medical paediatrics. Excluded from this ratio are:—

(i) Children admitted to hospital under the care of general surgeons and physicians.

(ii) Cases appropriate to E.N.T., eye, plastic and accident units.

(iii) Healthy neo-natal infants.

In addition to this specialised paediatric provision, there should be wards for children in every Regional and General Hospital.

ORTHOPAEDICS

6.33 The orthopaedic services are at present organised on a regional basis and are provided in special orthopaedic hospitals. We consider that this service should, in future, be integrated with the general hospitals. In order to avail of intensive care and to avoid duplication of facilities, high-risk orthopaedic surgery should be restricted to the Regional Hospitals and to some General Hospitals. This is because of their more comprehensive facilities for major surgery and because a patient may require the attention of physicians and other consultants as well as that of the orthopaedic surgeon. The existing orthopaedic hospitals should be used for routine orthopaedic surgery and as long-stay institutions for orthopaedic patients. They should be staffed at consultant level from the main hospital or hospitals of the region.

6.34 The staffing of an orthopaedic hospital should be based on the principle we have already laid down for consultant staffs generally,

namely, that it should be numerically sufficient to ensure a viable specialised unit. In determining this level of staffing it will be necessary to take into consideration the significant amount of travel required of orthopaedic consultants in the course of their duties. Some smaller General Hospitals would not require specialised orthopaedic units. These hospitals should have available to them the services of orthopaedic surgeons from the larger centres on an out-patient and hospital consultant service basis.

6.35 We realise that special cases will arise from time to time in which one orthopaedic surgeon may have a more specialised interest than another—indeed, we regard this as a development to be encouraged. To encourage this trend, the Consultants' Establishment Board should foster co-operation and close liaison between orthopaedic surgeons.

PARAPLEGIA

6.36 We consider that the present facilities are adequate. We recommend that the present major centre for this specialty in Our Lady of Lourdes Hospital, Dún Laoghaire, be continued, but we consider it very important that it should be integrated into the proposed regional hospital system and linked particularly with the South Dublin Regional centre.

ACCIDENT SERVICES

6.37 We consider that casualty services should be located in the Regional and General Hospitals and not in a separate special centre. Since many accident victims suffer a variety of soft tissue as well as bony injuries it is important that they be treated in the Regional and General Hospitals so that the full range of surgical and medical specialties is available. All these hospitals must have special arrangements on a round the clock basis, to ensure that emergency cases receive immediate attention.

REHABILITATION

6.38 Rehabilitation may be given to a patient on discharge from hospital when he is ambulatory or still needs domiciliary care. Where ambulatory, this can be undertaken at the out-patient department of the hospital provided facilities for this are available. For those needing domiciliary care the social services, including nurses, home helps, and social workers must be highly developed. Co-operation here with the voluntary organisations, should give great assistance. While it is not easy to estimate precisely how many patients may need rehabilitation, or to predict how much actual benefit may accrue, it might be advisable to have certain rehabilitation centres fully equipped and staffed in the country to promote the recovery and resettlement of patients.

OPHTHALMOLOGY

6.39 Ophthalmological work should be carried out in all Regional

and most General Hospitals. In considering the needs of this specialty cognisance was taken of the planned ratio in Scotland (0.06 beds per 1,000 population) and the recommendations in the Wright Report[1] for the North Eastern Region in Scotland (4 consultants and 5 supporting staff for a population of over 400,000). We also had regard to the fact that there are two categories of consultant in this specialty, namely specialised ophthalmic surgeons and general ophthalmologists.

6.40 We recommend that one of the major hospital groups in Dublin should have associated with it a main ophthalmic centre. Due to the increasing scope and complexity of the specialty it is necessary that individual ophthalmologists should have some branch in which they are specially interested and trained so that cases in such branches can be referred to them by their colleagues. This can be done better and more economically in one large centre. Another advantage in having one large centre is that it is easier to get specially trained staff, such as surgical registrars and nurses. Furthermore, post-graduate training and research need a large number of cases which, in a country of this size, can be better provided in one centre. Eye pathology, too, because of its highly specialised nature, can best be developed in one centre. We recommend that this ophthalmic centre be located in the South Dublin Regional Centre.

EAR, NOSE AND THROAT

6.41 We consider that this work should be carried out in all the regional centres and the General Hospitals. Expensive equipment for new techniques requiring complicated technical support may, however, need to be centralised. Cancer surgery of the head and neck should be closely associated with the specialty and with radiotherapy, chemotherapy and general surgery. This should be centralised in the South Dublin regional group. Oto-neurology, as associated with neurosurgery, should be concentrated in the North Dublin Centre.

6.42 As there is likely to be an expansion in the fields of audiometry and speech therapy there should be a training scheme for technicians. Facilities for speech therapy should be more readily available in all areas.

6.43 We consider it unnecessary to have ophthalmic and E.N.T. beds closely associated. Ophthalmic and E.N.T. units should, however, be closely associated with Regional and General Hospitals rather than in a separate hospital.

FEVER HOSPITAL SERVICES

6.44 **We recommend that Fever Hospitals cease to exist as separate entities.** Nowadays, owing to the considerably reduced incidence of notifiable infectious diseases and their more effective treatment and

[1]Medical Staffing Structure in Scottish Hospitals H.M.S.O. Edinburgh, 1964.

control, the maintenance of these institutions on an independent basis—except as emergency accommodation for major epidemic diseases—is no longer necessary nor desirable on medical or economic grounds. However, it will be absolutely—indeed increasingly—necessary to maintain an organisation of doctors experienced in treating infectious diseases, and nurses experienced in barrier nursing, for purposes such as those outlined in paragraph 6.45. These doctors and nurses should constitute the basic staff of an isolation unit which would be geographically and administratively integrated with a General or Regional Hospital. Such a unit should, preferably, be separated physically from the main building; but if not, it must be designed so that the transfer of airborne infection cannot occur. This may well pose a serious architectural and microbiological problem which must be solved before implementation of this suggestion (that it might be feasible to place these units under the main hospital roof) can be allowed.

6.45 The isolation unit should deal with the following types of case :

(1) Adults and children suffering from fevers necessitating isolation.

(2) Patients suffering from antibiotic resistant infections because they are a hazard to other hospital patients.

(3) Patients undergoing immuno-suppressive therapy, necessary for the treatment of certain malignant conditions and in the management of homotransplants, will necessitate the development of isolation units for this purpose in the hospitals where this work is carried out.

(4) Patients suffering from major burns.

These categories cannot be mixed in one area, but very many of the techniques involved are common to all, and it is, therefore, appropriate that they should be under the same medical supervision. Problems of the above nature are emerging as most important aspects of hospital planning. As there are many new considerations involved we suggest that they be considered promptly by a body of architectural and medical experts.

PSYCHIATRY

6.46 The present number of beds available for psychiatric patients throughout the country is generally considered excessive. The large number of mental hospital beds is due particularly to the fact that many senile patients are admitted to mental hospitals who should be accommodated elsewhere. Poor economic circumstances, lack of active therapy, including rehabilitation and physiotherapy, and inadequate community services tend to force the elderly into quite inappropriate institutions. This is a matter which had already been fully examined and documented by a special Commission[2] and some

[2]Report of the Commission of Enquiry on Mental Illness, 1966.

of these factors are already being corrected. Our terms of reference are essentially concerned with the organisation of general hospitals and full examination of the psychiatric services would be outside our scope.

6.47 It is, however, necessary to integrate the diagnosis and treatment of the mentally ill with general hospitals for a number of reasons. Psychiatric illness may have an organic background, and this is more easily diagnosed in the atmosphere of a general hospital where a wide choice of specialists is available. The admission to a general hospital, or investigation in its out-patient department, tends also to remove some of the inhibitions associated with mental disease and enables psychiatrists to remain physicians with wide interests, although having a special degree of skill in their specialty. It helps undergraduate teaching and therefore assists the recruitment of suitable junior staff. From the economic point of view, the highly specialised services of a general hospital should not be duplicated in a mental hospital, and this is apt to occur if the two are geographically separated, or if there is no common staff to both institutiions. The psychiatric training of general nurses is made possible and the standard of training for psychiatric nurses is improved by the wider experience. Finally, the close co-operation of both hospitals is essential for research. The advantages are not all one-sided: the psychiatrist is an essential member of the staff of a general hospital and with the increasing recognition of psychosomatic illness his influence is growing.

6.48 The recommendations which we put forward in the following paragraphs for the association of Regional and General Hospitals with psychiatric services are in accord with the recommendations contained in the report (Chap. IV, Sections 37-49) of the Commission of *Inquiry on Mental Illness.*

6.49 **We recommend that a psychiatric service for short-stay patients be provided in every General Hospital.** This will necessitate an adequate staff of social workers and day-room accommodation for recreation. Adequate out-patient services for the area should be organised and a suitable number of beds should be controlled by the psychiatric consultants. The latter staff would be based in the local mental hospital while holding an appointment in the General Hospital. In the Regional Hospitals, a unit maintained by one or more psychiatrists should be available. Furthermore, the same staff would be on the staff of the associated mental hospital, which should, if possible, be in the near vicinity of the general hospital, for the treatment of patients needing intermediate or long-stay care. The precise size of the mental hospitals is difficult to assess but they should be considerably smaller than existing institutions. The size would, however, be governed by the available accommodation elsewhere for the patients who, for economic reasons or because of senility, are unable to return home. The internal organisation of

any mental hospital for the provision of rehabilitation and other forms of therapy would be assisted by the establishment of close association with the departments of physical medicine and social medicine of the acute general hospital and its related intermediate stay unit.

GERIATRIC SERVICES

6.50 Old people are especially illness and accident prone and, as they form an increasing proportion of our population, **it is urgently necessary that special provision should be made for their needs for hospital beds.** The large number of elderly patients unnecessarily and, perhaps, to their own detriment occupying beds in acute care hospitals for social reasons or because they are chronically infirm, emphasises the need to make more suitable arrangements for them. While there is some variation of opinion from country to country, in Scotland where the structure of the population is similar to our own it is accepted that 12 to 15 beds per 1,000 of the population over 65 years of age should be provided. If we accept the recommendations of the Royal College of Physicians, Edinburgh, 20 per cent of the geriatric beds provided should be allocated to assessment and rehabilitation and 80 per cent to long-stay wards. Experience in this country and elsewhere indicates that geriatric beds for females should exceed those for males in the proportion of at least 3 to 1.

6.51 Our bed requirements will need to be looked at further in the light of particular population features, such as the high number of unmarried persons, the number of elderly people living alone, and the considerable variation throughout the country of the proportion of the population in the elderly age groups. We are aware that there is an Interdepartmental Committee which is studying this question, and their findings should prove valuable in determining our particular requirements.

6.52 A major influence on our requirement of geriatric beds will be the extent to which social services for the old are developed. As far as possible, the infirm elderly person should be cared for in his own home rather than in an institution. If this is to be done to the fullest extent possible, it will be necessary to extend the domiciliary services and, particularly, to expand the public health nursing services. The wider application of boarding-out arrangements and the extension of a system of home helps and "meals on wheels" should also be considered as methods for easing the lot of the old person. An expansion in this direction of voluntary effort, both religious and lay, should be most rewarding.

6.53 **In the investigation and treatment of old people a full range of hospital facilities is necessary. For this reason geriatric assessment units should be included in all the Regional and General Hospitals and should be staffed and administered by physicians of consultant**

status who would be trained in geriatrics. All persons referred to long-stay units should be investigated initially in one of the above-mentioned hospitals, its assessment unit or out-patient department. No person should be admitted to long-stay units without the direction of a consultant from the acute hospital. If it is in the interests of a patient later to transfer him back to the acute hospital this should be made administratively easy.

6.54 The long-stay wards should provide accommodation for four times the number of patients catered for in the assessment and rehabilitation wards. It is not essential that long-stay wards should be situated in the main hospital, but they should be associated with it and remain under the general clinical supervision of the consultants attached to the assessment unit. The physical medicine department of the general hospital should be closely linked with the care given in the long-stay units.

6.55 In order to provide the maximum care for the elderly, while using the minimum number of acute care hospital beds, a domiciliary consultation service with the family doctor, an out-patient clinic and a day hospital service should form part of the organisation for geriatric care. However, it is inevitable that some patients, although ambulant, will require institutional care on a permanent basis, and residential homes will be needed for them as near their own locality as possible. Later sections of this Report contain recommendations regarding specific arrangements in various regions.

TUBERCULOSIS SERVICES

6.56 **Tuberculosis continues to be a public health as well as a clinical problem. We consider that a major effort must be sustained to eradicate the disease.** The present machinery for population screening and for examination of contacts and the follow-up of known cases, especially those known to harbour resistant organisms, should be maintained. The system whereby this is operated from special clinics by doctors primarily orientated towards the Public Health Service should be continued. Domiciliary chemotherapy can be supervised from these clinics. However, we regard it as essential that the clinics should be geographically transferred, as occasion offers, to general hospital premises, without changing the medical personnel, in order to bring the service into a clinical milieu.

6.57 The clinical management of the hospitalised tuberculous patient no longer requires a long period of specialist training. **Tuberculous patients can be cared for in separate wards of general hospitals and these beds might be provided for in new hospitals;** nevertheless, sanatorium beds must continue to be used in the interim. Elaborate hospital facilities are unnecessary and there is no advantage in centralising the hospital care of tuberculous patients. The present small county sanatoria should be continued until their bed occupancy

renders them completely uneconomic. At present there are beds in such small units in Ennis (46), Tralee (83), Dundalk (62), Limerick (34), Waterford (50)—total 275. Additional units of 100 beds in Cork and Galway should be ample for present needs and would give a good geographical spread for social reasons. The balance of beds for Dublin and the Midlands could be provided in Peamount where about 300 beds are available. It would appear to us that the bed needs of Dublin cannot, in fact, be greatly in excess of 100. The location of Peamount in relation to Dublin is not ideal, but this disadvantage is outweighed by the advantage of freeing James Connolly Memorial Hospital for other hospital needs. We see no reason why non-tuberculous chest cases should be treated in a sanatorium. These properly belong in general hospitals, thus reducing the diagnostic facilities required in sanatoria. The general bed requirements for Dublin will have to have regard to this change, but we consider that the least dislocation will be caused by using James Connolly Memorial Hospital for these cases.

Social Medicine

6.58 As the hospitals have an important role to play in community medicine we suggest that the University Departments of Social Medicine be closely associated with the Regional Hospitals. Where possible, the headquarters of the Medical Officer of Health should be situated in the Regional or General Hospital. These two bodies should be responsible for the organisation of the services provided by medical social workers.

Medical Social Workers

6.59 The medical social worker assists hospital patients in regard to their personal, environmental and social problems. Many hospital patients, in addition to their illness, suffer from personal and social stresses. In some instances these are caused by admission to hospital with its consequent separation from family and sometimes cessation of earnings; in others, admission aggravates a pre-existing situation. The medical social worker helps to ease these problems by the mobilisation of available social services and financial support for their dependants. In collaboration with the medical and other staff, and through liaison with relatives and voluntary and statutory organisations, the medical social worker facilitates discharge and arranges for any necessary after-care. In the case of elderly and disabled patients and those with special problems, this is a most important function. By maintaining contact with the socially vulnerable ex-patient, she can prevent unnecessary re-admission. Thus, as a result of her activities she contributes to the patients' welfare and at the same time helps to reduce the duration of stay in hospital. We consider that if hospital beds are to be used efficiently and to the best advantage of the community, medical social workers should be regarded as essential members of the staff.

6.60 Voluntary social workers have made a valuable contribution in

the past and should be even more encouraged in the future. Such duties as running a library service for patients, raising funds for patients' comforts, and visiting elderly patients who live alone are examples of useful social work which they can perform. We consider that the humanitarian role of the hospital will be enhanced by continuing to have associated with it the valuable contribution of the voluntary worker.

ANAESTHETICS

6.61 Anaesthesiology has grown in volume and complexity over the years and anaesthetists are now expected to be responsible for post-anaesthetic recovery rooms and to take a full part in intensive care. We are of the opinion that general anaesthesia is now the field of the expert anaesthetist.

6.62 We estimate that a 300-bed hospital would need three consultants in anaesthetics with supporting junior staff.

LABORATORY SERVICES

6.63 Modern medicine is increasingly dependent on laboratory services for the prevention, diagnosis and control of disease. Pathology laboratories play a central role in the hospital, family doctor, public health and forensic services. Present day acute hospital medicine demands the presence of an adequate laboratory service in each hospital under the direction of a medically qualified pathologist. As a general guide to the provision of consultants in pathology we consider that there should be one per 150 acute hospital beds. Thus, a General Hospital of about 300 beds would require two pathologists or a pathologist and a non-medically qualified biochemist of senior status. Where a hospital employs a single medically qualified pathologist, his training should be in histopathology or clinical pathology, i.e., a pathologist with competence in the four major disciplines.

6.64 The four major disciplines, namely histopathology, haematology, biochemistry and bacteriology, and some of their associated sub-disciplines, will be represented at regional level. Certain specialised aspects of neuropathology, eye-pathology and skin pathology will require centralisation. Certain others such as cervical cytology and virology will require representation at regional level as well as the development of central reference laboratories and a data processing service.

6.65 Laboratory services are at present under extreme strain due to the tendency of the work load to double every three to five years approximately. Specialised qualification in one branch of the discipline may make recruitment of individual pathologists to General Hospitals difficult. We consider that this difficulty of isolation may

be overcome by allowing consultants to hold weekly sessions at the regional centre. We consider that all laboratories will require some degree of mechanisation while the larger regional laboratories will require maximum automation.

6.66 There is an acute scarcity of laboratory technicians in the hospital laboratory services because the demand for laboratory investigations has outstripped the capacity of laboratories in spite of increased out-put by technicians. There is a continuous loss of trained personnel to industry, State services and Institutes. The intake has also been sharply limited by the recent introduction of a full-time one year course of instruction in Dublin. The recruitment is predominantly female and the loss due to marriage is making it difficult to fill senior posts throughout the country. All pathologists are agreed that the present shortage of trained technicians places the existing services in jeopardy. This will delay the expansion of services unless steps are taken to remedy it.

6.67 We recommend accordingly that steps should be taken to make the career of the laboratory technician more attractive. Recruitment of University graduates as hospital biochemists, following an appropriate period of training in a Regional Laboratory, should be encouraged. This demands the creation of a new career structure. We recommend that this urgent problem requires investigation by a special committee.

6.68 A major development has been the introduction of automation, particularly in chemical pathology and haematology, and the extension of automation into bacteriology, cytology and histology is foreseen in the near future. Automation will facilitate screening of the population. Economies may result from this. Automation will also assist in out-patient diagnosis.

6.69 The regional organisation of pathological laboratory services will, by providing all essential services at General Hospital level, backed by specialised services at the regional laboratory, give a better service. There will be a more equitable distribution of facilities and linkage of staff with a central laboratory will ensure the integrated operation of the service. A more satisfactory career and promotion structure will be secured. Local services at a level not now available will also be provided.

6.70 In the light of the foregoing considerations we recommend the following distribution of the pathology services. Every General Hospital should provide a general practitioner service, haematology (blood transfusion, marrows and routine), biochemistry (routine and emergency), histology (frozen section available), autopsies and a coroner service.

In addition, the following services should be provided at regional

level: haematology and immunopathology, biochemistry, microbiology (general, public health and virology), cytology and morbid anatomy.

In addition, certain aspects of the following services will be centralised at national level:

Blood transfusion services,
Blood coagulation defects reference centre,
Neuropathology,
Eye pathology,
Skin pathology,
Virology,
Immunopathology,
Forensic pathology,
Cytology centre and committee
Population screening for inborn errors of metabolism,
Enteric reference centre,
Central reference laboratory for histology and cancer,
Cytogenetics.

6.71 The following is considered to be a reasonable staffing structure. For General Hospitals it is based on a ratio of one consultant pathologist to 150 beds. Extra staff may be required for teaching purposes.

Regional Laboratory

Histopathologist (including cytology)	3
Haematologist	1
Bacteriologist (including virology and public health) ...	2
Biochemist	1

General Hospital (about 300 beds)

General pathologist	1
Biochemist	1

Pathologists in the General Hospitals should, where appropriate, have sessions at the Regional Hospital.

TOXICOLOGY

6.72 We consider that an adequate emergency service can be provided in any centre where there is a consultant biochemist. Regional analysts might, however, be encouraged to deal with the forensic aspects of toxicology. A clinical pharmacologist attached to each Regional Hospital would serve useful functions; for example, in regard to quality control of drugs, advice re possible toxic reactions and also in the construction of clinical trials. Advice should be

sought from those interested such as university teachers of pharmacology and the recently appointed National Drugs Advisory Board.

FORENSIC PATHOLOGY

6.73 Some regional development of forensic pathology appears desirable and would need co-operation in development between the Departments of Justice and Health.

BLOOD TRANSFUSION

6.74 We consider that the centralised blood transfusion services should continue as at present but that they should be integrated into the general administrative system of the regional organisation.

DIAGNOSTIC RADIOLOGY

6.75 Each Regional Hospital complex should have as complete a diagnostic service as required for its general and specialised needs. Every General Hospital must have a routine diagnostic service with at least two radiologists. Where an unduly large amount of travelling is involved an additional radiologist may be required.

6.76 We wish to draw attention to a number of important problems which exist in the radiological service. These are :

(i) The need for adequate equipment

(ii) The need for adequate space

(iii) Expansion taking place in the field of radiology has highlighted the shortage of radiographers. In order to ensure that an adequate supply of radiographers will be available, the existing arrangements for their training should be reviewed. To make it more attractive as a career a better pay structure and better opportunities for promotion should be provided.

(iv) Adequate secretarial help should be available for radiologists.

RADIOTHERAPY

6.77 Radiotherapy units for the treatment of cancer are at present available in Dublin and Cork. Because of the increasing cost of equipment and the distribution of population it is probable that the major centre will remain in Dublin. It is unfortunate that the major centre at St. Luke's Hospital in Dublin is separated from a general hospital. Future plans should envisage the removal of this major centre to the South Dublin Regional Hospital Centre. Regional hospital centres in Cork and Galway should have smaller units. The Cork centre would serve the southern region while the Galway

centre would provide at least superficial therapy. Both would be associated with the Dublin centre and co-ordinated through the Consultants Establishment Board.

DIAGNOSTIC ISOTOPES AND NUCLEAR MEDICINE

6.78 Routine diagnostic isotope facilities should be made available at all Regional and General Hospital centres. These facilities should be under the general control of a single central unit of nuclear medicine. This central unit should be part of the South Dublin Regional Hospital centre and would carry out most isotopic therapy as well as some of the more highly specialised investigations. The acquisition of a reactor for routine supply and for the separation of short-life isotopes should be considered, not only from the point of view of research, but for reasons of economy. Nuclear medicine is a separate specialty from radiotherapy, but there are sound reasons for associating the major central unit of each with the same Regional Hospital.

CHAPTER SEVEN

FURTHER IMPORTANT CONSIDERATIONS

PRE-REGISTRATION MEDICAL STAFF

7.1 The pre-registration year is regarded by the Medical Registration Council and the General Medical Council of Great Britain as the last stage of the period of basic medical education. It is equally divided between medicine and surgery. At present such posts are recognised by the Medical Registration Council if it considers the facilities of the hospital to be adequate for the training of interns. Under existing legislation (the Medical Practitioners Acts) it is the responsibility of the Medical Registration Council to ensure that such posts provide adequate facilities. This contrasts with Great Britain where the responsibility lies with the individual medical schools. We suggest that these posts should be supervised more closely by the medical schools and the Registration Council. This supervision would help to ensure that adequate living accommodation is provided and married quarters made available. There should also be library facilities, teaching ward rounds, staff conferences and active laboratory services. Each intern should have no more than 30 beds under his care and preferably considerably less (e.g. 15), and the educational nature of the post should be fully understood and accepted by all concerned. A registrar must be available, so that the intern is not prematurely exposed to complete clinical responsibility.

HOUSE OFFICERS

7.2 These posts are normally held after completing the intern year and may be in general medicine, general surgery or certain specialties. The tenure is usually up to a period of three years. A doctor must at least have completed the intern year and two further years as house officer before being appointed a registrar.

REGISTRARS

7.3 This is both a service and a training post, and, in considering our registrar requirements, account must be taken not only of the service needs of the hospitals but also of the training needs for future hospital consultants. If a hospital is to attract registrars it must be large enough, and the work must be sufficiently varied to enable adequate registrar training to be developed. A select number of senior registrar posts should be filled through the Consultants Establishment Board by registrars who have had at least three years registrar experience, who have a higher degree, and who are regarded as being suitable candidates for possible future consultant appointments.

Senior registrar posts must be confined to a realistic number in

relation to the likelihood of further consultant appointment. Senior registrars, in order to avoid excessive numbers, must be appointed by the Consultants Establishment Board.

7.4 Registrars should be appointed on a regional basis. Arrangements must be made to allow the registrars to rotate through the various departments of medicine or surgery, as appropriate in the hospitals of the region.

POSTGRADUATE TRAINING

7.5 Postgraduate training in medicine, surgery, pathology, radiology and other similar branches will be greatly facilitated by the creation of larger hospital units throughout the country as proposed in this Report. Larger institutions with more staff can more readily provide registrars with broad experience and better opportunities for conferences and exchange of information. Many bodies granting specialist qualifications lay down increasingly stringent registrar training requirements including the provision that the training hospital must be of a certain minimal size, that it should possess adequate facilities in radiology and pathology and have an active medical library. Hospital authorities, including the Regional Hospital Board, must be fully alert in meeting the regulations which govern various training schemes, if we are to attract trainee medical staff of good quality.

STUDY LEAVE

7.6 We suggest a study leave allowance for registrars to be arranged through their hospital management committees. We consider that staffs in general should be encouraged in all hospitals to attend refresher courses, lectures and conferences. Travel abroad to specialist and international meetings by consultants should also be encouraged and supported.

RESEARCH

7.7 **Medical research is an essential part of modern hospital activity. Professional standards are improved if practised in the atmosphere of questioning self-criticism.** Furthermore the enthusiasm of a clinician in his daily routine is enlivened by the sense of excitement engendered by the pursuit of knowledge. Research is a vital factor in the education of junior staff. Research should not be looked upon as an intellectual luxury. Clinical research is vitally important for a dynamic health service : it prevents stagnation in the development of new ideas and ensures that patients are treated by methods which are up to international standards.

7.8 The term "clinical research" should, strictly speaking, be reserved for research in which a patient is personally involved. Not all research in hospitals can be termed clinical as the following classification indicates :—

(1) the social surveys of illness and their correlation with a wide variety of possible aetiological factors;

(2) the pursuit of the cause or treatment of disease by developing new techniques.

(3) the analysis of the results of a new procedure or drug;

(4) the analysis of the cost of particular treatments;

(5) the pursuit of fundamental questions by the co-operation of the patient.

The overall responsibility for the promotion of research lies with the Medical Research Council which at present controls a far too limited budget for its many requirements. The Council spends less than £30,000 per annum in clinical research—a sum which is totally inadequate. We must emphasise also that medical schools have a clear responsibility for promotion of the more fundamental or less immediately applicable research in teaching hospitals. This should involve the Department of Education, acting finally through the medical schools. In recent years an increasing amount of money for research has come from private sources and is collected by societies devoted to the study of particular diseases. This is a laudable public activity but it has the disadvantage that available funds are apt to fluctuate with economic changes and thus it inhibits the organisation of long-term research projects which require a greater degree of continuity of employment.

7.9 **The main responsibility of the various hospital authorities in the matter of research should be to ensure that adequate space is available for the development of research units in every major hospital.** Special laboratories are essential for most clinical research departments. These are often separate from the main central laboratory unit or separate even from the service laboratories, which high grade specialties such as gastroenterology, endocrinology, metabolism, etc. require for their routine function. In the modern teaching hospital each department should have access to a research laboratory unit including animal research facilities.

7.10 We are conscious of the ethical problems which are liable to arise in the organisation of some clinical research. It is, therefore, imperative that a hospital authority ensure that research is never detrimental to the welfare of the patient, is never performed without his knowledge and consent and should in some respect be capable of helping to improve medical practice.

MEDICAL RECORDS

7.11 Well-kept and competently serviced medical records form an integral and vital part of an efficient hospital system. While it is not within the scope of this body to make detailed proposals on this

subject, nevertheless we consider it to be of such importance that we make the following recommendations :

(i) **Each hospital must have a central records office adequately staffed and working to the best of its ability pending the development of a national system.**

(ii) The hospital record system throughout the country should be standardised.

(iii) It should be on the unitary system, i.e. all the data relating to a particular patient should be contained in a single file under one continuing number.

(iv) The basic documents should be designed in a form suitable for data-processing.

(v) Emphasis must be laid on the confidential nature of medical records and they must be so labelled. It is essential that staff dealing with such documents are informed—and constantly reminded—of this fact.

7.12 The development of a national system of hospital records will involve the use of computers. Subject to the advice of experts in this important matter, it would seem best to us to create a full-scale computer service which would retain all the data relating to hospital patients at a single national centre. The most important feature of this service would be the availability at short notice of the previous hospital records of every patient, irrespective of the hospital or hospitals involved. In addition, the standardisation of records and access to a computer would make available a great wealth of medical material for statistical use, for example in research, community health, hospital planning, drug usage and ambulance services. As we have been informed that the recording of clinical data demands a bigger computer than that necessary for the narrower field of statistical data manipulation, we realise that there may be a conflict of interest in the use of computers for these two purposes and we consider that this matter should be examined in greater detail by an appropriately qualified group.

7.13 In order to facilitate the setting up of an efficient and standardised records system in every hospital, expert advice should be available immediately to the hospitals. An advisory board of this nature should have a high component of clinicians experienced in hospital records. We consider that this matter is one of great urgency.

LIBRARY

7.14 An adequate library and reading room must be available in General and Regional Hospitals and will be essential if the statutory requirements for intern appointments are to be fulfilled. There should be a regular supply of books and journals.

MEDICAL ILLUSTRATION

7.15 The importance of medical illustration for teaching, research and record purposes should be recognised and all the main hospital centres should have an adequately staffed and equipped department to provide this service.

NURSES

7.16 **We are fortunate in the Republic in having excellent candidates for the nursing profession. This is by no means common throughout the world and we should encourage it by ensuring good conditions for the nurses, both in education, status, remuneration and representation.** Facilities for post-graduate training should be developed. Post-graduate training should encompass practical and theoretical aspects of nursing including administration. Nurses should be selected for post-graduate training on application for training in any of the courses of the curriculum by a selection committee. Successful candidates should derive an incremental salary benefit.

7.17 A wider range of promotion opportunities, modelled on the recommendations of the Salmon Report[1], should be provided for nurses.

7.18 All nursing posts, including and above the level of staff nurse, should be permanent and pensionable. Every effort should be made to achieve standard conditions of service and remuneration for all nurses in the hospital service. Certain nursing duties of a demanding nature, such as occur in operating theatres and intensive care units, should receive a bonus over and above the basic pay. The terms of remuneration should be determined by an independent tribunal.

7.19 Irish nurses returning from British hospitals to work in Ireland should receive credit for their cross-channel service in fixing their remuneration.

7.20 Nurse training schools should be associated with the Regional and General Hospitals by arrangement with An Bord Altranais.

7.21 A representative of the nurses of the region should be on each Regional Hospital Board.

PARAMEDICAL SERVICES

7.22 **The increasing importance of paramedical services must be recognised as a feature of modern hospital organisation.** Such services include radiographers, physiotherapists, laboratory technicians, medical social workers, dieticians, orthoptists, speech therapists, and technicians in electronic medicine e.g. electroencephalography and electro-cardiography. Each such service group may

[1]Report of the Committee on Senior Nursing Staff Structure, 1966 H.M.S.O.

itself already be governed by its own organisation in regard to standards of education and employment. In such cases it remains for the hospital authority to promote the environment necessary for education both for basic qualification and for continuing improvement of standards of work. However, in partially or incompletely organised groups, we feel that it may be necessary for the Department of Health to take the initiative in laying down the courses and standards.

PUBLIC RELATIONS AND COMMUNICATIONS

7.23 **We consider that hospital authorities generally have inadequate arrangements for dealing with the public from the public relations point of view.** The criticisms most frequently heard relate to the casualty and out-patient departments. Delay in dealing with patients in these departments is often unavoidable and we are unaware of any system which completely surmounts it, but a worried patient or anxious relative cannot be expected to be conscious of the problems involved. An explanation, a reassuring word, some indication that the patient is not being ignored or forgotten are simple but welcome gestures which, not infrequently due to stress of work, may be lacking. To remedy this situation it is not necessary to create an expensive public relations system. The appointment of a number of girls, specially selected for their sympathetic and understanding qualities, whose sole duties would be to receive patients and their relatives at the hospital, to explain delays and deal patiently with enquiries would, we feel, be a simple but valuable measure which the public and the profession would appreciate.

7.24 Every hospital should have sufficient telephone lines and telephonists to enable its normal business to be contracted without unreasonable delay. Telephonists should be given some training on attitudes to be adopted in dealing with the public. Internal communications should be such that personnel can be contacted quickly.

7.25 We consider that patients who have travelled long distances to out-patient clinics and others who may be delayed while awaiting investigation or treatment should, if they wish, be able to get a meal at the hospital. We are of course, conscious of the limited and overcrowded facilities in many of our present out-patient departments and we would recommend that the future planning of these departments should include provision for cafeterias.

CENTRALISED SERVICES

7.26 We consider that the centralised services provided by the Blood Transfusion Service Board, the Hospitals Joint Services Board, the National Drugs Advisory Board and the Mass Radiography Association should be brought into close association with the proposed regional authorities when they have been established. This would be facilitated by the appointment of representatives of the various Regional Boards to the Boards of these four bodies.

7.27 We consider that the concept of separating appropriate ancillary services from individual hospitals and basing them on central units should, in the interests of efficiency, continue to be applied with due regard for the provision of protective mechanisms to guard against emergency break-downs.

AMBULANCE SERVICE

7.28 **The concentration of active care hospital services into a small number of centres increases in importance of the ambulance service and makes it essential that it be brought to the highest level of efficiency.** As a first step, we recommend that the Minister for Health establish an Ambulance Board to advise him, and, eventually, the Regional Boards, on the various medical and technical aspects of organising and operating an ambulance service. The Board should include appropriate medical representation together with engineers and persons experienced in communications and the organisation of emergency services. The present *ad hoc* committee in charge of the training of ambulance personnel would appear to us to be a suitable body on which to base the initial Board.

7.29 The ambulance service should eventually be organised on a regional basis but close co-ordination between the various regions would be important. Each region should have an ambulance committee to keep the service in its area under review.

7.30 There should be an ambulance control centre in each Regional and General Hospital. This centre would be in communication by radio-telephone with its ambulance vehicles and with the ambulance stations in the periphery. Pending the development of the various Regional and General Hospitals envisaged by us, provision should be made for all hospitals dealing with emergency cases to be in radio-telephonic communication with the ambulances so that advance warning may be given when emergency cases are being brought in.

7.31 Responsibility for ensuring the effective operation of the ambulance staff and equipment from the medical aspect might be assigned to a surgeon or an anaesthetist at each hospital centre where there is an ambulance control. A full-time Ambulance Officer at each centre would have responsibility for the day-to-day operation of the service at the centre and its associated peripheral stations. He would also be concerned with the organisation of the routine transport of patients.

7.32 Expensive, highly-equipped ambulances should not be used for the routine transport of patients suffering from non-urgent conditions. Public transport should be used where feasible and the number of minibuses used by Regional Hospital Boards for this purpose might be increased.

7.33 It is essential that there should be medical supervision through the proposed Ambulance Board of the emergency ambulance services operated by the Dublin, Cork, Limerick and Dún Laoghaire Fire Brigades. These should be integrated with the regional ambulance service.

7.34 We note the valuable contribution which the emergency helicopter service has made since its introduction a few years ago. This service, like the road ambulance service, will increase in importance as the hospital system becomes more concentrated. A drawback in the helicopter service is that its use is restricted to the hours of daylight. Small aeroplanes should also be considered for ambulance use. We would also urge the Minister for Health to take up with the Department responsible the question of the reduction or withdrawal of the present high charge for the services of the helicopter.

7.35 Some private concerns have shown praiseworthy initiative in establishing commercial ambulance services which are equipped to deal with emergency work. The changes we envisage in the public ambulance services should recognise that these firms will continue to perform a useful role in this field.

PRIVATE BEDS

7.36 We consider that both the General and Regional Hospitals should have an adequate provision of beds for persons seeking private accommodation in order to ensure that the most scientific care will be available to all at the terms they desire. Where specialised units are concerned there should be an appropriate component of private beds. The more highly specialised the specialty, the greater the necessity to localise its private beds within the unit, for the greater safety of the patient. It would seem to us that this component of private beds in the above circumstances would be in the order of 15 per cent of the total beds of the unit.

SINGLE ROOM ACCOMMODATION FOR ELIGIBLE PATIENTS

7.37 All public ward accommodation should have approximately 10 per cent of their beds in single rooms for patients who, for various reasons, should desirably be accommodated apart from other patients.

CHAPTER EIGHT

THE WESTERN REGION

Extent of the Region

8.1 **This region is based on the medical teaching centre in Galway. We consider that it should consist of Counties Galway, Mayo, Roscommon, Donegal, Sligo, Leitrim (except part of South Leitrim which is convenient to Cavan), part of North-West Cavan and a section of North and West Clare.**

Population

8.2 The population of the region is approximately 500,000. Although the populations of Galway and of a number of the towns have shown recent increases, the population of the region as a whole is declining: in the inter-censal period 1961 to 1966 when the population of Ireland increased by 2.3 per cent the population of this region fell by about 4.3 per cent. We are conscious of governmental and voluntary efforts to check this trend, but in considering the long-term hospital requirements of the area one must have regard to current indications.

8.3 Another demographic feature of this region, which is relevant to any consideration of its hospital needs, is the age structure of the population. The demand for hospital services increases rapidly with advancing age so that for a population of fixed size the greater its proportion in the older groups the greater is the demand for hospital services. In the area comprising Connaught and Donegal persons aged 65 and over make up 14.4 per cent of the population. The corresponding percentage for Ireland as a whole is 11.2 and for Dublin City 8.6.[1]

Existing Hospital Provision

8.4 The following is the present provision in the region of hospital beds covered by our terms of reference.

	Beds
Regional Hospitals:	
Galway Regional General Hospital (teaching)	577
Western Regional Sanatorium, Merlin Park, Galway	683
County Hospitals:	
Letterkenny	108
Manorhamilton	89
Castlebar	193
Sligo	127
Roscommon	112

[1] *Census of Population of Ireland*, 1966. Volume II. Ages and Conjugal Conditions.

District Hospitals:

Donegal (County Donegal)	48
Dungloe (County Donegal)	36
Ballyshannon (County Donegal)	29
Carndonagh (County Donegal)	38
Lifford (County Donegal)	40
Mohill (County Leitrim)	32
Ballina (County Mayo)	90
Belmullet (County Mayo)	22
Swinford (County Mayo)	42
Boyle (County Roscommon)	31
Clifden (County Galway)	40

Voluntary Hospitals:

Portiuncula Hospital (Franciscan Sisters of the Divine Motherhood), Ballinasloe	204
Sheil Hospital (*Committee of Management*), Ballyshannon	50

Private Hospitals:

Calvary Private Hospital, Galway (Little Company of Mary)	65
Bon Secours Home (Bon Secours Sisters), Tuam	75

Fever Hospitals:

Galway	42
Swinford	15
Roscommon	12

OUTLINE PLAN

8.5 In accordance with the general principles which we have already enunciated, we consider that the structure of the hospital organisation for this region should comprise a Regional Hospital containing community beds of a general nature for its surrounding area, together with specialised units serving the entire region; a small number of General Hospitals, each providing a general medical, surgical, obstetric and gynaecological service for its area; Community Health Centres and District Nursing Homes providing certain facilities and amenities on a local basis.

8.6 **Galway City with its University College, including a medical school, where there is already in existence a major hospital, is an obvious choice as Regional Hospital centre. We recommend that the associated General Hospitals should be located at Castlebar, Sligo and Letterkenny.**

GALWAY REGIONAL HOSPITAL

8.7 Galway has a large modern general hospital, the Galway Regional General Hospital, which is the main teaching hospital associated with the medical school of University College, Galway. There is a total of 577 beds in this hospital and, in addition, it has an associated fever unit with 42 beds. The hospital was built as a regional hospital for the Western counties but, because its staff and facilities have not been adequately developed, it has functioned largely as a local hospital for County Galway. The Western Regional Sanatorium, which is also a modern hospital, is at Merlin Park, about 3½ miles from the general hospital. The Sanatorium has a total of

683 beds but, with the considerable decline in recent years in the demand for tuberculosis beds, only 158 beds (including a vacant unit of 50 beds) are at present being used for this purpose. The remaining beds are used for orthopaedic cases (168 beds) non-tubercular chest conditions (116 beds) and geriatric patients (241 beds).

8.8 Steps have already been taken to amalgamate the Regional General Hospital and the Regional Sanatorium to form a major hospital group with a total of about 1,300 beds. We consider that the integration of these two hospitals should provide, without large-scale building, a hospital complex with sufficient accommodation to cater for all the specialties of the region, together with a large part of its community bed requirements. In order that a hospital organisation of this size may function with maximum efficiency the standard of the supporting facilities, such as operating theatres, laboratories, out-patients and radiological departments should match that of the accommodation for patients. It will be a matter for detailed planning to ensure that these facilities are available. In the long term it is envisaged that most of the acute medicine and surgery would be consolidated on the present Regional Hospital site. Provision must be made for site expansion in the future by land acquisition.

8.9 As in the case of the other regional centres, we consider that Galway Regional Hospital should contain, in addition to the more routine medical and surgical specialties, a number of major specialised units. In some specialties consultants from the Regional Hospital would do some of their work at the associated General Hospitals and thus avoid the necessity of bringing all their patients into the regional centre. We have recommended in Chapter Six the manner in which the various specialties might be distributed throughout the regions generally. In the following paragraphs we give our views as to the extent to which these specialties might be provided for at Galway Regional Hospital and its associated General Hospitals.

SPECIALISED SERVICES

8.10 **Neurological Medicine and Surgery.** This work would be confined to the Regional Hospital. Priority should be given to setting up a medical neurology service and the service should be developed as outlined in Chapter 6.

8.11 **Cardio-Thoracic and Vascular Surgery and Medicine.** This work would be confined to the Regional Hospital. The general increase in the level of diagnostic facilities in the region will undoubtedly lead to increased demands for cardio-thoracic and vascular surgery in the future. The development of a unit in this region is subject to the general considerations set out in Chapter 6.

8.12 **Plastic Surgery.** A regular visiting consultant service should

initially be provided. The development of a special unit in the Regional Hospital should be reviewed in the light of this experience.

8.13 **Nephro-Urology.** The consultant staff will consist of a urologist, and a nephrologist with supporting staff who will work in close co-operation, particularly in the maintenance of a haemodialysis service.

8.14 **Obstetrics and Gynaecology.** It will be necessary to increase the number of beds in Galway Regional complex. The balance of maternity beds necessary for the region would be provided in the General Hospitals, Community Health Centres and District Nursing Homes.

8.15 **Paediatrics.** We recommend increasing the staffing of the main centre in Galway, and we consider that it should include a unit for physically handicapped children and for speech therapy. An additional smaller unit in Sligo Hospital should be staffed by one paediatrician with support as needed from the Galway centre. Castlebar Hospital should have children's beds under the care of one of the general physicians and be visited by a paediatrician from Galway. A similar arrangement should be made for the paediatrician in Sligo to visit Letterkenny.

8.16 **Paediatric Surgery.** With an actively growing demand on the paediatric service in Galway Regional Hospital, and in the region generally, it is felt that there will be plenty of scope for a general surgeon who would spend a considerable part of his time in paediatric work in close collaboration with the paediatric unit of the Regional Hospital.

8.17 **Orthopaedics.** To meet the operative and out-patient needs of the Region, additional consultant staffing will be needed in the main unit in Galway. A smaller unit will be needed in Sligo, staffed by a consultant orthopaedic surgeon.

8.18 **Ophthalmology.** The specialist ophthalmic surgical staff requires to be increased in the main unit in Galway. An additional specialist ophthalmic surgeon will be needed to work in the unit in Sligo. In addition, there is a need for several general ophthalmologists in the Region.

Out-patient and consultative services will be provided at Castlebar and Letterkenny Hospitals.

8.19 **Ear, Nose and Throat.** The staffing of the main unit needs to be increased so as to allow for the development of specialised operative work, and the provision of an adequate consultant service on a visiting basis to the associated General Hospitals. A smaller unit should be located in Sligo Hospital, staffed by an additional con-

sultant associated with the Regional Hospital. Out-patient and consultative services will be provided at Castlebar and Letterkenny Hospitals.

8.20 **Social Medicine.** The university department of social medicine should establish a unit in the Regional Hospital.

8.21 **Geriatrics.** The provision of an adequate service on the lines laid down in Chapter 6 constitutes one of the main priorities in the Western Region.

8.22 **Psychiatry.** An acute psychiatric unit should be associated with the Regional Hospital complex.

8.23 **Infectious Diseases.** The existing fever hospital in Galway is a separate building in the grounds of the Regional Hospital. It has a total of 42 beds. We consider that the location of this unit makes it suitable for continuance as an isolation unit attached to the Regional Hospital. Responsibility for the unit should be given to the department of medicine at the Regional Hospital and a physician with a special interest in this work should be assigned to it as part of his duties. This 42-bed unit should meet in full the requirements of the region and the existing fever hospitals at Roscommon and Swinford should be closed.

8.24 **Dermatology.** A dermatologist providing a regional service should be based on a unit in the Regional Hospital.

8.25 **Pathology.** We consider that the main regional laboratory should be staffed as outlined in Paragraph 6.64. An extra pathologist may be required to provide a service at Letterkenny General Hospital.

8.26 **Radiology.** We recommend that the radiological services for the region be organised in the following manner :

Regional Hospital :	4 Consultant Radiologists. The specialised equipment necessary for neurological and vascular work and for radioisotope scanning should be provided.
Sligo General Hospital :	2 Radiologists.
Castlebar General Hospital :	2 Radiologists.
Letterkenny General Hospital :	1 Radiologist.

8.27 **Metabolism.** A metabolic unit should be developed which would have diagnostic isotope facilities.

8.28 **Routine Medical and Surgical Bed Requirements.** In addition to providing specialised services for the region as a whole, we con-

sider that the Regional Hospital should meet the routine medical and surgical bed needs of that part of the region comprising County Galway, South Roscommon and portion of North and West Clare. At present this area has, in addition to the Regional Hospital and the Regional Sanatorium, a 204-bed proprietary voluntary general hospital in Ballinasloe and a 112-bed County Hospital in Roscommon. The future role of these hospitals is considered in a subsequent paragraph. There are also two private hospitals in the region, viz. the Bon Secours Hospital, Tuam, and Calvary Hospital, Galway. There is also a 40-bed District Hospital in Clifden. We propose that, in common with other District Hospitals, this hospital should in the future be used as a District Nursing Home for its immediate surroundings.

CASTLEBAR GENERAL HOSPITAL

8.29 **We have chosen Castlebar as the General Hospital centre for Mayo in view of its central location in the county, the fact that it is the county town and because of its prospects for future development.** There is already a modern county hospital in the town. This hospital has recently been extended by the addition of a new maternity unit and now has a total of about 200 beds. We consider that this hospital should be developed further to the viable size already recommended for General Hospitals and be staffed as recommended.

8.30 There is a relatively large district hospital in Ballina. This is at present an active medical and maternity hospital. We consider, however, that with the development of a viable General Hospital in Castlebar, 24 miles away, it would be unnecessary and undesirable to continue the Ballina hospital in its present form. This hospital might be assigned the function of a District Nursing Home with a unit for routine maternity cases.

8.31 This area also has district hospitals in Swinford and Belmullet and we recommend that they become District Nursing Homes for their respective localities and be associated with the consultant service in Castlebar General Hospital.

SLIGO GENERAL HOSPITAL

8.32 **Sligo Town is centrally situated in relation to Counties Sligo, Leitrim and South Donegal, North-West Cavan and North Roscommon and is a suitable location for a General Hospital serving this area.** At present it has a county hospital with 127 beds providing a general medical, surgical, obstetric and gynaecological service. This is a modern hospital building and a major extension is at present being built on to it. This extension will increase the capacity of the hospital by about 100 beds. The extension includes the provision of specialised paediatric, ear, nose and throat, and ophthalmic units.

8.33 In determining the future requirements of the Sligo Hospital regard must be had to the Leitrim County Hospital which is located in Manorhamilton, 16 miles from Sligo. This is a modern hospital with 89 beds but, because of its location and the relatively small population served by it, it has never become a particularly active acute hospital. We consider that acute medical and surgical cases should be dealt with in Sligo only. The hospital at Manorhamilton might assume the character of a Community Health Centre.

8.34 We recommend that the Sligo Hospital should be further developed to attain viable size and to enable it to cater for the enlarged area which it is proposed it should serve. It should be staffed according to the principles already referred to in earlier paragraphs.

8.35 There is a 50-bed public voluntary hospital in Ballyshannon, the Sheil Hospital, which, as an interim arrangement and until the Sligo General Hospital is sufficiently developed to take over this role, will continue to provide an acute surgical service for South Donegal. Further consideration is given to the future of this hospital in a subsequent paragraph.

8.36 There are District Hospitals in Mohill (in South Leitrim) and in Boyle (in North Roscommon). These two hospitals are at present used largely for the care of chronic sick and geriatric patients and it appears likely that their future role will continue to be in this field. In South Donegal there are District Hospitals in Donegal Town and in Ballyshannon. While we accept the value of the service which has been provided in the past by these hospitals we are satisfied that small detached units such as these cannot continue to provide a satisfactory hospital service. The effort to improve the hospital service in this area should concentrate primarily on developing the General Hospital in Sligo. The location of Donegal Town in relation to its own immediate surroundings, and to the area west of it towards Killybegs and Glencolumbkille, justifies the retention there of a District Nursing Home. We consider that there should be peripherally based ambulances in this area.

LETTERKENNY GENERAL HOSPITAL

8.37 In considering the hospital needs of the western counties we concluded that, in view of its geographic features, the northern area of Donegal requires that special provision be made for it. The part of County Donegal which we have in mind is that north of a line roughly joining Barnesmore Gap in the south east of the county to Gweebarra Bridge on the west coast. This area has a population of about 80,000 and, in considering its needs, we took account of its remoteness, of its distance from the centres in Galway and Sligo and

of the difficulty of access to it during certain winter months. We are of opinion that these considerations warrant the provision of a General Hospital. It would appear to us that a hospital of about 200 beds should meet the needs of this area even though a hospital of this size would not be in keeping with the general principles recommended by us in Chapter 3.

8.38 Letterkenny is the principal town of the area and contains a newly-built County Hospital with 108 beds which provides a general medical, surgical, obstetric and gynaecological service for the area. **We consider that this hospital should be developed into a General Hospital staffed by two physicians, two surgeons and two obstetrician/gynaecologists.** Reference has been made in previous paragraphs to the specialist services which might be provided here.

8.39 The District Hospitals at Dungloe and Carndonagh provide a useful service for remote parts of the county and we consider that there is a special case for continuing their services as District Nursing Homes closely associated with the consultant service at Letterkenny General Hospital.

CHANGE IN ROLE OF CERTAIN HOSPITALS

8.40 Hospitals are at present functioning in Roscommon (County Hospital), in Ballinasloe (Portiuncula Hospital) and in Ballyshannon (Sheil Hospital). The re-organised service envisaged in this report, involving a more centralised hospital service with larger and fewer hospital centres, makes it impracticable in the long term to continue to use these hospitals for acute medical and surgical services. In the short-term, while the main centres are being developed to acceptable standards, the hospitals at Roscommon, Ballinasloe and Ballyshannon will continue, as at present, to provide a necessary service for their immediate surroundings. Close ties should be developed between these hospitals and the main centres. In the case of Portiuncula Hospital and Roscommon County Hospital these ties should be with the Regional Hospital in Galway while the Sheil Hospital should be linked to the General Hospital in Sligo. With the implementation of the programme aimed at having all acute work dealt with in these centres, a new role must be found for these three hospitals, one or more of which might become Community Health Centres. This might be determined in the light of experience by the Regional Hospital Board.

PRIORITIES

8.41 **We recommend that in the development of the hospital service in this area priority be given to the following matters:**

(i) The integration of the activities of the present Regional General Hospital and the Western Regional Sanatorium and the provision of additional accommodation at the

former hospital to include improved out-patient, operating theatre, radiological, laboratory and teaching facilities.

(ii) The extension of the present County Hospital at Castlebar to provide, in particular, extra operating theatres, improved geriatric, paediatric, radiological and pathological facilities.

(iii) The provision of improved pathological and radiological facilities at Sligo General Hospital.

(iv) The development of geriatric services in the region generally.

CHAPTER NINE

THE SOUTHERN REGION

Extent of the Region

9.1 **This region is based on the medical teaching centre in Cork. We consider it should consist of Counties Cork, Kerry, Limerick, Clare (except parts of North and West Clare), North Tipperary, most of South Tipperary and West Waterford.**

9.2 We gave consideration to the question whether Waterford City would be more appropriate to a region based on Cork or to one based on Dublin. We took into account the fact that Waterford is in the province of Munster and has its historic ties with that province. On the other hand, if a major hospital is to be developed in Waterford, its service area will extend north and east to large parts of Kilkenny, Wexford and South Carlow which, in most regards, are orientated towards Dublin. It is for that reason we consider it more appropriate to associate the Waterford City area with the Eastern Region rather than with Cork. We feel, however, that some association might be maintained between Waterford City and the Southern Region. This could be achieved by having a representative from the Southern Region on the management committee of the Waterford General Hospital and on the Eastern Regional Hospital Board.

Population

9.3 The population of the region is approximately 800,000. This represented a small increase (1.1 per cent) during the period 1961 to 1966 and it took place largely in County Cork and to a smaller extent in County Limerick. The population of Kerry declined by over 3,500 and in the remaining counties it stayed more or less static.

Existing Hospital Provision

9.4 The following hospitals now serve this area:—

Voluntary Public Hospitals:	*Beds*
Mercy (Cork City) (Sisters of Mercy)	200
North Charitable Infirmary (Cork City) (Teaching) (Committee of Management)	120
South Charitable Infirmary (Cork City) (Teaching) (Committee of Management)	134
Victoria (Cork City) (Governing Council)	74
Erinville Maternity (Cork City) (Governing Council)	72
Eye, Ear and Throat (Cork City) (Committee of Management)	59
Barrington's (Limerick City) (Committee of Management)	94
St. John's (Limerick City) (Committee of Management)	100
Valentia Village (Co. Kerry) (Committee of Management)	12
Cobh General (Co. Cork) (Sisters of Bon Secours)	35

Voluntary Private Hospitals:

St. Patrick's (Mount Alvernia) Mallow (Franciscan Sisters)	60
Bon Secours, Cork (Sisters of Bon Secours)	279
Bedford Row Maternity Hospital, Limerick (Governing Committee)	26
Bon Secours, Tralee (Sisters of Bon Secours)	83
Cahercalla, Ennis (Sisters of St. John of God)	45

Large health authority hospitals:

	Beds
St. Finbarr's, Cork, acute sections (Teaching)	368
Limerick Regional General (Teaching) (including paediatric unit in Foynes)	372
Limerick Regional Maternity (Teaching)	107

County Hospitals:

Bantry	128
Mallow	98
Tralee	190
Cashel	90
Clonmel	114
Nenagh	100
Ennis	116

District Hospitals:

	Beds
Ennistymon (County Clare)	24
Kilrush „	38
Raheen „	24
Bandon (County Cork)	23
Castletownbere (County Cork)	30
Clonakilty (County Cork)	46
Dunmanway „	24
Fermoy „	53
Kanturk „	49
Kinsale „	26
Macroom „	40
Midleton „	33
Millstreet „	25
Schull „	19
Skibbereen „	41
Youghal „	31
Cahirciveen (County Kerry)	37
Dingle (County Kerry)	44
Kenmare „	28
Killarney „	44
Listowel „	33
Roscrea (County Tipperary N.R.)	32
Thurles „	55
Carrick-on-Suir (County Tipperary S.R.)	23
Clogheen „	22
Tipperary „	55
Lismore (County Waterford)	19

Orthopaedic Hospitals:

	Beds
St. Mary's, Gurranebraher, Cork	192
St. Nessan's, Croom	120

Fever Hospitals:

	Beds
Killarney	34
St. Finbarr's, Cork, Fever Unit	80
Croom	29

T.B. Institutions:

	Beds
St. Stephen's Regional Sanatorium	494
St. Camillus Hospital Limerick (T.B. section only)	34
Edenvale Sanatorium, Ennis	46
Edenburn, Tralee	113

Military Hospital:

	Beds
Collins Barracks, Cork	105

9.5 This region, and particularly Cork City and County, is characterised by a relatively large number of hospitals and hospital beds. Much of the accommodation, however, is old and obsolete and altogether unsuitable for use as modern hospital premises. St. Finbarr's Hospital, Cork, the major local authority hospital in the region, is based on an old workhouse building and, although some new building has been added in recent years, the hospital is largely unsuitable for development into a Regional Hospital. In addition to the general and fever hospitals, St. Finbarr's has a county home section with about 550 beds.

9.6 The voluntary hospitals in Cork City, with the exception of the Mercy and Erinville Hospitals, are also old buildings on restricted sites. The Mercy Hospital is based on an old mansion but extensive new building has been added in recent years. Erinville is a relatively modern hospital. The Bon Secours private hospital is also a modern hospital building.

9.7 The region has a total of six County Hospitals (regarding the hospitals at Cashel and Clonmel as forming one complete County Hospital). These hospitals are largely in modern buildings but they suffer from the disadvantages inherent in small isolated units. There is a total of twenty-nine District and cottage hospitals in the region. Many of these, particularly the District Hospitals in Cork, are used mainly as homes for the care of chronic sick and geriatric patients.

9.8 In Limerick the Regional General Hospital and Regional Maternity Hospital are of recent construction. The two voluntary general hospitals in the city are in old buildings. There is also a small private maternity hospital in this city.

9.9 As in other regions, there is a clear need for rationalising and co-ordinating the services provided by the hospitals in these counties. This must eventually involve a drastic reduction in the large number of hospitals and the development of a Regional Hospital and associated General Hospitals in accordance with the general principles already recommended by us.

OUTLINE PLAN

9.10 **The hospital plan which we recommend for this region envisages a Regional Hospital in Cork City containing about one-third of the community bed requirements of Cork City and County, together with most of the main specialised units for the entire Southern Region. There will be need, in addition, for a separate General Hospital in Cork City. This hospital might be based on the federated voluntary hospitals in Cork and might contain two-thirds of the community beds and some of the specialised units. It should be closely associated with the Regional Hospital. There should be a large General Hospital with some specialist services in Limerick and a General Hospital of viable size in Tralee. The services provided by**

these hospitals should be supplemented by a number of Community Health Centres and District Nursing Homes. The Regional and General Hospitals in Cork and the General Hospital in Limerick should all be full teaching hospitals attached to the Cork Medical School.

CORK CITY HOSPITALS

9.11 Cork is the country's second largest city and a medical teaching centre, and it is an obvious choice as a Regional Hospital centre. At present, the general hospital services of the city are provided by one local authority, four voluntary and one private hospital, together with a voluntary maternity hospital, a voluntary eye, ear and throat hospital and a local authority orthopaedic hospital. The need to have a large modern general hospital in Cork City has long been accepted, but, largely due to difficulties in financing it, a project for the provision of a new Regional Hospital has been postponed on a number of occasions. Two years ago the Minister for Health established a statutory body, the Cork Hospital Board, to undertake the planning of the hospital on a site which had already been acquired at Wilton and planning has since been proceeding. We have no doubt about the urgent need for this hospital as a medical and as a teaching centre and we consider that steps should be taken to ensure that the project is completed as soon as possible.

9.12 The six voluntary public hospitals, with a total of 659 beds, have recently federated and we consider that this federated group should provide the basis of a General Hospital in Cork.

9.13 The hospital beds in the city will serve the community needs of a population of something less than 400,000 (Cork City, Cork County, West Waterford and part of South Tipperary but excluding the Rathluirc area of County Cork), and, in addition, will provide the majority of the regional specialties for a population of about 800,000 in the Southern Region. A planning ratio of 2.7 beds per 1,000 population to cover general medicine, general surgery, obstetrics and gynaecology indicates that over 1,000 community beds are required. Based on the planning guides adopted in paragraph 5.12 and on the considerations relating to the specialised services described in Chapter 6, our recommendations for the various specialised services required for the region are set out in the following paragraphs.

SPECIALISED SERVICES

9.14 **Neurological Surgery and Medicine.** A unit should be provided at the Regional Hospital and staffed initially by a neurosurgeon and a neurologist together with adequate junior and ancillary staff.

9.15 **Vascular Surgery and Medicine.** A unit should be provided at the Regional Hospital.

9.16 **Cardio-Thoracic Surgery and Medicine.** We accept the need for having a unit at the Regional Hospital. The size of the unit and the type of work to be undertaken in it will depend on the volume of work arising in the area. The development of this service is subject to the general considerations set out in Chapter 6. There should be a respiratory assessment unit in the Hospital.

9.17 **Plastic Surgery.** A unit should be provided at the Regional Hospital. This unit should be closely associated with the cancer unit, the dental hospital, the facio-maxillary unit and the burns unit.

9.18 **Urology and Nephro-Urology.** A specialised urological unit staffed by at least two urologists and a nephrologist should be developed in Cork. The unit could have beds in both the Regional Hospital and the General Hospital but should be under unified staffing control. Urology should be carried out in both the Regional and General Hospitals. It is envisaged that nephrology, including haemodialysis, will be centred in the Regional Hospital, while the major part of the urological services will be done in the General Hospital.

9.19 **Obstetrics and Gynaecology.** The obstetrical and gynaecological bed provision for the Cork area presents a rather special problem. The obstetrical department at St. Finbarr's Hospital, built within the past 12 years, comprises 52 beds. The obstetrical unit at the Bon Secours Hospital has 59 beds with all modern facilities and has, in recent years, served as the obstetrical unit for many middle-class patients who would not normally use the Hospital for other than obstetrical services. It should, therefore, we feel, receive consideration in the planning of the obstetrical services in the area. When the obstetrical beds at the Bon Secours Hospital, together with those at the Community Health Centres and District Nursing Homes are allowed for, we estimated that 130 further beds are needed. We recommend that these be provided in the General Hospital complex and that they ultimately replace the present maternity unit in St. Finbarr's Hospital. At present 55 of these beds are already provided for in the Erinville Hospital. In the interim, there should be closer co-ordination between the obstetrical units in Erinville and St. Finbarr's Hospitals. We recommend that two-thirds of the gynaecological beds required should be in the General Hospital and one-third in the Regional Hospital. The University Department of Obstetrics and Gynaecology would be situated in the General Hospital. The consultant and registrar staffs should be common to both hospitals.

9.20 **Paediatrics.** At present, most of the paediatric beds in Cork are situated in the unit in St. Finbarr's Hospital. We recommend that the Regional Hospital should similarly contain the major proportion of the general paediatric beds of the area, as well as the beds which would be used for specialised regional paediatric work.

The General Hospital should have a smaller paediatric unit, but the service would be shared between the paediatricians who would be jointly appointed to both hospitals. The University paediatric department should, in due course, be in the Regional Hospital. The General Hospital in Limerick should have a paediatric unit while the Tralee General Hospital should have paediatric beds. A surgeon suitably trained should devote an appreciable part of his time to paediatric surgery.

9.21 **Orthopaedics.** This region has at present orthopaedic hospitals in Gurranebraher, Cork (192 beds) and Croom, Limerick (120). There is also a unit of 25 beds in Tralee County Hospital. The planning ratio of 0.33 beds per 1,000 population puts the total bed requirements of the region at 264. It would seem, therefore, that the capacity of the two existing orthopaedic hospitals is more than sufficient to meet the needs of the region.

9.22 In accordance with the general principles which we have set out in paragraphs 6.37 to 6.39, we recommend that the orthopaedic hospitals should be closely associated with the Regional and General Hospitals and that all orthopaedic surgery on high-risk patients should be done at these hospitals. For the present, and until the necessary facilities are available at the Regional and General Hospitals, it will be necessary to continue to a large extent the services now provided in the orthopaedic hospitals. As Croom Orthopaedic Hospital is 12 miles from Limerick, we consider that, as soon as possible, major orthopaedic surgery should be transferred to the General Hospital in Limerick and the hospital in Croom used for minor work and for long-stay orthopaedic patients. Operative orthopaedic work should not continue to be done other than at the specialised units.

9.23 We recommend that this region should have a total of five orthopaedic surgeons. Three of these should be in Cork, with beds initially in St. Mary's Hospital, Gurranebraher but attending both the Regional and General Hospitals.

9.24 **Accident Service.** Major accident work should be carried out in a single well developed and adequately staffed casualty unit in Cork. This should be based in either the Regional or General Hospital but we are making no specific recommendations in this regard.

9.25 **Ophthalmology.** The consultant staff of the region should consist of four specialised ophthalmic surgeons, three in Cork and one in Limerick. In addition, there would be several general ophthalmologists in the region.

9.26 **Ear, Nose and Throat.** We recommend that the major unit for this specialty in Cork should be in the General Hospital. There

should also be well staffed units in Limerick and Tralee. The Tralee unit should be closely associated with the unit in Cork.

9.27 **Geriatrics.** Geriatrics in the region should be developed along the principles set out in paragraphs 6.51 to 6.56. In the Cork area much of the geriatric accommodation is provided in units which are substandard. We suggest that these be replaced by using some of the units which will become available when our recommendations are implemented. This consideration also applies to the Kerry area.

9.28 **Infectious Diseases.** There is at present an 80-bed fever unit attached to St. Finbarr's Hospital in Cork. This unit should meet in full the requirements of the region and it should be possible to close existing fever hospitals at Killarney and Limerick. Ultimately, this unit should be replaced by isolation units attached to the Regional and General Hospitals. The principles on which these units should be established are set out in paragraphs 6.45 and 6.46.

9.29 **Dermatology.** Beds should be provided for this in both the Regional and General Hospitals. These would service the region and the consultant in charge would do out-patient sessions in Limerick and Tralee.

9.30 **Pathology.** We consider that a large single regional laboratory should be developed at the Regional Hospital to service the Cork Regional and General Hospitals and to undertake specialised work for the entire region. This laboratory might be staffed, at consultant level, by three histopathologists, two bacteriologists, one haematologist and one consulant biochemist. In addition, the laboratory at Limerick General Hospital might have a staff of three general pathologists and one consultant biochemist. The laboratory at Tralee General Hospital might have one general pathologist and one biochemist. The pathologist in Tralee General Hospital should have sessions in the Regional Laboratory in Cork.

9.31 **Radiology.** The main radiological department of the Regional Hospital should provide a complete diagnostic service, including scanning. The service should include an isotope unit and facilities for neuro-radiology. The radiologists in Cork should, as early as possible, combine to provide an integrated service. They should have access to the main radiological department. We consider that there will be need for at least seven radiologists in Cork and for four in Limerick. There should be two radiologists attached to the Tralee General Hospital and a routine radiological service should be available there.

9.32 **Nuclear Medicine.** It is intended to transfer the present radiotherapy unit at St. Agatha's and the associated beds at St. Finbarr's Hospital to the Regional Hospital Site. This should provide a radiotherapy service for the region. Isotope and planning facilities should be in the Regional Hospital. Routine isotope facilities should be available at each of the General Hospitals.

9.33 **Metabolic Unit.** A unit should be established in the Regional Hospital. A complementary unit could be established in the General Hospital in Cork if required. It would share fully the laboratory and isotope facilities available at the Regional Hospital.

9.34 **Dentistry.** It has already been decided to build a Cork Dental Hospital and School on the Regional Hospital site. Beds for oral services should be made available in the Regional Hospital.

OUTPATIENT SERVICES

9.35 In Cork City these should be provided at the Regional and General Hospitals. Should both of these be developed at the Regional Hospital site, facilities should be shared. If the General Hospital is developed elsewhere a separate outpatient department would be needed for it. Full outpatient facilities should be developed at the General Hospitals in Limerick and Tralee. In addition, a range of outpatient services would be available at the various Community Health Centres in the region.

ORGANISATION OF BED REQUIREMENTS OF THE CORK CITY HOSPITALS

9.36 The resultant total bed requirements of the Cork area, based on the foregoing recommendations, may be summarised as follows :—

Community Beds (general medicine, general surgery, obstetrics and gynaecology).	1,080
Regional Specialties (E.N.T., ophthalmology, paediatrics and urology).	265
Orthopaedics and Infectious Diseases (as at present available).	272
Highly Specialised Units (neurosurgery, plastic surgery, vascular surgery, etc.).	The actual numbers will be determined in the light of experience but we estimate the total figure at roughly 130 beds.

Omitting the orthopaedic and fever units, which will continue in their existing premises for some time, and allowing for the Bon Secours private hospital which we assume will also continue, the balance of the bed requirement is of the order of 1,200. These beds will be provided from two sources, the new Cork Regional Hospital, and a General Hospital to be based on the six voluntary public hospitals. We consider that the new Regional Hospital should contain many of the specialised units, as detailed in the preceding paragraphs, together with about one-third of the community bed requirements of the area. It will also require an acute psychiatric unit and geriatric assessment unit. We consider that doubt about the size of individual units should not delay the planning of the new Regional Hospital which should be done on a flexible basis with provision for later extension, if necessary. We recommend that the General Hospital should contain the balance of the community bed requirements of the area. We also recommend that the General Hospital should

contain (as the voluntary public hospitals do at present) most of the ophthalmology, E.N.T., obstetrics and gynaecology beds in the area, including the specialised work in these branches.

9.37 At present, some of the voluntary hospital beds are housed in modern buildings, while some are in much older buidings in poor structural repair. We recommend, therefore, that the building of the new General Hospital should commence as soon as the Regional Hospital has been completed. It would probably contain about 600 beds, but it should be possible to estimate more accurately its actual bed requirements when the Regional Hospital has been built. The advantages of building this Hospital on the Regional Hospital site are obvious, as it would provide the city with a single medical centre, and enable many services to be shared most efficiently and economically. These would include, in particular, an intensive care unit, outpatient facilities and operating theatres, while the specialised units in each hospital would be readily available to both. If, however, this was not feasible, the alternative we recommend is that the General Hospital be developed on the Mercy Hospital site.

General Recommendations Regarding Cork Hospitals

9.38 The new hospitals which we envisage for Cork will clearly take some years to plan and build. In the meantime, we consider that an approach towards improving the hospital situation in this area might be made along the following lines :

(a) Regional specialties should be developed in existing hospitals (e.g. St. Stephen's Hospital) and in temporary buildings. These specialties should be in existence and fully developed when the Regional Hospital is completed.

(b) If our recommendations are accepted, the appointments in these hospitals will eventually be governed by the administrative arrangements outlined in Chapter Four. In the meantime, steps should be taken to co-ordinate appointments of the staffs of both the present local authority and the six voluntary public hospitals. Consultations should take place immediately between the management authorities and medical staffs of both groups to see how this could be implemented. The urgency of these consultations is stressed.

(c) Certain specialties should be developed as a unified service, even though all their divisions may not be situated in the same hospital. We have in mind, particularly, histopathology, microbiology and virology, chemical pathology, haematology and radiology. This unification should result in opportunities for individual specialists to develop their interest in certain branches of the subject and should also result in considerable economy by avoiding duplication of expensive equipment.

(d) Although it is not strictly part of our terms of reference, we feel that it is worthwhile suggesting that the University department of social medicine be developed in the General Hospital. We say this because two-thirds of the community-type medicine and surgery, as well as one-third of the general paediatrics, would be carried out in this Hospital. Similarly, the University departments of obstetrics and gynaecology, of ophthalmology and otorhinolaryngology would, we think, best be situated in the General Hospital where most of the beds in these specialties will be located. The other clinical University departments would be in the Regional Hospital.

(e) All investigational facilities developed either in the Regional or General Hospitals in Cork should be available equally to the staffs of both Hospitals. The entire group would be under the control of the Southern Regional Hospital Board which would ensure that the services provided in both Hospitals supplemented each other, and that there was no unnecessary duplication. Similarly, the staffs of both hospitals should be so co-ordinated that every consultant should be available for consultations in either Hospital.

The Limerick Area

Limerick General Hospital

9.39 The area which we envisage should be served by the Limerick General Hospital consists of Limerick City and County, County Clare (except the part of North and West Clare in the Galway Region), Tipperary North Riding and Tipperary South Riding (except those parts which are more convenient to Cork and to Waterford). The southern part of Offaly, in the Roscrea district, would also seem appropriate to this area, as well as a small part of North Cork around Rathluirc. The area has a population of something over 300,000. About 800 general hospital beds are required for a population of this size.

9.40 **The general hospital service for this area, at present provided from a variety of hospitals, should have its central focus on a major General Hospital in Limerick City. We consider that this Hospital should be developed on the present Regional General Hospital site. It should provide a large part of the community bed requirements of the area, together with the specialised services as outlined in previous paragraphs.**

Voluntary Hospitals

9.41 The relationship of the voluntary and local authority hospitals in Limerick presents a special problem. It is clear that the concentration of acute work in Limerick will involve the expansion of existing facilities for diagnosis and treatment. In order to obtain a reliable estimate of these needs we consider that a careful study of

the present service is required. Immediate consultations might be undertaken between the authorities and staffs of the voluntary and local authority hospitals as to the possibility of integrating staffs and functions. If the voluntary hospitals are prepared to accept such integration their staffs should have the right to appropriate appointments at the Limerick General Hospital.

Tralee General Hospital

9.42 **We are of opinion that because of its area, population and geographical features County Kerry should have its own General Hospital.** We consider that Tralee, which is the county town, the largest town in Kerry, and the centre of the most populous part of the county, is the most suitable hospital centre. Taking into account the size of the population to be served and the fact that some maternity services will be provided in the District Nursing Homes, we consider that this hospital should be of viable size and staffed as defined in Chapter Three. The implementation of this recommendation will involve the building of an entirely new hospital in Tralee.

Change in the Role of Certain Hospitals

Mallow County Hospital

9.43 Mallow County Hospital is a 98-bed hospital in a modern building providing a general medical, surgical and maternity service and staffed at consultant level by one surgeon and one physician. This hospital is 23 miles from Cork and is serving an area from which access to Cork is easy. The area north of it, around Rathluirc, is convenient to Limerick. We recommend that the role of this hospital be changed to that of a Community Health Centre and that its acute hospital functions be transferred to Cork and Limerick hospital centres as appropriate.

Bantry County Hospital

9.44 The position of Bantry County Hospital is not easily resolved. This is a 128-bed modern hospital 56 miles from Cork City and serving the relatively isolated area of West Cork some of which may be up to 100 miles from Cork. The present area served by it has a resident population of the order of 40,000 and is a popular tourist centre during the summer. To leave it without a hospital would involve hospital patients and their visitors in journeys to and from Cork and it is open to the objection that medical risk might be involved for some emergency cases. On the other hand, it must be accepted that with the proposed re-organisation of the hospital services in a small number of highly developed hospital centres, small isolated hospital units, such as that in Bantry, will be limited in the scope and quality of their work and cannot hope to provide a service of the standard available in the major centres. We appreciate the difficulties and inconvenience which distances of this order involve, but we feel that the paramount consideration must be to ensure that

the best possible hospital service is available to all patients. We have considered at length the various factors involved in catering for the Bantry area and we are satisfied that the interests of the patients will be served best by transferring the acute-in-patient service from Bantry to Cork when the facilities there permit of this being done. There is a good road system connecting this area to Cork and that its development as a tourist area will tend to improve these roads in the future. A first-class ambulance service is necessary, however, and ambulances should be stationed in the area. This, together with certain local emergency facilities such as blood transfusion and resuscitation, can overcome most of the difficulties associated with distance from the hospital centre. The hospital at Bantry should continue in existence in the role of a Community Health Centre and full out-patient facilities should be provided there.

ENNIS COUNTY HOSPITAL

9.45 This is a 116-bed hospital in a modern building, staffed by a surgeon and a physician. As Ennis is only 23 miles from Limerick, we could not contemplate its development as an independent hospital centre. We are satisfied that the general hospital needs of this area can best be met from the major General Hospital in Limerick. We recommend accordingly that Ennis County Hospital should have its role changed to that of a Community Health Centre on the lines which we have outlined in paragraphs 3.38 to 3.40

TIPPERARY HOSPITALS

9.46 At present there are County Hospitals in Nenagh, Cashel and Clonmel. The hospital in Nenagh provides a general medical, surgical and maternity service for North Tipperary while the two hospitals in Cashel and Clonmel combine to provide a similar service for South Tipperary. Our recommendation is that the role of these three hospitals should be changed to that of Community Health Centres. We realise that this recommendation involves leaving County Tipperary without its own hospital service. It has been fundamental to our approach, however, that county boundaries have little or no relevance in the proper organisation of the hospital service and, in fact, many areas can more conveniently be served from centres in other counties. Nenagh is less than 25 miles from Limerick on a fast main road and we could not justify the development there of a hospital which would duplicate many of the services which will be available at Limerick General Hospital. Cashel is about 36 miles from Limerick while Clonmel is less than 30 miles from Waterford. We are satisfied that the areas now served by these hospitals can be fully catered for from the hospital centres in Cork, Limerick and Waterford. In spite of the absence of a hospital within the county no potential patient will be at a greater distance than 60 miles from a well equipped and staffed Regional or General Hospital (vide Map Three). There will, of course, be available locally the out-patient facilities provided by the consultant staffs of the main hospitals at the Community Health Centres.

DISTRICT HOSPITALS

9.47 There is a total of 27 District Hospitals in this region. These, together with the cottage hospitals in Cobh and Valentia, have a total of nearly 1,000 beds. They can be divided very broadly into two categories : those which are actively engaged in providing a general practitioner medical and maternity service and those which are used mainly as homes for the care and maintenance of chronic sick patients. We consider that these two categories which have developed over a number of years should form the basis of the future use of these hospitals : the more active District Hospitals should become District Nursing Homes on the general lines indicated in paragraphs 3.33 to 3.37. Some of the others can provide a useful adjunct to the geriatric service by catering in small units in their own locality for geriatric patients who need a minimum of medical attention, while some will become redundant. It will be a matter for the Regional Hospital Board to decide which category is the more appropriate for each hospital.

PRIORITIES

9.48 **We consider that, in the development of the hospital services in this region, priority should be accorded to the following :**

Buildings

1. **A new Regional Hospital in Cork.**
2. **Extra paediatric accommodation in Limerick General Hospital.**
3. **A new General Hospital in Tralee.**

Services

1. **The development of the regional specialties, neurosurgery, nephro-urology, and vascular surgery is an urgent necessity and should not await the building of the Regional Hospital, but rather should proceed forthwith.**

2. **The rationalisation of certain existing services (pathology, radiology, gynaecology, ophthalmology, and otorhinolaryngology) should be executed as soon as possible after consultation between the management authorities and staffs of the hospitals concerned.**

3. **Immediate consultations should take place between the proprietors and staffs of the voluntary and local authority hospitals with a view to ensuring that future appointments to both hospitals would follow a co-ordinated, rational plan based on the principles set out in previous recommendations in this report.**

CHAPTER TEN

THE EASTERN REGION

10.1 **We consider that the Eastern Region should consist of the whole of Leinster (except part of South Offaly which is more appropriate to the Southern Region), County Monaghan, County Cavan (except part of North-West Cavan which is included in the Galway Region), part of South Leitrim, East Waterford (including Waterford City) and South-East Tipperary. The reasons for including Waterford City and its surrounding area in this region are set out in Chapter 9.**

POPULATION

10.2 At the 1966 census this region had a population approaching 1,600,000, representing a substantial increase since the previous census in 1961. During that period the population of Leinster increased by 6.2 per cent, and although the greater part of this increase took place in Dublin, most of the Leinster counties also made their contribution. The only county which was significantly out of line with this trend was Longford where the population continued to decline sharply and has reached a new minimum population level for an Irish county of less than 29,000. Kilkenny and Laoighis also had small decreases in population during this period. The population of Cavan and Monaghan continued to fall, while that of Waterford City increased by some 5 per cent.

10.3 It would clearly be impossible at this stage to predict with confidence the net outcome in the years ahead of these varied elements in the demographic situation, but the expected developments in the Dublin area point to further substantial increases in the population of this area. If projections which have been made in relation to the population of Dublin and its surrounding areas materialise, the population of the whole region is likely to approach two millions within the next 20 years. While the programme of hospital development which is outlined in this chapter is based on existing population figures, the need for flexible planning to enable targets to be modified to adjust to changing circumstances must be kept in mind.

EXISTING HOSPITAL PROVISION

10.4 The following hospitals now serve this region :—

Voluntary Public Hospitals (Teaching)

Adelaide (Board of Management)	154
Charitable Infirmary, Jervis Street (Committee of Management)	245
Sir Patrick Dun's (Board of Governors)	168
Mater Misericordiae (Sisters of Mercy)	433
Meath (Committee of Management)	282
Mercer's (Board of Governors)	124
Royal City of Dublin (Board of Directors)	193

Voluntary Public Hospitals (Teaching)—Contd.

St. Laurence's (Board of Governors)	358
St. Vincent's (Irish Sisters of Charity)	240
Dr. Steevens' (Board of Governors)	203
St. Michael's, Dún Laoghaire (Sisters of Mercy)	136
Coombe Maternity Hospital (Board of Management)	265
National Maternity Hospital (Executive Committee of Governors)	227
Rotunda Maternity Hospital (Board of Governors)	208
Royal Victoria Eye and Ear (Board of Governors)	135
St. Anne's (Cancer) (Sisters of Charity of St. Vincent de Paul)	63
St. Joseph's, Temple Street (including St. Anthony's Auxiliary Hospital, Elm Park) (Irish Sisters of Charity)	231
National Children's, Harcourt Street (Committee of Management)	91
Our Lady's Hospital for Sick Children, Crumlin (Committee of Management)	320
St. Mary's, Cappagh (Irish Sisters of Charity)	220
Our Lady of Lourdes, Drogheda (Medical Missionaries of Mary)	245

Voluntary Public Hospitals (Non-Teaching)

Monkstown (Trustees and Committee)	34
Drumcondra (Committee of Management)	40
City of Dublin Skin and Cancer, Hume St. (Board of Management)	89
Our Lady of Lourdes, Dún Laoghaire (Sisters of Mercy) (The National Medical Rehabilitation Centre)	115
Teach Ultain (Board of Management)	93
St. Patrick's Infant Hospital (Irish Sisters of Charity)	100
Peamount Hospital (Women's National Health Association of Ireland)	417
Incorporated Orthopaedic Hospital, Clontarf (Board of Governors)	132
St. Mary's Auxiliary, Baldoyle (Irish Sisters of Charity)	115
County and City Infirmary, Waterford (Board of Governors)	66
Martin, Portlaw (Incorporated Company)	17
Drogheda Cottage (Committee of Management)	50
Meath County Infirmary, An Uaimh (Joint Committee of County Council and Governors)	43
Drogheda Memorial, Kildare (Trustees)	17
Waterford Maternity Hospital, Airmount (Medical Missionaries of Mary)	65
St. Joseph's Orthopaedic Hospital, Coole (Sisters of Charity of St. Vincent de Paul)	160

Voluntary Private Hospitals (Non-Teaching)

Bon Secours, Dublin (Bon Secours Sisters)	140
St. Vincent's Private Hospital (Irish Sisters of Charity)	115
Mount Carmel, Rathgar (Little Company of Mary)	120
Mater Misericordiae Private Hospital (Sisters of Mercy)	100
St. Joseph's, Edenmore, Raheny (Sisters of St. Joseph)	65

Local Authority Hospitals (Miscellaneous)

St. Kevin's, Dublin	1,286
James Connolly Memorial Hospital, Blanchardstown	524
St. Mary's, Phoenix Park	546
Orthopaedic Hospital, Kilkenny	90
Orthopaedic Hospital, Navan	82
Dundalk Sanatorium	62

Local Authority Hospitals (County Hospitals)

Cavan (Surgical)	70
Cavan (Medical)	84
Dundalk	132
Kilkenny	166
Longford	50
Loughlinstown	186
Monaghan	161
Mullingar	108
Naas	93
Navan	113
Portlaoise	124

Local Authoritiy Hospitals (County Hospitals)—Contd.

Tullamore	121
Ardkeen, Waterford	287
Wexford (Surgical)	107
Wexford (Medical) Enniscorthy	40

Local Authority Hospitals (District Hospitals)

Carlow (County Carlow)	61
Muinebeag „	33
Auxiliary Hospital (County Kilkenny)	36
Castlecomer „	30
Abbeyleix (County Laois)	42
Longford (County Longford)	34
Trim Maternity (County Meath)	18
Birr (County Offaly)	24
Edenderry (County Offaly)	21
Dungarvan (County Waterford)	36
Athlone (County Westmeath)	99
Gorey (County Wexford)	28
New Ross (County Wexford)	27
Baltinglass (County Wicklow)	42
Wicklow (County Wicklow)	28

Local Authority Hospitals (Fever Hospitals)

Cherry Orchard, Dublin	282
Clonskeagh, Dublin	149
New Ross	66

Military and Garda Hospitals

St. Bricin's, Dublin	171
Curragh	242
Leopardstown (British Ex-Servicemen)	131
Garda Hospital, Phoenix Park	18

State Controlled Hospital

St. Luke's (Cancer) Hospital	147

OUTLINE PLAN

10.5 **We propose that in Dublin there should be two major hospital groups representing the Regional Hospitals with at least 1,000 beds in each, one in the North side of the City and the other in the South side. Each of these major groups will have associated with it at least one General Hospital in Dublin (each containing 300 to 500 beds) as well as other General Hospitals in the region outside Dublin.**

10.6 **Outside Dublin we recommend that General Hospitals be established at Waterford, Tullamore, Cavan and Drogheda. The hospitals at Tullamore and Cavan should be of minimum viable size, each containing about 300 beds. The Waterford hospital, serving a larger population, would probably require at least 500 beds. When extension work now under way at Our Lady of Lourdes Hospital, Drogheda, has been completed the hospital will have a total of 333 beds. We estimate that this will be more than necessary to meet the needs of the area which the hospital will serve as a General Hospital.**

10.7 All the foregoing figures of bed requirements are broad estimates. The exact requirements of the two major hospital groups

and of the General Hospitals are subject to the general considerations mentioned by us in Chapter Five and can only be determined after a closer study of the various factors involved.

DUBLIN CITY HOSPITALS

10.8 Although no fixed dividing line has been drawn between North and South Dublin for the purposes of determining where patients should go, it is convenient to consider separately the services provided in the North City and those provided in the South City, i.e. North and South of the Liffey.

10.9 Each of the two major hospital groups will probably have at least 1,000 beds and should have the usual comprehensive range of medicine and surgery for a community service. In addition, the highly specialised and complex work for Dublin and its region should be concentrated in these centres together with certain national services. These two centres should ultimately include, either between them or separately, the specialties which are at present catered for in special hospitals, such as ophthalmology, E.N.T. and radiotherapy. In the meantime, the special hospitals should be integrated administratively into the main hospital groups by the Dublin Regional Hospital Board.

10.10 Each General Hospital will have a total of 300 to 500 beds and will provide a wide range of general medicine and surgery, together with related specialties. It should be closely associated with one of the major hospital groups and staffed at consultant level from that group. A consultant's time between his hospitals should not, however, be excessively fragmented. That is, only exceptionally should he have more than one major hospital interest, though certain sessions might be spent attending another hospital.

10.11 We accepted at an early stage in our deliberations that each of the two major hospital groups should be developed on a single site and we gave lengthy consideration to the various sites which might be suitable for this purpose and for the associated General Hospitals. The recommendations in the following paragraphs about the locations for these hospitals are made in the light of the information available to us and we do not exclude the possibility that they may need to be changed if planning considerations, such as the amount of land available for building purposes, show that it is necessary to do so.

LOCATION OF THE SOUTH DUBLIN HOSPITALS

10.12 The main general hospitals at present in this area are the Federated Dublin Voluntary Hospital group, St. Vincent's Hospital, St. Kevin's Hospital, St. Michael's, Dún Laoghaire, and St. Columcille's, Loughlinstown. There is also a private hospital in Rathgar (Mount Carmel) and a small voluntary hospital in Monkstown.

The Federated Group is comprised of seven hospitals—Adelaide, Sir Patrick Dun's, Meath, Mercer's, Royal City of Dublin, Baggot Street, Dr. Steevens' and the National Children's Hospital, Harcourt Street—with a total of about 1,200 beds. The Federated Hospitals' buildings are old and out of date and one of the principal reasons for the federation was their replacement by a single hospital, which would combine all the services at present provided in the individual hospitals. Planning of the new Federated Hospital has reached only the stage of preliminary investigation. A site at Ballyfermot, attached to Cherry Orchard Fever Hospital, has been under consideration. The new St. Vincent's Hospital is at present nearing completion on a site at Elm Park located between the important main roads leading from the city to Bray and Dun Laoghaire. It is close to the new buildings of University College, Dublin at Belfield. The hospital will contain 450 beds, an increase of over 200 on the present St. Vincent's. There are also on this site a number of other units under the control of the Irish Sisters of Charity, namely, St. Anthony's Rehabilitation Centre, St. Anthony's Auxiliary Children's Hospital, St. Joseph's Blind Asylum and Madonna Home. St. Kevin's Hospital has a total of 1,286 beds but almost 900 of these are used for geriatric patients.

10.13 **A site adjoining the new St. Vincent's Hospital at Elm Park must, we feel, be the first choice for the major hospital on the South side.** It has a number of important advantages. The new St. Vincent's Hospital will be the most modern general hospital in Dublin and it presents therefore a suitable nucleus around which a larger complex might be developed. Furthermore its location offers certain important advantages. It is close to the Science Department of University College, Dublin and is situated between two arterial roads. Another important consideration is that land is available for further building development.

10.14 We considered a number of possible locations for a General Hospital on the South side. We felt that there was much in favour of developing this hospital in association with Our Lady's Hospital for Sick Children in Crumlin because of its central location and because of the existence there of a large modern hospital. We understand, however, that the restricted nature of adjoining sites would make it impracticable to consider developing a General Hospital there. The site of St. Luke's Cancer Hospital in Rathgar was also considered, but while it has certain advantages it is not ideally located in relation to the population which it would serve. The site of Cherry Orchard Fever Hospital in Ballyfermot was also considered. There is an extensive area of land available; but the hospital on the site was specifically designed for fever isolation and would not be suitable as a nucleus for a general hospital.

10.15 The site which we considered to have most advantages was that of St. Kevin's Hospital. There is an extensive area of land

within this hospital site and many of the buildings are of modern construction and should enable a General Hospital to be developed without much new building. The hospital is conveniently situated in relation to the main southern arterial roads and it is also close to Crumlin Children's Hospital. **We recommend that a General Hospital of not more than 500 acute care beds be provided at the Rialto end of St. Kevin's Hospital.** Architectural advice will be necessary to see how this can best be done but we feel that it may be possible to provide the required accommodation by erecting a central building which would link up some of the existing buildings.

10.16 We visualise that it may become necessary at a future date to have a second Community Hospital in South Dublin.

10.17 St. Michael's Hospital, Dun Laoghaire and St. Columcille's Hospital, Loughlinstown should be associated with the major hospital group in South Dublin. The exact role of these hospitals will have to be determined later.

LOCATION OF THE NORTH DUBLIN HOSPITALS

10.18 The main general hospitals at present in this area are the Mater Misericordiae (433 beds), St. Laurence's (358 beds), and Jervis Street (245 beds) Hospitals. The Mater is a sound and well constructed building and major extensions have been added in recent years. Jervis Street and St. Laurence's Hospitals are old buildings and the latter, in particular, is in urgent need of replacement. The provision of a new St. Laurence's Hospital is one of the major projects visualised in the White Paper on the Health Services and their Further Development (1966) and a site for this purpose has been acquired in Cabra.

10.19 In considering the location of the major regional hospital group for North Dublin the possibilities which we had under consideration were:

(i) provision of the hospital on the Mater site by adding to the accommodation already there;

(ii) building a new hospital on the Cabra site;

(iii) building a new hospital on part of the land attached to St. Brendan's Mental Hospital, Grangegorman;

(iv) using the site and some of the buildings of the James Connolly Memorial Hospital in Blanchardstown;

(v) building a new hospital in some other part of Dublin with a high density of population or prospects for major expansion.

We are satisfied that, if it is possible, it would be preferable to use the existing Mater Hospital as a base on which the major regional

hospital group can be developed, rather than build a new hospital on another site and thus fragment the desired main hospital complex. As the Mater Hospital is in excellent condition, the development of this site would be the most economical solution and would avoid the considerable delays which can be expected in planning a completely new hospital. The Mater is centrally located in relation to arterial roads. Its proximity to Temple Street Children's Hospital would facilitate the association of that hospital with the group. We have enquired about the extent of the site which might be available at the Mater and adjoining it for new building and it appears that adequate land is available to increase the hospital complex up to 1,000 beds. We understand that part of the area between the Mater site and Dorset Street is becoming available for redevelopment and we strongly urge that this area be reserved for hospital purposes. In addition, the acquisition of some property in Leo Street would make it possible to provide an entrance to the Mater from Dorset Street.

10.20 **The Regional Sanatorium (James Connolly Memorial Hospital) at Blanchardstown provides a good basis for a General Hospital.** The main hospital building with its present surgical facilities could form the nucleus of this hospital and there is ample land available for further building. The General Hospital would ulimately, have up to 500 beds. We understand that the surrounding area is scheduled for major housing development in the near future. A further important advantage of using this hospital is that it is immediately suitable for limited use as a General Hospital while awaiting further development.

MANAGEMENT AND ADMINISTRATION OF THE PROPOSED DUBLIN HOSPITALS

10.21 **The hospitals which we recommend for South Dublin would involve bringing together St. Vincent's Hospital and the Federated Dublin Voluntary Hospitals.** The major regional hospital group on the Elm Park site would consist of the new St. Vincent's Hospital (both general beds and specialised units) together with a further new hospital which would represent some of the general beds and all the major specialised units of the present Federated Hospitals. The entire hospital group would be under the Eastern Regional Hospital Board but the day-to-day running of the St. Vincent's and Federated Hospitals on the Elm Park site would be controlled by their respective managements who would be responsible for the policies and practices to be followed by the hospital medical staff. A South Dublin medical centre co-ordinating committee representative of both managements would, however, aim to secure the highest degree of co-operation in the activities of the two hospitals. Central facilities, such as laboratory and x-ray services, should be shared and doctors from the two hospitals working in the same discipline should have their beds and equipment associated.

10.22 **We consider that the General Hospital to be sited at St.**

Kevin's Hospital should be developed by transferring to some of the existing buildings in that hospital the general services now provided in one or more of the Federated Hospitals. The buildings allocated for this purpose in St. Kevin's Hospital would come under the day-to-day management of the Federated Hospital authorities and the remaining units would continue under the management of the St. Kevin's Hospital authorities. We recommend that the acute surgical work of St. Kevin's Hospital and the surgical personnel associated with it be transferred to the surgical unit of the Federated Hospitals General Hospital. A joint committee representative of the management committees of both hospitals would be responsible for co-ordinating the services and developing the various units. The staff of the General Hospital should, in the first place, be provided from the existing staffs of St. Kevin's Hospital and the Federated Group. In the future the staffs of the hospitals at the Elm Park site and the General Hospital at St. Kevin's should have a permanent inter-relationship, being, as they are, part of one group. The Consultants Establishment Board should be asked to take cognisance of this association when making appointments. To facilitate the early transfer of some of the Federated Hospitals to the St. Kevin's site it is suggested that the Eastern Regional Hospital Board might consider taking over some of these hospitals for the geriatric care of persons who come from the immediate area in which the Hospitals are located. Such an arrangement would help to free for General Hospital purposes some of the accommodation now allocated to chronically infirm patients in St. Kevin's Hospital. It is possible that in the future some similar use might be negotiated for the present St. Vincent's Hospital on St. Stephen's Green.

10.23 **In North Dublin the major hospital group on the Mater site should contain general beds and specialised units of the present Mater, Jervis Street, and St. Laurence's Hospitals.** Temple Street Children's Hospital should be closely associated with this hospital group though retaining its present Managing Authority. The recommendations which we have made in paragraph 10.21 aimed at achieving the integration of the work of St. Vincent's and the Federated Hospitals apply equally to the grouping of hospitals on the Mater site. Thus, while we consider that there should be separate management committees representing the Mater, St. Laurence's, and Jervis Street authorities, we would envisage that the organisational and administrative arrangements generally would be orientated towards close co-operation by the North Dublin medical centre co-ordinating committee representative of the hospital interests involved.

10.24 **The development of a General Hospital at James Connolly Memorial Hospital, Blanchardstown should involve sections of the staffs of the Mater, Jervis Street and St. Laurence's Hospitals.** This is a development which, we feel, could take place immediately without any new building if the Dublin Health Authority and the voluntary hospital authorities concerned are prepared to accept the arrangement.

10.25 We are very conscious that the arrangements we have suggested in the above paragraphs, particularly those involving the formation of the two major hospital groups, and which are based on the principles outlined in Chapter Three, give rise to very complex issues. Important implications are involved not only for the hospital authorities concerned but for individual members of the staffs of these hospitals. Patience, goodwill and understanding will be necessary if these measures are to be effectively implemented. We do not, therefore, feel in a position to go beyond expressing broad recommendations as to the manner in which this should be done. The detailed aspects will need considerable discussion and negotiation. **If the Minister for Health accepts our suggestion, we consider that he should, as soon as possible, ask the hospital authorities involved to form committees representing the authorities and their staffs to examine and recommend how these desirable measures can be achieved.** We suggest that he request them to report to him within a stated period of time.

MAJOR SPECIALISED UNITS

10.26 Each of the Regional Hospital groups will provide a full range of specialist services, with the exception of those specialties which should more appropriately be concentrated, or largely concentrated, in one unit. We suggest that these particular specialties be allocated between the two hospital groups in the manner set out in the following paragraphs.

10.27 **Neurosurgery.** The main unit would be located in the North Centre. A subsidiary unit would be included in the South Centre but the consultant staffs should be common to both centres.

10.28 **Vascular Surgery.** There should be a full unit at each of the main Dublin Centres.

10.29 **Cardiac Surgery.** The main cardiac surgical unit would be associated with the North Centre.

10.30 **Urology.** Units would be required in both the North and South Centres. They should, as far as possible, complement each other.

10.31 **Plastic Surgery (including burns and maxillo-facial work).** This specialty would be included in the South Centre.

10.32 **Haemodialysis and Renal Transplantation.** This work would be initially associated with the North Centre.

10.33 **Hyperbaric Unit.** The work might initially be concentrated at the South Centre.

10.34 **Gastro-enterology.** Units would be required in both the north and south centres. They should as far as possible complement each other.

10.35 **Metabolic Unit.** There should be complementary units at both hospital centres.

10.36 **Special Maternity Cases.** We consider that facilities for maternity patients at risk of grave medical or surgical complications should be available at each of the main hospital groups.

10.37 **Orthopaedics.** A major orthopaedic centre should be developed at St. Mary's Orthopaedic Hospital, Cappagh to which the consultants from the Dublin North and South regional centres would have access. The consultant staff at Navan Orthopaedic Hospital would also be associated with this centre.

10.38 **Major Accidents.** Major accident work should be based upon the two main hospital groups. Separate accident hospitals should not be set up.

10.39 **Ophthalmology.** We consider that each of the two major hospital groups should have an adequate ophthalmic service. We also recommend that one of these groups should have associated with it a main ophthalmic centre. Due to the increasing scope and complexity of the specialty, it is necessary that individual ophthalmologists should have some branch in which they are specially interested and trained so that cases in such branches can be referred to them by their colleagues. This can be done better and more economically in one large centre. Another advantage in having one large centre is that it is easier to get specially trained staff, such as surgical registrars and nurses. Furthermore, post-graduate training and research need a large number of cases which, in a country of this size, can be better provided by one centre. Eye pathology, too, because of its highly specialised nature, can best be developed in one centre. We recommend that the main ophthalmological centre be developed on the South City site. The present ophthalmic service for children (e.g. that provided in Our Lady's Hospital for Sick Children, Crumlin) should be retained.

10.40 **Geriatric Accommodation.** The assessment units should be in the General or Regional Hospitals and the intermediate-stay beds should be in, or close to, the main hospital centres. Future building developments at these centres should provide for this. Existing accommodation at St. Kevin's, St. Mary's (Phoenix Park), Cherry Orchard Fever Hospital and some of the vacated Dublin voluntary hospitals can be considered for long-stay geriatrics. The length of stay in the intermediate-stay units should be limited and, within this time limit, patients should be discharged home or referred back to the acute hospital or to a long-stay unit as necessary.

10.41. **Existing Convalescent Homes.** We consider that the present homes such as those at Linden, Beaumont and Cheeverstown might be used for intermediate-stay patients requiring some degree of nursing care. They would also serve a useful purpose accommodating country patients undergoing investigation at the main hospital centres who do not need to occupy an expensive hospital bed.

10.42 **Fever Accommodation.** We have outlined earlier some general considerations relating to the isolation and treatment of cases of infection and we recommend the abolition of fever hospitals as separate entities. However, pending the provision of isolation units in the general hospitals, we recommend that Vergemount Hospital be used as an isolation unit associated with the major hospital group in Elm Park and that, for North Dublin, a similar isolation unit should be developed in Blanchardstown.

10.43 **Tuberculosis Accommodation.** We have dealt with the tuberculosis bed requirements of the Dublin area in Chapter 6.

10.44. **Laboratory Services.** We consider that the major laboratory services in North Dublin and in South Dublin should be centralised at the two Regional Hospital sites. We recommend that an initial step in the development of each of the two major hospital groups should be the provision of comprehensive pathology on each site, providing a service for all the hospitals forming part of or associated with that group.

10.45 **Cancer Radiotherapy.** This work would be associated with the South Centre.

10.46 **Nuclear Medicine.** The main unit would be associated with the South Centre.

10.47 **Dentistry.** There should be a dental hospital attached to the South Dublin Centre in close association with the plastic and facio-maxillary units.

Out-Patient Services

10.48 We consider that out-patient services to be conducted by the consultants from the main hospital centres in Dublin should be concentrated at these centres and at the General Hospitals. It may be necessary to make special arrangements for the transport of patients to the out-patient sessions at these centres.

Hospitals Outside Dublin

Waterford General Hospital

10.49 **We propose that the General Hospital centre for the South-East should be in Waterford.** There are no obvious boundaries to the

area involved but in considering its requirements the following areas might be included :—

(i) Waterford City and County, excluding West Waterford which has been allocated to the Cork Region;

(ii) County Wexford, with the exception of the northern part of the county from which the people may find it more convenient to go to Dublin;

(iii) County Kilkenny, although there may be a tendency for people in the north of the county to go to Dublin;

(iv) The South-East of Tipperary South Riding, including the towns of Clonmel and Carrick-on-Suir;

(v) the southern part of County Carlow.

10.50 At present the major general hospitals in this area are in Waterford (Ardkeen), Wexford (County Hospital) and Kilkenny (County Hospital). We were satisfied at all stages in our consideration of this area that it should be served by a single General Hospital located at one of these three centres. The selection of one centre at the expense of the other two posed a very difficult problem which we examined at considerable length.

10.51 The size of Waterford City and its prospects for future expansion give it a special claim for a hospital. At the 1966 census it had a population of 29,842 representing an increase of 5.4 per cent over the 1961 figure. The fact that it has been selected by the Government as a development centre suggests that its expansion will continue and perhaps accelerate. An argument against the location of the hospital in Waterford is that it is eccentric to the area which it would serve. While this is so, it is an argument that could be applied to most of our major towns and cities because they are situated on the coast. Ardkeen Hospital, which was built since the war as a sanatorium and is now being used as a general hospital, with a tuberculosis unit and a phychiatric unit, would form the basis of a General Hospital in Waterford.

10.52 Wexford, with over 83,000 people, is the most populous county in this area. It does not, however, have a single centre of population to compare with that in Waterford City. The county town, Wexford, has 11,500 inhabitants while the second-largest town, Enniscorthy, has a population about half this size. Geographically, Wexford town is inconveniently located for a General Hospital, particularly in relation to parts of Kilkenny and South Tipperary. Furthermore, any major hospital development in Wexford would require complete new building as the existing county hospital is old and unsuitable for further development.

10.53 Kilkenny is probably the most centrally situated of the three centres although its distance from Wexford town (50 miles) is a factor. Like Wexford, it has no single centre of population to compare with

Waterford, the population of Kilkenny City being about 10,000 with no indications of increase. There is a modern county hospital with 166 beds in Kilkenny. In addition, the regional orthopaedic hospital, a modern building with accommodation for 90 patients, is at Kilcreene, about one mile from Kilkenny.

10.54 Having carefully considered all these factors, we are satisfied that, on balance, Waterford is the most suitable location for a General Hospital for this area.

10.55 It is difficult to say precisely what population would be served by the Waterford Community Hospital but it is reasonably clear that it would be well over 200,000. A total of about 500 beds would be necessary to provide general medical, general surgical, obstetrical and gynaecological services for a population of this size. Further accommodation would be necessary to provide for the specialised units to which we have already made reference. Pathology and radiology departments, staffed to provide a full range of services, should be provided. Further accommodation, appropriately staffed, would be necessary for specialised units in E.N.T., ophthalmology and paediatrics. The main acute centre for orthopaedics should be situated in Waterford. Long-stay orthopaedic accommodation should continue to be provided in Kilkenny.

10.56 The development at Waterford of a hospital which would take over many of the functions of the existing county hospitals in Wexford and Kilkenny cannot readily be achieved and it is likely that it will take place over a number of years. In the meantime, the continued functioning of the hospitals in Wexford and Kilkenny will be necessary to meet local demands. It should be accepted, however, that any development or expansion of the service for the area should take place in Waterford only. A first step towards bringing the Wexford and Kilkenny hospitals into closer association with the parent hospital in Waterford could be taken by giving the consultant staff of the two county hospitals access to the Waterford General Hospital. We have already dealt generally with arrangements of this sort in Chapter Three.

10.57 There are two voluntary hospitals in Waterford city, the County and City Infirmary, a 66-bed general hospital, and Airmount Maternity Hospital which has 65 beds. We consider that at an early date these two hospitals should be brought into close association with the General Hospital at Ardkeen. All consultants will have the right to appropriate appointments at the General Hospital. As Ardkeen Hospital develops to the extent that it can take all the acute hospital work for Waterford, the County and City Infirmary might assume the role of a Community Health Centre.

FUTURE ROLE OF WEXFORD AND KILKENNY COUNTY HOSPITALS

10.58 When the General Hospital in Waterford has developed

sufficiently to take over the acute in-patient services now provided in Kilkenny and Wexford County Hospitals, these two hospitals will provide services as Community Health Centres in accordance with the general principles already outlined by us.

TULLAMORE GENERAL HOSPITAL

10.59 In the Central Midlands areas there are at present county hospitals in Portlaoise, Tullamore and Mullingar. All these hospitals are modern buildings, they are comparable in size and the towns in which they are located are also comparable in size. The three towns are situated on a line running roughly South to North: Tullamore is 20 miles north of Portlaoise while Mullingar is 22 miles north of Tullamore. In our consideration of this area it was clear to us that the development of General Hospitals in more than one of these centres would be difficult to justify. In considering the merits of the different centres we had regard to the impact of our selection on the areas to the north and to the south. If, for example, Portlaoise was to be developed as a General Hospital centre it would infringe on the area which one would expect might be served by Waterford General Hospital while Mullingar, if chosen for development, might be expected to draw patients from Cavan without adequately catering for the Cavan/Monaghan area. **The situation of Tullamore, roughly half-way between Mullingar and Portlaoise, reasonably close to both and centrally located in relation to the entire area now served by the three hospitals, gives it, we feel, a stronger claim for development as a main hospital centre.** Finally, there is the point that the alternative to choosing Tullamore as a hospital centre is to have hospitals at both Portlaoise and Mullingar and we are of opinion that the development of major hospitals in both these towns, relatively close to each other and within easy reach of Dublin, would not be justified. **Accordingly we recommend the selection of Tullamore as a centre for a General Hospital.**

10.60 The area to be served by the Tullamore General Hospital might cover roughly Counties Westmeath, Offaly and Laoighis, together with the southern half of Longford. The southern tip of Offaly is more convenient to Limerick while the northern section of Westmeath could be served from Cavan. This area has a population of about 150,000. The size of the hospital will have to be subject to further investigation but, in accordance with the principles already stated, it should desirably have about 300 beds with the addition of at least a paediatric unit. Other consultant services would be provided on a regional basis.

CAVAN GENERAL HOSPITAL

10.61 **Our choice of Cavan as a centre for a General Hospital springs from its central location in the north midlands area.** This area consists mainly of counties Cavan and Monaghan, together with sections of Leitrim, Longford, Westmeath and Meath. It has a

population approaching 150,000. At present there are county hospitals functioning in Cavan and Monaghan towns. The Cavan hospital is contained in two separate buildings; the surgical hospital is in an old county infirmary building in Cavan town, while the medical and maternity hospital is at Lisdarn, about a mile outside Cavan town, in a building which was erected in recent years as a tuberculosis sanatorium. It is probable that any future hospital development in Cavan would take place in Lisdarn as the surgical hospital building has come to the end of its useful life. This hospital should be constituted as outlined in paragraph 10.60.

10.62 There is a modern 161 bed hospital in Monaghan. We considered the arguments in favour of placing a General Hospital there but we are satisfied that the location of the town in relation to the area which it would serve is unsuitable for this purpose.

10.63 Our consideration of the present position in regard to hospital services in County Louth places us in a dilemma. Dundalk and Drogheda each have a newly-built hospital. In Dundalk there is a 132 bed county hospital and there is a 245 bed hospital of recent origin in Drogheda operated by the Medical Missionaries of Mary. A new wing is at present being added to the Drogheda hospital and when this is completed the hospital will have a total of 333 beds. Both hospitals are in large industrial towns—Dundalk has a population of 20,000 while Drogheda has 17,900—but on the other hand, the two towns are only 22 miles apart and Drogheda is less than 30 miles from Dublin. It would be contrary to the principles which guided us in our selection of centres for General Hospitals to countenance the development of two separate viable hospitals so close to each other and to Dublin.

10.64 **Our recommendation in regard to this area is that a General Hospital be based on Our Lady of Lourdes Hospital, Drogheda, and that the County Hospital at Dundalk assume the role of a Community Health Centre.** The area to be served by this General Hospital might include County Louth and parts of Counties Monaghan, Meath and Dublin comprising a population of the order of 100,000. The Hospital when extended to 333 beds will be a viable unit, if staffed to the requirements which we have suggested, and its accommodation should be more than necessary to serve the needs of the area. The County Hospital at Navan will no longer be necessary as a surgical unit. It will continue to be used as a Community Health Centre while the surgery will be transferred to the other hospitals of the region. The consultant staff must be suitably integrated into the proposed regional arrangements.

10.65 The consultant staff of the Lourdes Hospital, Drogheda must be expanded to bring it into line with the staffing standards already recommended by us if it is to be integrated into the regional hospital scheme. In this connection the consultants attached to the present

County Hospital at Dundalk should be taken on to the staff of the Drogheda Hospital.

ROLE OF THE DISTRICT HOSPITALS

10.66 The Eastern Region has a total of 15 District Hospitals containing in all, over 500 beds. Most of these hospitals have active medical and maternity units and we consider that, by continuing as District Nursing Homes on the lines indicated in Paragraphs 3.32 to 3.36 they will fill a valuable supplementary role in the hospital service.

PRIORITIES

10.67 **The most urgent priority in this region is the replacement of the present St. Laurence's and Dublin Federated Hospitals and the creation of the two major hospital centres recommended by us at the Mater Hospital and Elm Park sites. The first step towards achieving these developments should be the setting up, as a matter of urgency, of committees representing the authorities and staffs of the hospitals concerned to explore the manner in which our recommendations might quickly be implemented.**

10.68 **If the various hospital authorities concerned are prepared to be associated as envisaged by us the first step in creating the two Dublin hospital groups might be the centralisation on the two sides of the pathological services for the hospitals involved.**

10.69 **In view of the existing condition of the Surgical Hospital at Cavan the provision of new surgical accommodation at Lisdarn Hospital should be undertaken as soon as possible.**

We thank the Minister for Health for allowing us this opportunity to present our views, which we hope will be of help to him in his arduous task of rationalising the Irish Hospital Services.

We are indebted to the Secretary and the Chief Medical Officer of the Department of Health for the facilities which they so freely allowed us in the preparation of this document.

We wish also to acknowledge the superlative service and unfailing courtesy afforded to us by the Secretaries, Mr. J. A. Robins, B.A., B.Comm., D.P.A., Mr. S. Trant, B.A., A.I.S., and Mr. T. Ó Donnagáin during the past six months. It is fair to say that without their

assiduous help this Report would have taken very much longer to produce.

Patrick FitzGerald, Chairman.
Bryan G. Alton.
P. C. Bresnihan.
Dermot M. Collins.
H. E. Counihan.
W. G. Fegan.
Colm Galvin.
P. B. B. Gatenby.
William Kearney.
J. Kennedy.
W. A. L. MacGowan.
John Nash.
Seán O'Beirn.
J. St. L. O'Dea.
D. K. O'Donovan.
W. F. O'Dwyer.
Eoin O'Malley.
Denis J. O'Sullivan.

Joseph A. Robins, Secretary.

Shaun Trant, Assistant Secretary.

16th June, 1968.

APPENDIX A

HOSPITAL STATISTICS—YEAR ENDED 31st DECEMBER, 1966

PUBLIC VOLUNTARY HOSPITALS

GENERAL HOSPITALS

Name of Hospital	Total bed Complement	Average Number of beds occupied daily	Percentage Occupancy (Based on bed complement)	Average duration of stay (days)	Total Annual cost per occupied Bed
					£
DUBLIN:					
Adelaide	154	117·3	76·2	15·9	1,988·7
Jervis Street ..	245	185·5*	75·7	12·3	2,066·8
Dun's (Sir Patrick)	168	152·9	91·0	15·4	1,736·1
Mater	433	369	85·2	15·8	1,651·3
Meath	282	260	92·2	13·8	1,601·6
Mercer's ..	124	97·9	79·0	14·9	1,671·8
Royal City of Dublin ..	193	163	84·5	17·0	1,896·3
St. Laurence's ..	358	316·3	88·4	18·3	1,801·3
St. Vincent's ..	240	231·0	96·3	17·3	2,087·6
Dr. Steeven's ..	203	163·6	80·6	15·0	1,498·0
DUBLIN COUNTY:					
Monkstown ..	34	29·3	86·1	13·8	1,294·3
St. Michael's ..	136	119	87·5	13·5	1,460·8
CORK:					
Cobh General ..	35	37·7	107·7	47·0	350·9
Mercy	200	204·0	102·0	17·1	907·7
North Charitable Infirmary ..	120	113·4	94·5	16·7	1,350·1
South Charitable Infirmary ..	134	128·8	96·1	17·0	1,057·8
Victoria	74	61·2	82·7	13·9	1,351·7
LIMERICK:					
Barrington's ..	94	76·0	80·9	10·2	1,373·3
St. John's ..	100	86·0	86·0	10·3	959·2
GALWAY:					
Portiuncula, Ballinasloe ..	204	163·0	80·0	16·0	1,074·0
WATERFORD:					
County and City Infirmary ..	66	60·0	90·8	14·0	1,110·1
Martin	17	16	94·1	107·1	284·2
LOUTH:					
Drogheda Cottage	50	44	88·0	16·3	1,330·5
Our Lady of Lourdes, Drogheda ..	245	227·7	93·0	12·0	1,289·5
KILDARE:					
Drogheda Memorial	17	12·0	70·6	16·2	761·0
KERRY:					
Valentia Village ..	12	7·8	65·0	42·1	462·8
MEATH:					
Meath County Infirmary ..	43	39·0	90·7	40·0	496·8
DONEGAL:					
Shiel, Ballyshannon	50	30·7	61·3	14·7	1,034·1
TOTALS ..	4,031·0	3,512·1	87·1	15·1	

*A block of about 50 beds was not in use during this year because of Structural Works at the hospital.

PUBLIC VOLUNTARY HOSPITALS

SPECIAL HOSPITALS

Name of Hospital	Total bed Complement	Average Number of beds occupied daily	Percentage Occupancy (Based on bed complement)	Average duration of stay (days)	Total cost per occupied Bed
					£
MATERNITY:					
Coombe Lying-in	128	127·4	99·5	8·2	1,846·7
National Maternity	199	216·0	108·5	8·9	1,546·0
Rotunda	208	185·2	89·0	7·6	2,106·3
Erinville, Cork ..	72	75·9	92·6	8·9	1,252·2
Waterford Maternity ..	65	64·4	99·1	12·9	818·2
CHILDREN:					
National Childrens', Harcourt Street	91	86·1	94·6	14·3	1,883·6
Our Lady's Hospital for Sick Children	320	298·2	93·2	14·0	1,355·4
Teach Ultain ..	93	76·0	81·7	26·5	898·9
Temple Street ..	231	238·1	103·1	16·2	1,038·8
CANCER:					
St. Anne's ..	63	48·7	77·3	14·8	1,534·3
City of Dublin Skin and Cancer ..	89	73·4	82·5	26·3	1,265·6
St. Luke's ..	147	114·5	77·9	15·7	1,984·7
EYE AND EAR:					
Royal Victoria Eye and Ear ..	135	115·0	85·2	9·0	1,515·0
Eye, Ear and Throat, (Cork)	59	52·9	89·7	11·1	1,168·4
ORTHOPAEDIC:					
Incorporated Orthopaedic ..	132	83·0	62·9	100·8	613·9
St. Mary's, Cappagh	220	195·0	88·6	74·7	736·1
St. Mary's Auxiliary Baldoyle ..	115	119·9	104·3	134·0	538·8
Our Lady of Lourdes, Dun Laoghaire ..	115	108·0	93·9	52·6	1,742·9
St. Joseph's, Coole	160	114·6	71·6	231·1	394·8
TUBERCULOSIS:					
Peamount ..	347	230·0	30·7	138·1	886·2
OTHER INSTITUTIONS:					
Dublin Dental Hospital Board	—	—	—	—	—
Cork Dental ..	—	—	—	—	—
Beaumont Convalescent Home	92	72·5	78·8	37·4	386·4
Cheeverstown Convalescent Home	40	31·0	77·5	16·8	344·3
Linden Convalescent Home	154	121·3	78·8	30·1	403·9
Clifton Convalescent Home, Cork	35	27·0	77·1	22·4	348·3
St. Patrick's, Cork	76	97·0	127·6	349·6	557·1
St. Patrick's Infant	100	87·0	87·0	147·6	343·9
Our Lady's Hospice	206	196·8	95·5	183·2	634·3
Dublin Rheumatism Clinic	—	—	—	—	—
SPECIAL HOSPITALS	3,692	3,305·8	89·3	19·0	
GENERAL HOSPITALS	4,031	3,512·1	87·1	15·1	
GRAND TOTALS ..	7,723	6,817·9	88·2	16·8	

MAJOR LOCAL AUTHORITY HOSPITALS

	Bed Complement	Average daily Occupancy	Percentage Occupancy	Average duration of stay (days)	Average cost (1966/7) per Patient week	Average cost (1966/7) per Patient
					£	£
St. Kevin's Hospital, Dublin						
Medical	665	574·4	86·4	66·7		
Surgical	112	108·8	97·1	23·6		
Maternity ..	86	115·2	134·0	8·3		
Gynaecological ..	5	5·0	100·0	32·6		
Paediatric ..	50	47·8	95·6	21·8		
Geriatric ..	280	279·7	100·0	98·3		
Arthritic ..	26	27·4	105·4	58·4		
Genito-Urinary ..	51	49·6	97·3	37·3		
Total ..	1,275	1,207·9	94·8	35·5	15·3	77·9
James Connolly Memorial Hospital (non T.B. section)						
Surgical	32	24·7	77·2	28·5	*	*
St. Mary's Hospital, Dublin						
Medical	116	77·4	66·7	29·7	*	*
Galway Regional Hospital						
Medical	154	155·7	101·1	22·3		
Surgical	208	180·4	86·1	14·4		
Maternity ..	70	46·9	67·0	8·2		
E.N.T.	18	13·9	77·2	9·9		
Ophthalmic ..	18	20·5	113·9	15·3		
Paediatric ..	40	42·5	106 3	19·3		
Orthopaedic ..	14	16·6	118·6	12·1		
Cardiological ..	40	35·9	89·8	32·7		
Gynaecological ..	10	10·1	101·0	5·8		
Total ..	572	522·5	91·3	16·0	24·2	52·4
Merlin Park Hospital, Galway (non T.B. section)						
Cardiological	69	4·1	72·9	21·9		
Other non-T.B. chest		46·2		29·2		
Total ..	69	50·3	72·9	28·4	*	*
Limerick General Hospital						
Medical	123	108·9	88·5	10·4		
Surgical	124	101·9	82·2	10·0		
Gynaecological ..	13	11·3	86·8	4·9		
E.N.T.	23	15·1	65·7	6·1		
Ophthalmic ..	23	14·9	64·8	10·9		
Paediatric ..	30	36·7	122·3	10·2		
Total ..	336	288·8	86·0	9·5	24·8	33·7

MAJOR LOCAL AUTHORITY HOSPITALS

	Bed Complement	Average daily Occupancy	Percentage Occupancy	Average duration of stay (days)	Average cost (1966/7) per Patient week	Average cost (1966/7) per Patient
					£	£
LIMERICK MATERNITY HOSPITAL						
Maternity ..	68	59·7	87·8	7·7		
Paediatric ..	39	22·2	56·9	16·1		
TOTAL ..	107	81·9	76·4	9·0	31·0	39·8
ARDKEEN HOSPITAL, WATERFORD						
Medical	54	49·0	90·7	15·6		
Surgical	50	44·3	88·6	10·5		
Maternity ..	14	12·1	86·4	9·2		
E.N.T.	22	17·2	78·2	7·9		
Ophthalmic ..	16	10·3	64·4	9·3		
Orthopaedic ..	38	37·0	97·4	24·8		
TOTAL ..	194	169·9	87·5	12·6	*	*
ST. FINBARR'S HOSPITAL, CORK						
Medical	112	117·7	105·1	22·6		
Surgical	87	82·7	95·1	21·2		
Maternity ..	52	48·7	93·7	9·7		
Neo-natal ..	16	9·0	56·3	21·3		
Dermatology ..	23	16·5	71·7	24·0		
Cancer	20	16·7	83·5	59·9		
Orthopaedic ..	10	21·5	215·0	16·2		
Paediatric ..	52	46·6	89·6	28·0		
Gynaecology ..	6	3·3	55·0	10·4		
TOTAL ..	378	362·7	95·9	19·3	*	*
SARSFIELDSCOURT HOSPITAL, CORK (non-T.B. Section)						
Cardiological }	40	10·1	88·8	29·8		
Others }		25·4		25·4		
TOTAL ..	40	35·5	88·8	26·4	*	*

*Where the figures relate to a unit which forms part of a larger hospital complex separate cost figures for that unit are not available.

Hospital	Bed Complement				Average daily occupancy				Percentage Occupancy	Average duration of stay (days)				Average cost (1966/67) per	
	Med.	Surg.	Maty.	Children under 16	Med.	Surg.	Maty.	Children under 16		Med.	Surg.	Maty.	Children under 16	Patient Week	Patient
														£	£
Bantry	32	62	16	20	33·8	53·5	9·5	17·0	87·5	20·8	15·2	11·5	11·4	18·6	40·4
Cashel	10	63	6	11	1·6	48·3	4·0	5·3	65·8	8·7	11·2	10·1	8·4	30·2	46·3
Castlebar ..	56	75	24	22	48·5	68·0	17·1	18·5	90·0	9·6	9·7	6·5	4·9	24·0	28·3
Cavan	44	60	34	16	37·9	41·3	16·3	8·3	67·4	14·1	7·9	9·3	7·7	27·1	37·3
Clonmel	66	—	27	21	53·2	—	23·6	10·8	76·8	15·4	—	8·7	12·3	18·2	32·4
Dundalk	46	58	11	17	41·6	45·8	7·7	10·5	80·0	18·0	10·3	8·7	8·4	22·4	38·0
Ennis	40	49	15	12	41·4	43·8	10·0	8·3	89·2	9·4	9·9	7·4	9·4	24·4	32·7
Kilkenny	50	65	25	26	41·2	57·3	20·1	18·0	82·3	12·4	10·4	7·1	10·1	21·5	31·2
Letterkenny ..	26	46	26	10	23·6	37·9	19·7	10·1	84·5	15·2	10·6	5·3	10·3	30·4	40·3
Longford ..	—	50	—	—	—	35·2	—	—	70·4	—	9·3	—	—	20·1	26·9
Loughlinstown ..	90	40	28	28	64·1	32·5	19·8	14·3	70·3	34·7	13·7	8·4	17·1	22·9	57·6
Mallow	33	50	5	10	29·4	47·0	1·8	7·6	87·6	19·9	11·6	5·5	10·1	24·7	45·9
Manorhamilton ..	33	36	10	10	25·3	25·8	6·3	3·1	68·1	18·7	24·4	8·4	7·6	15·8	37·8
Monaghan ..	68	69	12	12	67·0	50·5	7·3	12·3	85·2	19·8	10·6	8·2	8·0	19·5	36·2
Mullingar ..	45	47	16	—	38·1	43·0	10·9	—	85·2	12·4	9·5	6·6	—	27·0	38·4
Naas	56	37	—	—	45·8	31·4	—	—	83·0	17·9	9·5	—	—	21·8	41·0
Navan	55	58	—	—	46·6	58·6	—	—	93·1	22·7	9·1	—	—	22·5	39·7
Nenagh	40	44	10	6	34·6	33·6	9·6	10·1	87·1	20·1	10·5	7·1	7·9	26·6	44·1
Portlaoise ..	42	43	19	20	33·6	28·2	16·2	10·4	71·3	16·4	10·1	6·2	7·4	24·8	35·4
Roscommon ..	39	58	10	5	29·5	42·6	9·8	12·1	83·9	12·6	12·3	7·0	7·1	22·8	34·3
Sligo	46	65	16	—	42·5	63·4	13·9	—	93·5	14·2	12·7	7·2	—	20·6	35·0
Tralee	68	101	21	—	43·5	91·4	14·3	—	78·5	17·0	13·1	7·9	—	17·0	33·6
Tullamore.. ..	33	55	21	16	25·5	36·6	22·4	12·0	77·2	11·7	10·0	12·6	7·6	25·5	38·2
Wexford ..	38	69	15	38	30·4	54·4	10·7	15·6	69·2	23·3	10·7	6·9	7·7	29·7	47·2
Totals and Averages	1,056	1,300	367	300	878·6	1070·2	269·8	204·3	80·1	15·8	10·9	7·6	8·4	23·4	37·7

Notes:
(*a*) Up to 60 beds are available in the County Home, Cavan to take any overflow of medical cases from the County Hospital.
(*b*) The maternity statistics for Letterkenny County Hospital include gynaecological patients.
(*c*) The surgical statistics for Tralee County Hospital include ortho-surgical cases. There are 26 ortho-surgical beds in the Hospital.

DISTRICT HOSPITALS

County	Hospital	Bed Complement			Average Daily Occupancy			Percentage Occupancy	Average Duration of Stay (days)			Average Cost (1966/7) per	
		Medical and Minor Surgery	Maternity	Children under 16	Medical and Minor Surgery	Maternity	Children under 16		Medical and Minor Surgery	Maternity	Children under 16	Patient Week	Patient
												£	£
Carlow	Carlow	19	—	2	14·4,	—	0·2	69·5	9·6	—	5·4	17·4	23·7
	Muinebeag ..	33	—	—	22·2	—	—	67·3	11·2	—	—	10·8	17·2
Clare	Ennistymon ..	22	2	—	12·7	2·0	—	61·3	12·3	7·0	—	19·8	31·7
	Kilrush	33	5	—	28·6	1·7	—	79·7	18·9	6·8	—	15·4	37·8
	Raheen	20	4	—	16·3	1·0	—	72·1	16·6	7·9	—	15·0	33·5
Cork (*a*)	Bandon	17	4	2	10·1	0·6	0·1	47·0	78·4	6·5	2·2	13·6	143·4
	Castletownbere ..	24	2	3	16·3	0·6	0·2	59·0	25·3	6·2	3·2	13·4	42·1
	Clonakilty ..	40	4	2	16·2	0·8	1·0	40·0	26·3	8·4	16·3	7·4	47·4
	Dunmanway ..	20	1	3	15·4	0·1	0·1	65·0	92·4	12·0	9·5	9·4	120·3
	Fermoy	33	9	—	34·5	1·4	—	85·5	104·1	6·5	—	8·1	197·0
	Kanturk	31	10	8	18·3	1·2	2·5	44·9	23·5	5·8	8·6	12·3	48·9
	Kinsale	16	3	3	9·8	0·6	1·5	54·1	14·7	9·0	16·9	14·6	34·7
	Macroom ..	36	4	—	5·1	0·1	—	15·5	39·3	8·7	—	6·0	119·4
	Midleton ..	23	2	8	10·4	0·5	0·6	34·8	27·8	4·3	72·3	12·3	60·4
	Millstreet ..	23	2	—	12·2	0·5	—	50·8	23·5	8·0	—	10·7	50·8
	Schull	15	2	2	18·1	0·1	0·4	97·9	44·6	5·6	12·9	7·4	47·9
	Skibbereen ..	33	6	2	32·5	1·7	0·4	84·4	22·8	8·1	5·3	8·2	27·1
	Youghal	20	5	6	16·4	2·3	0·7	62·6	26·0	6·1	5·8	10·4	39·7
Donegal	Ballyshannon (*b*)	19	10	—	16·5	6·7	—	80·0	17·9	11·6	—	16·7	37·0
	Carndonagh ..	21	11	6	20·2	3·8	1·4	66·8	22·8	7·8	9·3	16·8	40·0
	Donegal (*c*) ..	37	11	—	30·1	8·9	—	81·3	15·5	12·6	—	18·4	38·6
	Dungloe	21	9	6	21·0	5·2	1·8	77·8	19·1	9·5	17·1	16·2	37·0
	Lifford	34	6	—	24·7	2·5	—	68·0	22·1	5·3	—	15·2	35·5
Galway	Clifden	30	9	—	25·9	1·2	—	69·5	22·1	9·2	—	10·7	31·9

DISTRICT HOSPITALS (*continued*)

County	Hospital	Bed Complement			Average Daily Occupancy			Percentage Occupancy	Average Duration of Stay (days)			Average Cost (1966/7) per	
		Medical and Minor Surgery	Maternity	Children under 16	Medical and Minor Surgery	Maternity	Children under 16		Medical and Minor Surgery	Maternity	Children under 16	Patient Week	Patient
												£	£
Kerry	Cahirciveen ..	27	8	2	21·8	2·9	2·5	73·5	14·5	7·4	19·5	10·7	20·5
	Dingle	39	5	—	34·2	0·6	—	79·1	26·0	6·2	—	11·0	38·7
	Kenmare ..	20	7	1	18·0	2·4	0·7	75·4	20·4	10·0	8·9	15·1	37·8
	Killarney ..	30	10	4	30·2	7·1	2·7	90·9	19·0	6·7	7·7	12·0	22·8
	Listowel	28	5	—	24·6	3·7	—	85·8	17·0	7·0	—	13·2	26·9
Kilkenny	Auxiliary ..	36	—	—	26·3	—	—	73·1	12·4	—	—	8·3	14·7
	Castlecomer ..	30	—	—	20·4	—	—	68·0	33·9	—	—	13·1	63·4
Laois	Abbeyleix ..	42	—	—	39·9	—	—	95·0	87·2	—	—	13·9	174·0
Leitrim	Mohill	22	10	—	19·4	0·7	—	62·8	150·6	6·6	—	13·0	161·6
Longford	Mount Carmel ..	34	—	—	29·4	—	—	86·5	28·7	—	—	9·5	38·7
Mayo	Ballina	64	17	9	56·1	7·8	4·3	75·8	16·1	7·5	6·4	15·9	29·7
	Belmullet ..	19	3	—	12·8	2·2	—	68·6	16·8	7·0	—	24·5	48·7
	Swinford ..	36	6	—	31·7	2·2	—	94·3	33·8	6·8	—	11·8	45·7
Meath	Trim Maternity	—	18	—	—	6·0	—	33·3	—	7·4	—	—	—
Offaly	Birr	12	8	4	6·9	2·8	2·3	50·0	16·5	7·7	9·9	24·0	40·8
	Edenderry ..	21	—	—	14·4	—	—	68·6	22·6	—	—	13·6	43·8
Roscommon	Boyle	31	—	—	26·2	—	—	84·5	44·2	—	—	10·9	61·4
Tipperary (N.R.)	Roscrea	22	4	6	15·1	5·8	1·1	68·8	23·8	11·6	8·5	19·0	47·4
	Thurles	41	8	6	29·3	4·2	5·3	70·5	20·7	9·4	24·7	12·6	33·7
Tipperary (S.R.)	Carrick-on-Suir	12	3	8	11·0	1·0	2·3	62·2	25·6	6·6	14·4	18·3	50·9
	Clogheen ..	18	4	—	18·0	1·3	—	87·7	25·3	7·4	—	12·7	40·0
	Tipperary ..	41	7	7	36·2	1·9	8·0	83·8	17·6	6·4	14·2	5·6	12·7
Waterford	Dungarvan (*d*) ..	36	—	—	35·8	—	—	99·4	18·2	—	—	10·9	28·2
	Lismore	19	—	—	19·2	—	—	101·1	91·0	—	—	8·3	108·4

DISTRICT HOSPITALS (*continued*)

County	Hospital	Bed Complement			Average Daily Occupancy			Percentage Occupancy	Average Duration of Stay (days)			Average Cost (1966/7) per	
		Medical and Minor Surgery	Maternity	Children under 16	Medical and Minor Surgery	Maternity	Children under 16		Medical and Minor Surgery	Maternity	Children under 16	Patient Week	Patient
												£	£
Westmeath	Athlone	77	10	12	56·0	7·0	3·6	67·3	19·4	7·3	13·5	16·4	37·9
Wexford	Gorey	18	10	—	15·3	5·6	—	74·6	13·1	7·0	—	16·4	24·8
	New Ross ..	20	7	—	15·3	4·7	—	74·1	10·0	7·1	—	16·1	20·9
Wicklow	Baltinglass (*e*) ..	32	10	—	26·1	3·1	—	69·5	13·3	5·4	—	20·8	34·4
	Wicklow ..	28	—	—	23·8	—	—	85·0	15·2	—	—	14·5	31·4
TOTALS AND AVERAGES ..		1,475	281	112	1,160·2	113·9	43·5	70·2	20·9	7·6	11·3	14·8	37·4

NOTES:

(*a*) Beds in some of the Cork District Hospitals which are designated for geriatric patients have been omitted. The beds so omitted are:—

Dunmanway	—	5
Fermoy	—	103
Kanturk	—	10
Kinsale	—	4
Schull	—	5
Skibbereen	—	5
Youghal	—	15

In the case of Bandon, Castletownbere, Clonakilty, Macroom, Midleton and Millstreet district hospitals there was no number of beds specifically designated for geriatric patients but figures relating to patients classified as geriatric patients have not been included. This has given rise to occupancy figures which are lower than those actually experienced.

(*b*) The medical and minor surgery figures for Ballyshannon District Hospital include figures for major gynaecological surgery.

(*c*) (i) The medical and minor surgery figures for Donegal District Hospital include figures for major surgery.
(ii) The figures of cost relate to the District and Fever Hospitals combined.

(*d*) The medical and minor surgery figures for Dungarvan District Hospital include figures for major surgery.

(*e*) The emdical and minor surgery figures for Baltinglass District Hospital include figures for major surgery.

(*f*) Where accurate information is not available figures of cost are not given.

Hospital	Bed Complement			Average Daily Occupancy			Percentage Occupancy	Average duration of stay (days)			Average Cost (1966/7) per	
	Adults	Children under 16	Total	Adults	Children under 16	Total		Adults	Children under 16	Total	Patient Week	Patient
											£	£
Ennis	26	10	36	5·5	4·9	10·4	28·9	17·1	16·6	16·8	11·1	26·8
St. Finbarr's ..	38	42	80	4·7	35·0	39·7	49·6	45·2	25·6	29·2		
Donegal (*a*) ..	14	8	22	6·5	3·8	10·3	48·2	15·0	18·0	16·0	18·4	38·6
Cherry Orchard ..	282		282	38·1	188·1	226·2	80·2	23·8	25·9	25·5	19·0	69·3
Vergemount ..	10	139	149	9·6	55·3	64·9	43·6	14·0	13·9	13·9		
Galway	42		42	7·1	22·2	29·3	69·8	11·1	15·1	13·9	23·1	46·1
Killarney	26	8	34	27·7	7·7	35·4	103·1	20·1	13·2	18·0	8·3	21·3
Limerick City Home and Hospital	17	17	34	4·0	9·8	13·8	40·6	14·7	13·6	13·9		
Swinford	10	5	15	2·7	3·1	5·8	38·7	11·3	10·7	10·9	32·3	50·5
Clones (*b*)	16	4	20	2·9	2·1	5·0	25·0	43·0	11·0	19·5	18·3	50·9
Roscommon ..	21	6	27	2·2	2·6	4·8	17·8	10·8	13·1	12·0		
New Ross	48	18	66	5·6	13·4	19·0	28·8	10·6	13·2	12·3	18·9	33·2
			807			464·6	57·6			19·4		

NOTES:

(*a*) The figures of cost relate to the District and Fever Hospitals combined.

(*b*) Clones Fever Hospital closed with effect from 1st January, 1967.

(*c*) Where accurate information was not available, figures of cost were not given.

ORTHOPAEDIC HOSPITALS

Hospital	Bed Complement			Average Daily Occupancy			Percentage Occupancy	Average duration of stay (days)			Average Cost (1966/7) per	
	Adults	Children under 16	Total	Adults	Children under 16	Total		Adults	Children under 16	Total	Patient Week	Patient
											£	£
St. Mary's, Gurranebraher ..	143	49	192	110·1	50·6	160·7	83·7	39·1	38·7	39·0	19·4	107·8
Merlin Park, Galway	126	42	168	101·5	33·4	134·9	80·3	58·2	70·1	60·8		
Kilcreene, Kilkenny	90		90	82·6		82·6	91·8	46·5		46·5	18·6	123·7
St. Nessan's, Croom	92	30	122	63·9	41·5	105·4	86·4	26·9	52·6	33·3	18·3	87·2
Navan	82		82	73·3		73·3	89·4	40·2		40·2	20·8	114·9
TOTALS AND AVERAGES ..			654			556·9	85·2			42·5	19·1	105·6

NOTE: Accurate figures of cost for the orthopaedic section of Merlin Park Hospital were not available.

APPENDIX B

STATUTES ENACTED SINCE 1923 RELATING IN WHOLE OR IN PART TO THE IRISH HOSPITAL SERVICES

STATUTES ENACTED SINCE 1923 RELATING IN WHOLE OR IN PART TO THE IRISH HOSPITAL SERVICES

Year	Title	Number
1923	Local Government (Temporary Provisions) Act.	9
1924	Local Government (Temporary Provisions) (Amendment) Act	13
1925	Medical Act	2
1925	Local Government Act	5
1926	Medical Act	4
1926	Local Authorities (Officers and Employees) Act	39
1927	Medical Act	2
1927	Local Government Act	3
1927	Medical Practitioners Act	25
1929	Poor Relief (Dublin) Act	40
1930	Public Charitable Hospitals (Temporary Provisions) Act ..	12
1930	Local Government (Dublin) Act	27
1931	Poor Relief (Dublin) Act	7
1931	Local Government Act	19
1931	Pharmacopoeia Act	22
1931	Public Charitable Hospitals (Amendment) Act	24
1931	Local Government (Dublin) (Amendment) Act	25
1931	Midwives Act	35
1931	Public Charitable Hospitals (Amendment) (No. 2) Act ..	49
1931	Public Charitable Hospitals (Amendment) (No. 3) Act ..	51
1932	Public Charitable Hospitals (Amendment) Act	8
1933	Local Government Act	5
1933	Public Hospitals Act	18
1934	Registration of Maternity Homes Act	14
1934	Local Government (Amendment) (No. 2) Act	44
1935	Local Government (Temporary Provisions) (Amendment) Act	19
1935	Cork Fever Hospital Act	44
1936	Poor Relief (Dublin) Act	9
1936	Dublin Fever Hospital Act	21
1936	Local Government Act	46
1936	Local Authorities (Miscellaneous Provisions) Act [Ss. 8 & 9]	55
1936	National Maternity Hospital, Dublin (Charter Amendment) Act	2P
1937	Public Assistance Act	2
1937	Dublin Hospitals Act	24
1938	Cork Fever Hospital (Amendment) Act	10
1938	Public Hospitals (Amendment) Act	21
1939	Hospitals Act	4
1939	Local Authorities (Combined Purchasing)Act	14
1939	Public Hospitals (Amendment) Act	15
1939	Public Assistance Act	27
1939	Public Hospitals (Amendment) (No. 2) Act	29
1940	Public Hospitals (Amendment) Act	9
1940	County Management Act	12
1941	Local Officers and Servants (Dublin) Act	15
1941	Local Government Act	23
1942	County Management (Amendment) Act	13
1943	St. Laurence's Hospital Act	3
1944	Midwives Act	10
1945	Tuberculosis (Establishment of Sanatoria) Act	4
1945	Local Government (Dublin) Act	8
1945	Mental Treatment Act	19
1946	Local Government Act	24
1947	Health Act	28
1947	Health Services (Financial Provisions) Act	47
1948	Local Government (Superannuation) Act	4
1948	Local Government (Dublin) (Temporary) Act	15
1948	Nurses Registration Act	19

Year	Title	Number
1950	Local Government (Repeal of Enactments) Act	26
1950	Nurses Act	27
1951	Meath Hospital Act	5
1951	Medical Practitioners Act	29
1951	Pharmacy Act	30
1952	Social Welfare Act [Seventh Schedule]	11
1953	Health Act	26
1953	Mental Treatment Act	35
1953	Royal Hospital for Incurables (Charter Amendment) Act	2P
1954	Health Act	23
1954	Cork Fever Hospital (Amendment) Act	24
1954	Sir Patrick's Dun's Hospital Act	1P
1955	Medical Practitioners Act	1
1955	Local Government Act	9
1955	City and County Management (Amendment) Act	12
1956	Local Government (Superannuation) Act	10
1956	Opticians Act	17
1957	Voluntary Health Insurance Act	1
1957	Health and Mental Treatment Act	16
1958	Local Government Act [Age Limit]	9
1958	Health and Mental Treatment (Amendment) Act	37
1958	The Convalescent Home, Stillorgan (Charter Amendment) Act	1P
1960	Health Authorities Act	9
1960	Health (Fluoridation of Water Supplies) Act	46
1961	Mental Treatment (Detention in approved Institutions) Act	4
1961	Mental Treatment Act	7
1961	Nurses Act	18
1961	Hospitals Federation and Amalgamation Act	21
1961	Social Welfare (Miscellaneous Provisions) Act [S. 19]	22
1961	Medical Practitioners Act	26
1961	Health (Corporate Bodies) Act	27
1962	Pharmacy Act	14
1962	Social Welfare (Miscellaneous Provisions) Act [S. 14]	17
1963	Social Welfare (Miscellaneous Provisions) Act [S. 16]	26
1964	Health (Homes for Incapacitated Persons) Act	8
1964	Social Welfare (Miscellaneous Provisions) Act [S. 5 (3)]	28
1965	Social Welfare (Miscellaneous Provisions) Act [S. 15]	20
1965	The Royal College of Surgeons in Ireland (Charter Amendment) Act	1P
1966	Health and Mental Treatment (Amendment) Act	2
1967	Local Government (Dublin) Act	4
1967	Social Welfare (Miscellaneous Provisions) Act [S. 12]	18

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