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COMHAIRLE NA NOSPIDÉAL

**Report
of the
Committee
on
Dermatology Services**

November 2003

Comhairle na nOspidéal

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Comhairle na nOspidéal

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EXECUTIVE SUMMARY

The Comhairle na nOspidéal Committee on Dermatology Services commenced its review of dermatology services in February 2002. At that time, dermatology services were acknowledged to be underdeveloped nationally and two health boards – the Midland Health Board and North Western Health Board – were without a locally based permanent consultant dermatologist. The areas requiring development were clear from the outset. There are currently 19 posts of consultant dermatologist approved by Comhairle na nOspidéal, representing a ratio of one consultant dermatologist per 206,000 population.

The work of the committee initially focused on reviewing the implementation of the recommendations of the previous Comhairle report on dermatology services, which was published in 1988. In addition, all health boards and relevant voluntary hospitals were asked to make submissions to the committee.

Over the course of a year the committee met with the Irish Association of Dermatologists, comprising the consultant dermatologists practising in the public hospitals in Ireland; managerial representatives from all of the health boards and relevant voluntary hospitals; carried out site visits to the Mater Misericordiae and Beaumont Hospitals; and visited a recommended centre of excellence for dermatology at Ninewells Hospital, Dundee. The committee also consulted literature relating to dermatology service provision in the UK, Europe, North America and Australia.

The main principles identified by the committee for the future development of dermatology services are

- An equitable and patient-centred service
- No consultant dermatologist working in isolation
- Regional self-sufficiency
- Collaboration between primary and secondary care

The key recommendations are as follows,

- A ratio of one consultant dermatologist per 100,000 population
- A doubling of the number of consultant dermatologist posts, from 19 to 38
- The immediate appointment of consultant dermatologists to the Midland Health Board and the North Western Health Board
- The priority appointment of 12 additional consultant dermatologists throughout the country and the subsequent appointment of an additional seven consultant dermatologists
- The development of a Moh's micrographic surgery service
- The transfer of Hume Street Hospital to the St Vincent's University Hospital campus
- The development of academic posts in dermatology
- The development of the role of specialist dermatology nurses.

1 INTRODUCTION

1.1 CONTEXT

1.1.1 Following the receipt of correspondence from the Irish Association of Dermatologists, it was decided, at the meeting of Comhairle na nOspidéal on 21st November 2001, to establish a committee to meet with representatives of the Association.

1.1.2 The following members were appointed to serve on the Dermatology Committee:

Dr C Twomey (Chairman)	Consultant Physician in Geriatric Medicine, Cork University Hospital;
Mr D Doherty	Director, The Health Boards' Executive;
Mr C O'Leary	Consultant in Emergency Medicine, Mid-Western Regional Hospital, Limerick;
Mr T Martin	Chief Officer, Comhairle na nOspidéal

Ms C Mellett, Executive Officer, was appointed as Secretary to the committee and she undertook the research for, and drafting of, this report.

1.1.3 The first meeting of the committee took place on 19th February 2002. The terms of reference of the Dermatology Committee were as follows:

"To examine the existing arrangements for the provision of consultant dermatology services nationally and following consultation with the interested parties, to make recommendations to Comhairle na nOspidéal on the future organisation and development of dermatology services. The review will focus on the 1988 Comhairle Report on Dermatology Services. It will examine the extent of the implementation of the recommendations of the 1988 report."

1.1.4 It was apparent to the committee that dermatology services in Ireland were concentrated mainly in the Dublin region, representing a significant inequity in service provision. Two health boards- the Midland and North West- had no consultant dermatologists, while two further health boards- the Mid-Western and South Eastern - were operating dermatology services with one consultant dermatologist. The areas requiring development were clear to the committee from the outset.

1.2 THE CONSULTATION PROCESS

1.2.1 Requests were made to each health board and relevant public voluntary hospital to make submissions to the dermatology committee. Each was asked to comment on:-

- the level of implementation of the Comhairle na nOspidéal Report on Dermatology Services (1988) and
- the recommendations of the Irish Association of Dermatologists on the future development of dermatology services in Ireland.

Each was also asked for information relating to workload, facilities etc. The list of questions posed is given at Appendix A. The submissions received are listed at Appendix B and some details of the responses are included at Appendix C.

1.2.2 The committee met with representatives of the Irish Association of Dermatologists (IAD) on 5th June 2002 and with management representatives of each health board and relevant voluntary hospital on 24th September 2002.

Representatives of the committee visited the dermatology facilities at the Mater Misericordiae Hospital in November 2002 and at Beaumont Hospital in March 2003. In February 2003, representatives of the committee travelled to Ninewells Hospital, Dundee, Scotland, to view

the dedicated dermatology facilities and consulted with key personnel there. This hospital had been recommended to the committee by the Irish Association of Dermatologists as a centre of excellence. The visit provided the committee with valuable information and advice vis-à-vis the future development of a high quality dermatology service.

The committee wishes to extend its gratitude to all those involved in the consultation process, in the compilation of submissions, and all those who provided additional information and assistance to the committee. The committee would like to pay particular thanks to the members of the IAD for their precise and informative presentations and their uniform approach to the national development of dermatology services in the Republic of Ireland, which was most encouraging to the committee. Special mention must be given to Dr Paul Collins, Dr John Bourke and Dr Rosemarie Watson who provided particular assistance, support and advice to the committee.

Note: This report is written and its recommendations are made in the context of the existing medical staffing system, hospital network and health board configuration. The committee is aware of the recommendations of the recently published report of the National Task Force on Medical Staffing (Hanly Report) and impending European Working Time Directive. The Committee believes that this Dermatology report will guide and further inform the implementation of the Report and the related implementation of the EWT Directive in Ireland.

2 WHAT IS DERMATOLOGY?

2.1 DEFINITION AND SCOPE OF DERMATOLOGY

Dermatology is the medical specialty caring for illnesses relating to the skin, hair and nails. Dermatology is also concerned with many diseases affecting the genitalia and the inside of the mouth. Dermatologists treat patients of all ages.

Apart from a small number of potentially fatal conditions, dermatology is not a "life or death" specialty, and as a consequence has seldom been a top priority for development at hospital management or medical board level, or nationally. Other, more high profile specialties tend to attract more public attention and media coverage. The fact is that skin disease is very common - between one third and one quarter of the population has a dermatological condition at any one time and most skin diseases are characteristically chronic. These conditions range from the more common acne, dermatitis and skin infections to Epidermolysis bullosa and skin cancer. Dermatological conditions result in major quality of life issues, with some conditions being physically disabling, disfiguring, painful and intensely irritating, resulting in loss of sleep, disruption of family life, teasing and bullying in schools, difficulty in obtaining work and severe problems in forming social relationships. The visual nature of skin disease is thought to render patients more susceptible to disturbed body image, lack of confidence and even depression.^{1,2,3}

2.2 THE WORK OF A CONSULTANT DERMATOLOGIST

Dermatology is, predominantly, an out patient specialty, with only a small proportion of patients requiring admission to hospital. A significant amount of the consultant's time (up to three sessions per week) can be taken up with consults for inpatients on medical and surgical wards under the care of other consultants.

2.2.1 Common Skin Conditions

Five groups of skin diseases make up 90% of the workload of a consultant dermatologist. These are Dermatitis, Psoriasis, Acne, Skin Cancer and Skin Infections.

Dermatitis

Atopic Eczema/Dermatitis affects up to 15-20% of children in Western Europe and a two to three fold increase in prevalence has been detected over the past 30 years.^{1,4}

Psoriasis

Psoriasis affects 2% of the population and has an important genetic factor.⁴ For the majority of sufferers, it is a chronic disease.¹ Many patients requiring phototherapy must attend for treatment 3 times per week and more severe cases need treatments that require monthly monitoring.

Acne

Acne affects 85% of the 15-30 year old population and can lead to social embarrassment and, in some cases, psychological damage. The condition is severe in 2% of the population.

Skin cancer

Skin cancer (melanoma and non-melanoma) represents the most common form of cancer and its incidence is increasing. On average every year in Ireland, approximately 400 cases of melanoma are detected and there are, on average, 60 deaths attributable annually to melanoma. Around 5,000 cases of non-melanoma are detected each year and there are approximately 30 deaths per year from non-melanoma cancer.⁵ The higher risk of skin cancer encountered by renal transplant recipients^{6,7} also needs to be taken into account.

Skin Infections

Skin infections include fungal infections, warts, scabies, bacterial infections, impetigo and cellulitis, some of which are relatively common.

2.2.2 Rarer Skin Conditions

Epidermolysis Bullosa (EB)

Epidermolysis Bullosa (EB) is a group of inherited conditions, typically manifested in infancy or childhood, in which there is fragility of the skin and mucous membranes. Any friction, rubbing or trauma to skin and/or mucous membranes causes blisters and skin to come off. It can range from a relatively mild condition to a severely disabling, and sometimes fatal, disease. There are an estimated 200 people with EB in Ireland.⁸ As yet, a cure has not been found for EB, nor has a treatment to completely control any form of EB. Many forms of EB begin to lessen to some degree as the child gets older.⁹ Currently, a consultant dermatologist based at Crumlin and St James's Hospitals has expertise in this condition and these hospitals have become referral centres for the rest of the country.

2.3 TRAINING IN IRELAND

2.3.1 UNDERGRADUATE TRAINING IN DERMATOLOGY IN IRELAND

Dermatology does not currently form part of the core training for medical students. Exposure to training in dermatology should commence at the undergraduate level of medical training and dermatology should form a core part of undergraduate medical training in Ireland. Currently undergraduate training in dermatology is determined by the location of consultant dermatologists and is restricted by the limited number of consultant dermatologists. The committee acknowledges that the current low level of undergraduate training in dermatology may be due, in part, to the inadequate number of consultant dermatologists in the state. The committee hopes that with the implementation of its recommendations, dermatology training of medical students will be significantly enhanced and will form part of the core training curriculum at this level. In Scotland, undergraduate teaching in dermatology continues to evolve. There, it is proposed that the undergraduate curriculum will involve exposure to an increasing level of dermatology each year. For example, in first year, there would be three dermatology lectures, increasing to a one-week attachment to a consultant dermatologist in third year and a subsequent two-week attachment. With the implementation of the committee's recommendations and the appointment of additional consultants in Ireland, the scope for similar development of undergraduate training in dermatology will exist.

2.3.2 Postgraduate Training in Medicine in Ireland

Following completion of the pre-registration intern year, medical graduates may enter post-graduate training schemes in their chosen specialty. Initial Specialist Training (2-3 years), previously known as general professional training is followed, depending on the specialty, by a duration ranging from 4 to 6 years of Higher Specialist Training (HST). The responsibility for the coordination of HST schemes in Ireland lies with the relevant training body for each specialty group. The Medical Council recognises twelve such training bodies. The Irish Committee on Higher Medical Training (ICHMT) of the Royal College of Physicians of Ireland (RCPI) is responsible for developing and coordinating the training programmes in medicine in Ireland. Centres for specialist registrar training are inspected by a Specialist Training Committee (STC) consisting of the National Specialty Director of the relevant specialty, an ICHMT representative, and the Dean or Associate Dean of the ICHMT. The team meet with the clinical and administrative staff of the hospital/training institution as well as the trainee(s). Following educational approval of centres for SpR training by the STC of the ICHMT, application to Comhairle na nOspidéal may be made for the formal approval of SpR posts. Following successful completion of the HST, the doctor is awarded a Certificate of Satisfactory Completion of Specialist Training (CSCST) and may apply to the Medical Council for inclusion on the Register of Medical Specialists.

2.3.3 Postgraduate Training in Dermatology in Ireland

Applicants to the higher specialist training (HST) scheme in dermatology must have completed a minimum of two years Initial Specialist Training in approved posts and obtained the MRCP(I) or MRCP(UK). The HST scheme in dermatology is of four years' duration and has been in operation since 1st July 1999. A minimum of one consultant dermatologist at a centre is required for educational approval by the STC. ICHMT guidelines state that each trainee can spend up to two years at any one training institution and a maximum of one year at a one-consultant unit and that a trainee can spend no more than one year training with any one trainer. The training programme allows for up to two years of overseas training (clinical or research). While all training can be completed in Ireland, many trainees choose to spend time training abroad.

There are six centres recognised for training in Ireland – Beaumont Hospital, the Mater Hospital, St James's Hospital/Crumlin Hospital, St Vincent's Hospital/Hume Street Hospital, the South Infirmary-Victoria Hospital, Cork and Waterford Regional Hospital. Each centre is recognised for one training post and all six SpR posts are approved by Comhairle na nOspidéal. Recruitment of trainees takes place once a year and is undertaken by the ICHMT.

2.3.4 GP training in Dermatology in Ireland

The amount of exposure to formal dermatology training for GPs varies. GP trainees are exposed to, and trained in the management of, common dermatological conditions during their GP-based training year. However, dermatology does not form part of the core training for trainee GPs. In some GP training programmes, some trainees get attachments to hospital dermatology outpatient departments during their first or second (hospital based) years of training.

A Higher Diploma in Medicine (Dermatology) for General Practitioners, recognised by the Irish College of General Practitioners, is run by University College Dublin at the Mater Hospital. GPs obtain extensive clinical exposure to patients throughout the six-month intensive period of study. Teaching is provided by many of the Consultant Dermatologists in Ireland. The course extends over approximately twenty weekends in Dublin and both written and clinical examinations must be passed. The committee has been informed that the course has been very successful.¹⁰ It is estimated that approximately 10% of the GPs practising in the state have completed the course. The committee has been advised that there is scope for the development of similar courses in other parts of the country. Some Irish GPs undertake a Diploma in Practical Dermatology, run by the University of Wales College of Medicine, Cardiff, by distance learning. This course is also approved by the ICGP for GPs in Ireland.¹¹

The Irish College of General Practitioners coordinate courses for GPs in minor surgery and cryosurgery, which incorporate some dermatology. A number of these day and weekend courses are run in different parts of the country throughout the year. The courses offer practical experience to GPs, however, no formal certification is issued on completion of the course.

The curriculum for Higher Medical Training in Dermatology in Ireland includes a module for the SpR trainees at the primary care level - 10 sessions to be held at an approved Health Centre during the course of the training scheme. In this way, future dermatologists may appreciate the needs and contribution of general practitioners to the provision of dermatology services.

2.4 DERMATOLOGY TRAINING OUTSIDE IRELAND

2.4.1 Dermatology Training in the UK

Higher specialist training in dermatology in the UK is similar to that in Ireland. The Higher Medical Training Scheme in Dermatology in the UK is accredited by the Joint Committee on Higher Medical Training of the Royal College of Physicians (London).¹² Applicants to the scheme must first have completed two years of postgraduate training in approved posts and obtained the MRCP(UK) or MRCP(I) or MRCPCH. The duration of higher medical training in dermatology in the UK is four years, leading to the award of CCST.

2.4.2 Dermatology Training in North America

The American Board of Medical Specialties (ABMS) is the umbrella organisation for the 24 approved medical specialty boards in the United States, one of which is the American Board of Dermatology. The postgraduate training scheme in dermatology in the US is accredited by the Accreditation Council for Graduate Medical Education (ACGME).^{13,14} The programme is of four years duration, the first of which is a broad-based year of clinical training. This is followed by three years of training in dermatology. Successful completion of the programme leads to eligibility to sit the examination for certification of the American Board of Dermatology, leading to the title of Diplomate of the American Board of Dermatology. The Board also certifies the subspecialties of Dermatopathology, Clinical and Laboratory Dermatological Immunology, and Paediatric Dermatology.

In Canada,¹⁵ applicants for higher training in dermatology must possess an MD, which usually follows a BSc degree. Application is then made for a residency place of five years duration in a chosen medical specialty. A residency in dermatology would comprise three years of rotation through various specialties, followed by two years concentrating on dermatology. Upon successful completion of these five years, the resident sits the exams of the Royal College of Physicians and Surgeons of Canada, the accreditation body for all medical specialists in Canada.

2.4.3 Dermatology Training in Australia

In Australia,¹⁶ the higher training scheme in dermatology is accredited by the Australian College of Dermatologists. Upon completion of the initial medical degree (5-7 years), two years are then spent in a public hospital. Application can then be made to the training scheme in dermatology, which is of four years duration. Successful completion of the scheme leads to Fellowship of the Australian College of Dermatologists (FACD). Fellowships in subspecialty areas such as Mohs' micrographic surgery, laser therapy, other advanced dermatological and cosmetic procedures, and skin allergy are also undertaken in Australia by dermatologists.

2.5 QUALIFICATIONS SPECIFIED FOR POSTS OF CONSULTANT DERMATOLOGIST

The following are the qualifications which are specified by Comhairle na nOspidéal for consultant appointments in dermatology:

2.5.1 Consultant Dermatologist

(a) Full registration in the General Register of Medical Practitioners maintained by the Medical Council in Ireland or entitlement to be so registered

and

(b) The possession of the MRCPI or a qualification in medicine equivalent thereto

and

- (c) (i) Inclusion on the division of dermatology of the Register of Medical Specialists maintained by the Medical Council in Ireland
- or
- (ii) Seven years satisfactory postgraduate training and experience in the medical profession including four years in dermatology.

2.5.2 Consultant Dermatologist with a special interest in paediatric dermatology

a, b and c, as specified above,

and

(d) including one year in paediatric dermatology.

3 EXISTING DERMATOLOGY SERVICES

3.1 PREVIOUS COMHAIRLE NA NOSPIDÉAL REPORT ON DERMATOLOGY SERVICES (JULY 1988)

Following an announcement by the Minister for Health on 19th May 1987, a major review of acute-hospital services in the country was undertaken by the Department of Health and Comhairle na nOspidéal. Subsequently, Comhairle was requested to undertake, *inter alia*, a review of dermatology services. The report of the Comhairle committee on dermatology services was published in July 1988. The concentration of dermatology services in the Dublin region identified in the 1988 report reflects a situation that prevails today. The principles and recommendations of the 1988 report are summarised at Appendix D.

The 1988 report was written during a period of considerable economic uncertainty and severe cutbacks in all areas of public spending, including health, when a number of hospitals were closed in 1987. The 1988 committee conceded that while single-handed consultant appointments should be avoided if at all possible, it would have been unrealistic, given the economic climate at the time, to expect the appointment of a large number of new consultant dermatologists. It was accepted in 1988 that pending an improvement in the economic situation, initial improvements in dermatology consultant manpower would have to take the form of single-handed consultant posts, if dermatology services in some health boards were to be provided. In view of cutbacks, it was decided to concentrate services in four centres (details are given at Appendix D).

Table 1 summarises the consultant staffing at the time of the drafting of the 1988 report, the recommendations of the report in relation to consultant staffing and the current situation.

Table 1

Health Board Area & Population (2002 census) ¹⁷	Consultant Posts (Sept 1987)	Total posts Recommended	Current Consultant Establishment (2003)	Implementation (current Consultant Establishment as % of recommendations of report)	Current Cons./Population Ratio (2003)
EHB / ERHA 1,401,441	8	10*	10	100%	1/140,000
MHB 225,363	0		0	-	-
NEHB 344,965	0		2	-	1/172,000
MWHB 339,591	0	2	1	50%	1/340,000
NWHB 221,574	0	1	1	100%	1/222,000
SEHB 423,616	0	2	1	50%	1/424,000
SHB 580,356	2	3	2	67%	1/290,000
WHB 380,297	1	2	2	100%	1/190,000
TOTAL 3,917,203	11	20	19	95%	1/206,000

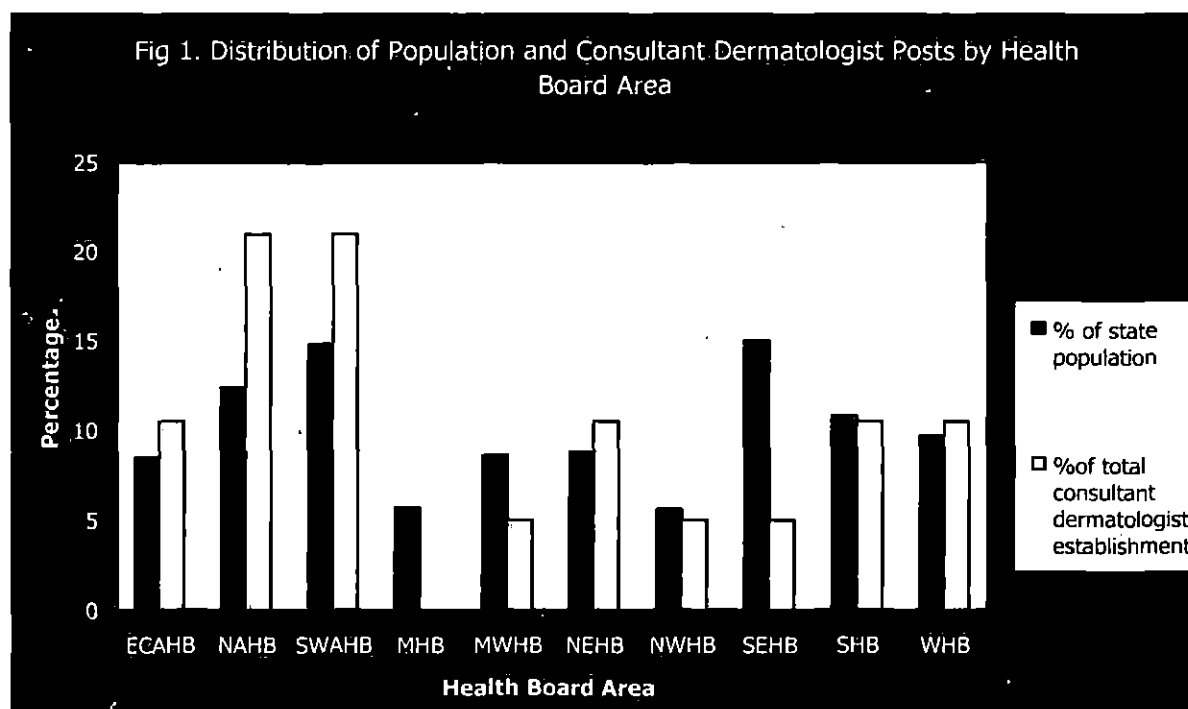
* The Dublin region was proposed as a dermatological centre to serve a catchment area including the North Eastern Health Board and the Midland Health Board

The recommendations, in terms of consultant staffing were implemented in the eastern region and the Western Health Board. The recommendation with regard to the North Western Health Board has recently (April 2003) been implemented. However the targets set for the other health board areas have not been realised. The recommendation that out-patient clinics be provided at Navan, Longford, Tullamore, Portlaoise by consultants based in Dublin hospitals has not been implemented. In light of economic circumstances at the time and the subsequent shift in opinion regarding regionalisation, the four regional centres recommended by the committee have not developed as recommended, particularly in terms of providing out-reach services to other general hospitals in their catchment areas.

3.2 NATIONAL DISTRIBUTION OF DERMATOLOGY SERVICES

3.2.1 DISTRIBUTION OF CONSULTANT DERMATOLOGY POSTS

There are currently 19 Comhairle approved permanent posts of Consultant Dermatologist in Ireland. Figure 1 illustrates the current distribution of consultant dermatology posts in the state. The ERHA, with 35.7% of the total population has 55.5% of all of the Consultant Dermatologist posts in the country. In contrast, the Midland Health Board with 5.7% of the population has no locally based consultant dermatologist.



All population figures used are those provided in the Census 2002 figures.¹⁷

3.2.2 Distribution of NCHD posts in Dermatology

There are 24.5 non-consultant hospital doctor posts in dermatology in Ireland. The ratio of consultants to NCHDs in dermatology compares favourably with that of other specialties. The NCHD posts in dermatology are distributed by hospital and grade as follows,

Hospital	SHO	Registrar	SpR	Total
Beaumont	1	1	1	3
Drogheda (OLOL)	2	1	0	3
Hume Street	1	0	1	2
Limerick Regional	0	1	0	1
Mater	1	1	1	3
Our Lady's Hospital, Crumlin	0.5	1	0	1.5
St James's	0	2	0	2
St Vincent's	0	1	0	1
South Infirmary - Victoria	1	0	1	2
Tallaght	0	1	0	1
UCH Galway	2	1	0	3
Waterford Regional	0	0	2	2
Total	8.5	10	6	24.5

Data derived from "Survey of NCHD Staffing at 1st October 2002", Postgraduate Medical and Dental Board.¹⁸

3.3 EASTERN REGIONAL HEALTH AUTHORITY

Population: 1,401,441

The dermatology service in the ERHA is provided at nine hospitals, including two children's hospitals and Hume Street Hospital. There are 10 consultants providing the service in these hospitals. While the number of consultants is disproportionately high in the eastern region, it should be remembered that some of these consultants provide specialised services, catering for patients from all over the country and not just the immediate catchment area. More significantly, the limited number of dermatologists in some neighbouring health boards has led to considerable referrals to dermatologists in the Dublin hospitals for routine dermatology diagnoses and treatments.

The statutory functions of the ERHA are the planning, commissioning, funding, monitoring and evaluation of all health and personal social services for the people of Dublin, Kildare and Wicklow. The three area health boards within the ERHA - the East Coast Area Health Board (population 333,458), the Northern Area Health Board (population 486,305), and the South Western Area Health Board (581,551) and the voluntary hospitals in the region are responsible for service delivery. The breakdown of sessions at each hospital in the ERHA is given in sections 3.4, 3.5 and 3.6 below.

3.4 EAST COAST AREA HEALTH BOARD

Population: ~333,488

The consultant staffing at the hospitals in the east coast area is outlined (as consultant sessions per week per consultant post at each hospital) as follows:

	St Vincent's/St Michael's	Hume Street
	Sessions per week	
Post 1	3.5	7.5
Post 2	8	3
Total	11.5	10.5

3.5 NORTHERN AREA HEALTH BOARD

Population: ~486,349

The consultant staffing, in the form of consultant sessions per week per consultant, at the hospitals in the northern area health board region is as follows:

	Beaumont	Mater	Temple St.	JCM Blanchardstown	Other
	Sessions per week			Sessions per week	
Post 1	6	3			2 (NEHB)
Post 2		8		3	Service to NEHB
Post 3 (unprocessed)	3	7		1	
Post 4*		3	6		2(MHB)
Total	9	21	6	4	4

*Consultant Dermatologist with a special interest in paediatric dermatology

3.6 SOUTH WESTERN AREA HEALTH BOARD

Population: ~581,603

The consultant staffing, set out as consultant sessions per week, at the hospitals in the south western area health board region is outlined as follows:

	Crumlin	St James's	Tallaght
	Sessions per week		
Post 1		11	
Post 2	6	5	
Post 3		2	9
Post 4*	8	3	
Total	14	21	9

* Consultant Dermatologist with a special interest in paediatric dermatology

3.7 MIDLAND HEALTH BOARD AREA

Population: 225,363

There is currently no permanent consultant dermatologist based in the Midland Health Board. A Consultant Dermatologist, based at Temple Street and the Mater Hospitals provides two sessions per week at the Midland Regional Hospital at Mullingar.

3.8 MID WESTERN HEALTH BOARD AREA

Population: 339,591

There is one Consultant Dermatologist in the Mid-Western Health Board, with 10 sessions at the Mid-Western Regional Hospital, Limerick and one session at Cork University Hospital. This consultant has no formal commitment to St John's Hospital in Limerick but attends as requested.

3.9 NORTH EASTERN HEALTH BOARD AREA

Population: 344,965

There are two Consultant Dermatologist posts approved in the North Eastern Health Board. The sessional commitments of the posts (consultant sessions per week) are distributed as follows:

	Drogheda	Dundalk	Monaghan	Cavan	Other
Sessions per week					
Post 1	7	2			2 (Beaumont)
Post 2 (V.A.)	2		6	3	
Total	9	2	6	3	2

(V.A. - "vacant approved" post)

For a number of years, two Dublin based consultant posts have had formal sessional commitments to the NEHB, amounting to one session per month at the hospitals in Drogheda, Dundalk and Cavan.

3.10 NORTH WESTERN HEALTH BOARD AREA

Population: 221,574

Until very recently (April 2003) there was no permanent, locally-based, post of consultant dermatologist in the NWHB. A visiting consultant from Altnagelvin Hospital NHS Trust provides a weekly session in Letterkenny General Hospital and a Comhairle approved temporary consultant dermatologist has provided services at Sligo General Hospital. In April 2003, Comhairle na nOspidéal approved the appointment of a permanent Consultant Dermatologist to the NWHB, with eight sessions per week at Sligo General Hospital and three sessions per week to Letterkenny General Hospital.

3.11 SOUTH EASTERN HEALTH BOARD AREA

Population: 423,616

There is one Consultant Dermatologist in the South Eastern Health Board, based at Waterford Regional Hospital. All in-patient dermatology work is carried out at Waterford Regional. Two out patient clinics per month are held at Wexford, Kilkenny and Clonmel respectively.

3.12 SOUTHERN HEALTH BOARD AREA

Population: 580,356

The dermatology unit for the Southern Health Board population is located at the South Infirmary-Victoria Hospital, Cork and is staffed by two consultants. The breakdown of the posts (average sessions/week) is as follows;

	South Infirmary- Victoria	CUH	Mercy	Other
Sessions per week				
Post 1	8	2	1	
Post 2	8.25	2.5		0.25
		(Out patient clinics & in patient consults)		(Out patient clinics in Tralee)
Total	16.25	4.5	1	0.25

3.13 WESTERN HEALTH BOARD AREA

Population: 380,297

There are two Consultant Dermatologists, both based at University College Hospital, Galway. In addition, out-patient clinics are held at a number of centres in the region, including Castlebar, Ballina, Roscommon and Portiuncula.

3.14 OTHER DERMATOLOGY SERVICES

3.14.1 DERMATOLOGISTS IN FULL-TIME PRIVATE PRACTICE

There are at least nine dermatologists working exclusively in private practice in Ireland while there are 19 permanent consultant dermatologist posts employed in the public sector many of whom also work in the private sector. This situation whereby one third of a specialty work solely in private practice is in sharp contrast to the distribution found in other specialties, which may reflect the failure to properly develop publicly funded dermatology services.

3.14.2 THE ROLE OF GENERAL PRACTITIONERS

Dermatology is an area where significant cooperation should exist between the primary and secondary care levels to ensure a seamless progression of treatment for the patient. Skin diseases account for approximately 15% of the workload of a general practitioner and 6% of GP prescriptions relate to skin disease.^{1,2} Approximately 76% of dermatology consultations in primary care arise from a small number of conditions, including eczema, psoriasis, acne and leg ulcers. UK studies^{1,2} have estimated that only 5% of patients presenting to GPs for dermatological treatment are referred to a Consultant Dermatologist. However, the vast majority of patients referred to secondary dermatological care suffer severe or chronic conditions and there is clearly an unmet need at this level.^{1,2}

3.14.3 DERMATOLOGY IN MATERNITY HOSPITALS

The committee has been advised that there are some skin conditions peculiar to pregnant women that may necessitate the opinion of a Consultant Dermatologist. It is important that pregnant women and neonates with atypical skin rashes can access the opinion of a Consultant Dermatologist with an interest in these areas.

4 MAJOR ISSUES CONSIDERED BY THE COMMITTEE

4.1 INTERNATIONAL CONSULTANT STAFFING LEVELS

The Irish Association of Dermatologists recommends a consultant/population ratio of 1/85,000. The existing ratios of specialists in dermatology to population in a number of countries are given below:

Country	Population (million)	Number of Dermatologists (posts)	Dermatologist / Population*
Ireland	3.9	19	1/206,000
Northern Ireland	1.5	12	1/125,000
Scotland	5.1	47	1/108,000
England & Wales	54.4	333	1/163,000
Canada	30.7	400	1/77,000
Denmark	5.3	153	1/35,000
USA	270.3	2,900	1/29,000
Sweden	8.88	340	1/26,000

Source of population figures: World Population Profile 1998 - US Bureau of the Census;¹⁹ Local census figures

* It should be noted that different hospital and medical staffing systems and hierarchies exist in different countries as regards grades of doctors so that direct comparison is difficult except with Northern Ireland, Scotland and England & Wales. For example, specialists, as distinct from consultants, are employed in most EU countries other than Ireland and the UK. The proportion of NCHDs to specialists/consultants employed in most EU countries and North America is also much lower than that in Ireland or the UK.

4.2 HUME STREET HOSPITAL

The 1988 Comhairle report on dermatology services recommended the transfer of dermatology services from Hume Street to the St Vincent's Hospital site:

"The (1988) committee (supports), as a matter of principle, the concept that dermatology services in this country should be located at and be an integral part of a major general hospital providing a comprehensive range of specialties including pathology and anaesthesia...It is recommended that the services at Hume Street Hospital should be physically transferred on to the St Vincent's Hospital site as soon as possible. Pending such transfer, there should be a joint management structure spanning St Vincent's Hospital and Hume Street Hospital."

The ERHA has recently (January 2003) carried out a review of the dermatology services in the eastern region, including the role of Hume Street Hospital. The review states, *inter alia*,

"The ERHA supports the provision of specialist dermatology services on the site of an acute general hospital because of the comprehensive range of specialties provided. This should be augmented through the provision of primary dermatology services provided in a community setting. Due to historical developments, many patients are treated at Hume Street as inpatients...This is not in keeping with current best practice as most dermatology services can be provided on an out-patient basis. It is hoped that the Hume Street service can be configured accordingly in consultation with major stakeholders and in keeping with best practice guidelines."

The current committee fully endorses this objective which also has the support of the consultants and management of Hume Street Hospital. The committee recommends that the 1988 Comhairle recommendation, as outlined above, be implemented without further

delay. While the committee has been advised that there is scope to maintain a day-care dermatology service at Hume Street, inpatient services should no longer be provided there. Indeed, with the development of the dermatology services at St Vincent's University Hospital and in the health boards surrounding the ERHA which account for a significant volume of the existing workload in Hume Street, the need for and viability of any dermatology service at Hume Street is questionable.

4.3 DERMATOLOGY SERVICES FOR CHILDREN

All consultant dermatologists in Ireland are trained to treat both adults and children. It is the advice of all of the dermatologists consulted with that this should continue to be the case. There are currently four consultant dermatologists who have sessional commitments to paediatric hospitals, two of whom have formal designations as consultant dermatologists with a special interest in paediatric dermatology. This designation has arisen from these posts being based at childrens' hospitals.

4.4 DERMATOSURGERY

Dermatosurgery covers the entire range of surgical activities related to the skin, ranging from diagnostic biopsies and dermatological oncology to cosmetic and aesthetic dermatology. Dermatological surgery, including micrographic surgery and laser therapy, is a component of the higher training scheme in dermatology. All consultant dermatologists do a limited amount of "dermatosurgery", including biopsies and simple excisions with very basic flaps.²⁰ Dermatologists with an interest in surgery carry out procedures such as reconstruction, grafts and complicated flaps, as well as specialised treatments such as Mohs' micrographic surgery*.

There is no recognised post of Consultant Dermatologist with a formally designated special interest in dermatosurgery in Ireland. However, a number of the submissions to the committee from individual hospitals identified some existing consultants with expertise in this area. Comhairle is aware that St. James's Hospital has proposed the appointment of a consultant dermatologist with a designated special interest in dermatosurgery. Refer to section 6.5 of this report for details of recommendations regarding sub-specialisation.

4.5 DERMATOPATHOLOGY

In Ireland, there is a small number of histopathologists with an interest in dermatopathology - a sub-specialty of histopathology. Dermatopathology is concerned with the study and diagnosis of diseases of the skin and the adjacent mucous membranes, cutaneous appendages and subcutaneous tissues by histological, histochemical, immunological, ultrastructural, molecular and other related techniques. Dermatopathologists are doctors who, after completing their training in either histopathology (Ireland, UK and parts of continental Europe²²) or dermatology (North America & parts of continental Europe), pursue additional training for the interpretation of skin biopsies. The accurate microscopic interpretation of the biopsy is important in the selection of appropriate therapies. Dermatopathology is an essential part of the specialist training programme in dermatology in Ireland. The committee advocates that each region should have a histopathologist with expertise in dermatopathology.

* Named after Frederic E Mohs (1910-2002), an American surgeon who, as a medical student, devised a system of microscopically controlled removal of skin tumours. It is an out patient procedure involving prior necrosis with zinc chloride paste, mapping of the tumour site and removal of a horizontal disc of tissue that is deemed to be the smallest amount that could possibly remove the tumour. The piece of tissue is then examined under the microscope (preferably by the dermatopathologist/histopathologist and the dermatologist) to look for evidence of tumour cells on the edges of the sample. If any is found, another thin layer of tissue is removed and examined. This procedure is repeated until no evidence of cancer can be detected. Mohs' surgery is particularly effective for difficult and recurrent skin cancers such as basal cell carcinomas and lentigo maligna as it allows for a high cure rate while sparing normal tissue.^{20,21}

4.6 WAITING LISTS

Waiting lists for consultant dermatological services remain unacceptably high due, primarily, to the small number of consultant dermatologists in the public sector. Other factors include increased public awareness of treatments and heightened concern about skin cancer.² Data provided to the committee by hospital authorities relating to the number of patients on waiting lists and the waiting times for out-patient appointments (where available) are given at Appendix C.

5 PRINCIPLES FOR FUTURE DEVELOPMENT

5.1 EQUITABLE AND PATIENT-CENTRED SERVICE

All patients, regardless of their geographic location should have equal access to dermatology services.

The principles of equity, people-centredness, quality and accountability formed the foundations for the National Health Strategy 2001- "Quality and Fairness, A Health System for You".²³ The Strategy sought to achieve fair access to healthcare, to ensure equitable access to services based on need. The Strategy stressed that "...services must be organised, located and accessed in a way that takes greater account of the needs and preferences of the community they serve."

5.2 NO CONSULTANT DERMATOLOGIST WORKING IN ISOLATION

Each dermatology centre should be staffed by a minimum of two consultants. In addition, notwithstanding regional outreach commitments, each consultant dermatologist should have sessional commitments to a maximum of two hospitals.

It is envisaged that with the appointment of more consultants, the configuration of the existing posts would be altered to reflect this. Details are given in section 6.3.

5.3 REGIONAL SELF-SUFFICIENCY – A DERMATOLOGY SERVICE IN EACH REGION

Each region should be self-sufficient in the provision of dermatology services, except in the case of highly specialised areas (e.g. complex dermatosurgery, the management of Epidermolysis Bullosa etc.).

Each region should have its own regional dermatology centre, based in a major regional general hospital where the full range of clinical and laboratory services are provided.

5.3.1 The committee believes that self-sufficiency within each health board, as currently structured, is the way forward in the provision of dermatology care and that this is an achievable goal. This view is shared by the Irish Association of Dermatologists. The view of regionalisation expressed by Comhairle na nOspidéal in its 1988 Dermatology Report was influenced by the advice of the Irish Association of Dermatologists and the prevailing economic circumstances at the time. Regional self-sufficiency is consistent with government policy outlined in the 1994 Health Strategy "Shaping a Healthier Future – A Strategy for effective healthcare in the 1990s"²⁴ and echoed in the 2001 Health Strategy.

5.3.2 Dermatology is pre-dominantly an outpatient specialty. The committee reiterates the principles of the 1988 report that the major emphasis in the future development of dermatology services should be on out-patient clinics and day-care services rather than in-patient activity and that a network of peripheral clinics should be developed and maintained within each region to provide a local diagnostic and therapeutic service. The

small number of inpatients should be managed at the regional centre. The physical proximity of in-patient, out patient and day-care dermatology facilities would lead to a more integrated, and ultimately, a better dermatology service.

5.3.3 Facilities

Each regional centre should incorporate all facilities and equipment necessary to provide a high quality dermatology service. From the consideration of available literature^{25,26,27,28} and in consultation with consultant dermatologists in Ireland and Scotland, the committee suggests that the development of the facilities listed below would be appropriate in each regional dermatology centre. The committee has been advised that the capital investment required to ensure the provision of the facilities set out below is not excessive in the context of capital costs for developing some other specialties but the gain to patients and staff would be considerable.

The committee suggests that each regional dermatology centre should be located on the site of a major acute hospital. We have been advised that the following resources are required:

Core facilities:

- a dedicated outpatient dermatology department with a separate waiting area
- appropriate changing areas for patients
- appropriate areas for the application of topical treatments and dressings; appropriate bathing facilities for patients
- facilities for carrying out laser therapy and minor surgery, such as cryosurgery, curettage, simple excisions and biopsies, i.e. in a treatment room, under local anaesthetic. Larger and more complex surgical procedures should be done during dedicated theatre time
- equipment - including several phototherapy machines, including hand and foot phototherapy, equipment for photodynamic therapy and photosensitivity testing.
- Patch-testing facilities
- access to medical photography
- patient information and literature.

Inpatient facilities:

There is a requirement for a small number of inpatient dermatology beds (preferably together) in each regional dermatology centre

Patients with widespread chronic inflammatory skin diseases benefit from admission to hospital.²⁵ Patients requiring inpatient hospital care primarily with dermatology conditions are often admitted to various medical and/or surgical beds, sometimes resulting in sub-optimal dermatological care. Each regional centre should incorporate an in-patient unit with dedicated in-patient beds. The Royal College of Physicians (London)^{25,28} and the British Association of Dermatology recommend that;

“Two dedicated dermatological beds per 100,000 population are the minimum requirement, but eight beds are the minimum required to support appropriate staffing for a self-contained unit...Dermatological beds in general medical wards are only satisfactory if there are appropriate facilities for bathing and treatment and patients receive care from specialist dermatology nurses.”

The committee has been advised that these recommendations from the UK would be a useful guide to service provision in Ireland. Dermatological beds within any one hospital should be located together, to facilitate optimal care of patients and specialised training of nurses and other staff. Provision should also be made for isolation and photoprotection. There are currently insufficient numbers of protected dermatology beds in Ireland.

Personnel:

- a minimum of one consultant dermatologist per 100,000 population. This should allow for sufficient time for each patient. This is particularly important, for example, in the case of a child with atopic dermatitis, the treatment of which can be complex and time-consuming, with parents requiring considerable education and support²⁵
- The availability of 24-hour on-call advice from a consultant dermatologist
- Regular review of GP referral letters by a consultant to ensure fast and appropriate treatment of patients
- Referral of patient back to the GP (when appropriate) with details of the patient's status and treatment plan
- Dedicated nurses with training and expertise in dermatology are a vital component of a high quality service (see section 5.3.4 below)
- Medical Physicist to monitor UV output of PUVA units.

Teaching:

- facilities for teaching and research, including lab facilities, a dermatology reference library with relevant journals, internet access and audiovisual facilities for teaching and training.

5.3.4 Specialist Support Staff

Dermatology patients should have access to psychology, pharmacy, clinical photography, dietetics, physiotherapy and social worker services. In addition, dermatology nurse specialists play a vital role in the provision of dermatology services. While it is not directly within Comhairle's remit to make recommendations on nursing services, the committee felt that the important role played by dermatology nurse specialists warranted mention. The committee recommends that appropriate staff, including nurses with specific expertise in dermatology should be assigned to each regional centre. Dermatology nurse specialists can treat some patients in day-care units and on wards, carry out phototherapy treatment (PUVA & UVB) and patch testing as well as care for leg ulcers and wounds. They can provide advice and support to patients and demonstrate and apply treatments. They provide follow-up services for patients and ensure that dermatology patients in hospital wards receive appropriate treatment. Nurse-led dermatology clinics are currently provided at many hospitals in Ireland. Consultant dermatologists provide training to nurses. The recently established Irish Dermatology Nursing Association - a North/South group made up of nurses working in dermatology, both full-time and part-time, provides information to nurses regarding training in dermatology. Up until recently, nurses wishing to obtain formal qualifications in dermatology had to undertake courses in England, Scotland or Wales. However, in the past year, a course has been established in Northern Ireland. To date, no such course has been established in the Republic of Ireland. The committee feels that this issue needs to be addressed in the context of providing an enhanced dermatology service to Irish patients. Dermatology nurse specialists have a particularly vital role to play at outreach dermatology services.

5.4 DERMATOLOGY TEACHING AND RESEARCH

The work of consultant dermatologists includes the teaching and training of medical students, NCHDs, GPs, nurses and others. The British Association of Dermatologists estimates that consultant dermatologists may devote up to two sessions per week to teaching and training.²⁷ Teaching, including clinical audit, and research are important aspects of higher specialist training and of consultant activity.

5.5 TELEMEDICINE

The committee sought advice from representatives of the Irish Association of Dermatologists on the scope of telemedicine in the provision of dermatology services;

particularly in areas of wide geographic spread. The committee was advised that telemedicine is not commonly used in other countries for dermatology. It was felt that the development of locally based dermatology services would make telemedicine unnecessary, and that in any case, telemedicine is a poor substitute for the direct clinical evaluation of a patient's skin complaint. Dermatologists can better assess the patient by seeing and palpating the lesion, as well as ascertaining the often significant psychological aspect of skin disease. In countries where telemedicine is used, it generally only serves as an initial screening assessment of patients living in remote areas where, for example, distance or weather conditions are restrictive. Many patients would still need to be seen in a designated dermatology centre, as appropriate. It was felt that the only possible use for telemedicine in this country might be on islands off the west coast of Ireland. The use of telemedicine as a training tool of GPs is not recommended. Such training is more appropriately provided at designated dermatology centres.

5.6 COLLABORATION BETWEEN PRIMARY AND SECONDARY CARE

The remit of Comhairle na nOspidéal relates, *inter alia*, to the organisation and operation of hospital services and consultant appointments rather than GP services. However, the committee felt that it was important that the significant role played by GPs in dermatology service provision be highlighted, since this is often the patient's first port of call and only a minority of cases are referred on to consultant dermatologists.

As mentioned in section 3.14.2 of this report, there is significant scope for collaboration between the primary and secondary care areas in the provision of dermatology services. UK studies^{1,2} have estimated that GPs refer around 5% of patients presenting with dermatological conditions to consultant dermatologists. With sufficient training and knowledge, the capacity of GPs to manage dermatological conditions will be enhanced.

The committee feels that the level of GP training in dermatology needs to be increased and the committee agrees with the advice that it has received that all GPs should have training in dermatology, given that GPs see the majority of dermatology patients and such patients can represent a significant portion of the GP workload. The committee suggests a three-month rotation for all GP trainees at a hospital dermatology centre, with on-going links to the hospital.

While the committee stresses that GPs trained in the management of dermatology patients should not take the place of consultant-led dermatology services, even as a short-term solution, dermatology is a specialty where closer links between primary and secondary care provision would greatly benefit patients through effective and efficient treatment and an appropriate referral system. In fact, the committee has been advised that the referral rate of dermatology patients from GPs to consultant dermatologists increases from GPs with dermatology training. Sufficient training in dermatology amongst GPs could also facilitate the referral of patients back to GPs following treatment by a consultant dermatologist.

The committee has noted the NHS plan in Britain to appoint "general practitioners with a special interest" in a number of specialties, including dermatology.²⁹ The British Association of Dermatologists has recently reviewed the merits of the scheme and outlined the requirements for the scheme to be effective.³⁰

The committee suggests that the possibility of developing formal links between GPs and hospital dermatology centres be explored. GPs could have a particularly important role to play at the outreach centres, as part of a multi-disciplinary team, including a specialist nurse, community nurse etc. In the UK, integration between primary and secondary care settings has been strengthened by appointing community liaison nurses, appointing GPs to work in hospital dermatology clinics and developing specialist services in the community.^{27,28} Such services should be based upon improved collaboration between consultant dermatologists, GPs, community nurses and others.

6 RECOMMENDATIONS

6.1 EQUITY

The Irish Association of Dermatologists has recommended a long-term target of one consultant dermatologist per 85,000 population, but acknowledges that a ratio of 1/100,000 would be more realistic for Ireland and would result in a substantial improvement on the current level of service and staffing. **The committee recommends the target of 1/100,000 in the medium to long term. The committee has identified an initial tranche of 12 new posts in its priority recommendations, to give a total of 31 posts and a consultant/population ratio of approximately 1/125,000. It is recommended that this development be followed by the appointment of a further seven consultant dermatologists i.e. a total of 38 posts, matching the recommended target of 1/100,000.** The implementation of the recommendations of this report will immediately lead to a better, more equitable and more convenient, patient-centred service, allowing consultant dermatologists to provide their services more effectively and efficiently. The recommendations are set out in detail in Table 2 below.

6.2 REGIONAL SELF-SUFFICIENCY

Consultant-provided dermatological services should be located as near to the patient as possible. To this end, **the committee recommends that consultant dermatologists, based in regional centres, undertake out-reach clinics at other hospitals in their region.** The minimum requirement for a dermatology outreach clinic would be a dedicated space for dermatology and each clinic should be staffed by a specialist dermatology nurse. Due to the outpatient nature of dermatology, many patients will be able to receive treatment at the out-reach clinics. The shorter distances required to travel will benefit patients in terms of access to services. This will, in turn, take the pressure off the major hospital by ensuring that only those patients requiring more specialised treatments at the main centre will need to be referred there.

6.3 MODELS OF SERVICE PROVISION

While, in general, we recommend the centralisation of dermatology services at the regional dermatology centre, with appropriate outreach services to outlying general hospitals, the committee acknowledges, for some regions, that the application of this model would involve considerable travelling time. And yet it is important that dermatologists retain links with the regional centre as well as maintaining skills through a sufficient workload. The committee suggests that, as a general rule, all consultant dermatologists in a region should be based at the regional dermatology centre and provide outreach services to the region, with each consultant providing such services to a maximum of one peripheral unit.

While the committee would see this as the ideal model of service provision, it is accepted that in geographically wide areas where there is a significant distance (c. 60-70 miles) between the regional centre and the peripheral centres a different model of service provision may be required. This might apply, for example, to the south (Cork - Tralee), the west (Galway - Castlebar) and the north west (Sligo - Letterkenny). In these circumstances it is felt that a better use of a consultant's time would apply if the consultant were locally based especially where the 'outreach' hospital is located more than 60 miles from the regional centre. In the context of any such altered provision, the committee would stress the need for significant links for such dermatologists with the regional centre, perhaps in the form of a three sessions commitment. This would help to maintain expertise, case

variation and cooperation with colleagues. In addition, all histopathology specimens would be sent to the regional centre for analysis. To enable a consultant dermatologist to be appointed to such general hospitals, sufficient facilities and manpower would have to be provided at these hospitals, including a dermatology nurse specialist as well as minor surgery and phototherapy facilities, to minimise the need for patients being sent from the general hospital to the regional centre.

6.4 FUTURE CONSULTANT STAFFING

6.4.1 PRIORITIES

The committee has identified three priorities as follows for the development of dermatology services nationally.

FIRST PRIORITY

To establish consultant dermatology services in the Midland Health Board

All of those consulted in the course of the work of the committee, including the members of the Irish Association of Dermatologists, agreed that the first priority in terms of developing the dermatology service in Ireland was to establish a service in the health boards which do not have a locally-based consultant dermatologist (then the MHB and the NWHB). The Midland Health board is the only health board without any locally-based consultant dermatology posts.

SECOND PRIORITY

Enhancement of the existing services in the Mid-Western Health Board, the South Eastern Health Board and the North Western Health Board

Where there are "single-handed" dermatology services, such as in the MWHB, NWHB and SEHB, teams of two or more consultant dermatologists should be created. A locally based dermatology service has very recently been established in the North Western Health Board with the approval by Comhairle na nOspidéal, in April 2003, of the appointment of a permanent Consultant Dermatologist to be based at Sligo with outpatient services at Letterkenny.

THIRD PRIORITY

Further development of dermatology services nationally.

Table 2 illustrates the overall additional consultant dermatologist requirements envisaged by the committee.

Table 2

Health Board Area & Population*	Current Consultant Establishment	Recommendations (new posts)		Total Consultant Posts		Proposed Consultant/Population ratio
		Priority	Long Term	Priority	Long Term	
ECAHB ^{III} ~333,000	2	1	-	3	3	1/111,000
NAHB ^{III} ~486,000	4	1	-	5	5	1/97,000
SWAHB ^{III} 581,000	4	1	1	5	6	1/97,000
Total ERHA 1,401,441	10	3	1	13	14	1/100,000
MHB ^I 225,363	0	2	-	2	2	1/113,000
MWHB ^{II} 339,591	1	1	1	2	3	1/113,000
NEHB ^{III} 344,965	2	-	1	2	3	1/115,000
NWHB ^{II} 221,574	1	1	-	2	2	1/111,000
SEHB ^{II} 423,616	1	2	1	3	4	1/106,000
SHB ^{III} 580,356	2	2	2	4	6	1/97,000
WHB ^{III} 380,297	2	1	1	3	4	1/95,000
Total 3,917,203	19	12	7	31	38	1/103,000

* 2002 Census¹⁷ ^I First Priority ^{II} Second Priority ^{III} Third Priority

6.4.2 East Coast Area Health Board

The committee recommends the appointment of one additional post of Consultant Dermatologist in the east coast area, to give a total of three. Each of these posts would be based at St Vincent's Hospital. The sessional structures of the two existing posts should be altered to reflect the location of the regional dermatology centre at St Vincent's Hospital.

6.4.3 Northern Area Health Board

The committee recommends the appointment of one additional consultant dermatologist in this region, giving a total of five consultant dermatologist posts. In addition, the committee recommends that the current arrangements for service provision in the Midland Health Board and North Eastern Health Board by consultants based in north Dublin hospitals should be phased out and that the relevant posts be restructured upon the implementation of the committee's recommendations in relation to the two aforementioned health boards. The committee is aware of the planned move of Temple Street Hospital to the Mater Hospital campus. Due to the considerable reconfiguration of the sessional structure of the dermatology posts in the northern area, the committee's model for revised sessional configuration is given in tabular form at Appendix E.

6.4.4 South Western Area Health Board

The committee recommends one additional post for the region, with a further post to follow, resulting in a total of six consultant dermatologist posts. It is recommended that four consultant dermatologists would serve St James's and Crumlin Hospitals. It is envisaged that two of these would have a special interest in paediatric dermatology. Two consultants would be based at Tallaght Hospital and provide out patient/day care at Naas General Hospital.

6.4.5 Midland Health Board Area

There are currently no consultant dermatologists based in the Midland Health Board. The committee recommends the immediate appointment of two consultant dermatologists to the Midland Regional Hospital at Tullamore, with one providing outreach services to Mullingar and the other to Portlaoise.

6.4.6 Mid-Western Health Board Area

The Mid-Western Health Board area is currently served by one consultant dermatologist. The committee recommends the initial appointment of one additional consultant dermatologist, and the subsequent appointment of a third. The three posts should be based at Limerick Regional Hospital and the consultants should provide outreach services to the acute general hospitals at St John's, Nenagh and Ennis.

6.4.7 North Eastern Health Board Area

There is currently one consultant dermatologist in post based in the North Eastern Health Board. In addition, there is one Comhairle-approved post awaiting filling by the Local Appointments Commission. The committee recommends the appointment in the long-term of one additional post to the NEHB, to give a long-term total of three posts. It is recommended that all of the posts should be based at Our Lady of Lourdes Hospital, Drogheda and that the three consultants should provide outreach services to the acute hospitals at Cavan, Dundalk, Monaghan and Navan. This arrangement would require the restructuring of the existing, approved vacant post.

6.4.8 North Western Health Board Area

The committee had identified the North Western Health Board area, along with the Midland Health Board, as an area of top priority in the development of dermatology services. A post of consultant dermatologist was approved by Comhairle recently for the area. The committee recommends the immediate appointment of a second consultant to the region. As outlined in section 6.3 above, the committee feels that subject to Comhairle approval the configuration of services in the region would be best determined locally, by the health board due to the significant distances between the two acute general hospitals in the region.

6.4.9 South Eastern Health Board Area

The population of over 420,000 in the South Eastern Health Board area is currently served by one consultant dermatologist. The committee recommends the initial appointment of two new consultant dermatologists, followed by one additional post, to give a total of four consultant dermatologists for the area. It is recommended that all of the consultants should be based at Waterford Regional Hospital and that out-reach services be provided by the consultants to the acute general hospitals at Kilkenny, Wexford and Clonmel.

6.4.10 Southern Health Board Area

The committee recommends an initial increase in consultant dermatology staffing from two to four, with the subsequent appointment of two consultant dermatologists, to give a total of six for the Southern Health Board area. While the committee recommends that the consultant dermatologists should be based at the South Infirmary-Victoria Hospital, with outreach services provided at Cork University Hospital, Mercy Hospital, Cork, Tralee General Hospital and Mallow General Hospital, the committee acknowledges that the significant distance between Cork and Tralee may require the reconfiguration of consultant appointments to the region. The committee feels that such adjustment should be considered, in the first instance, locally by the health board and the relevant voluntary hospitals in the region and Comhairle approval for any such proposals should be sought.

6.4.11 Western Health Board Area

There are currently two consultant dermatologists based in Galway. The committee recommends the initial appointment of one additional consultant dermatologist and the subsequent appointment of another, resulting in a total of four consultant dermatologists in the west. The committee recommends that all of these should be based at University

College Hospital, Galway and outreach services should be provided to the hospitals at Ballinasloe, Castlebar and Roscommon. However, as outlined in section 6.3 above, the committee acknowledges the significant distances between Galway and Castlebar in particular and accepts that the appointment of consultant dermatologists to the region may have to be adjusted locally to reflect this. The committee believes that the health board is best placed to decide on this matter in the first instance and then seek Comhairle approval for any such proposals.

6.5 SPECIALISATION

The committee has been advised by the Irish Association of Dermatologists that, given the current underdevelopment of dermatology services in Ireland, the formal designation of sub-specialties within dermatology and their allocation to particular centres is not a priority. However, the committee has been advised that there is an urgent requirement for the appointment of a consultant dermatologist with expertise in Moh's micrographic surgery. This technique, as outlined in section 4.4 of this report, is particularly useful in the management of complex skin cancers, which may be recurrent, large in size or in delicate locations, such as the face. A Moh's service would require the availability of a special laboratory, space and equipment. To date, patients requiring treatment using this specialised technique have been referred to the UK. However, referrals to the UK are now being refused. The committee recommends the appointment of a Consultant Dermatologist with expertise in Moh's micrographic surgery to an academic centre in Dublin, where consultation with colleagues in plastic surgery, ophthalmic reconstruction and ENT reconstruction would be available. In the longer term, similar appointments should be made to the academic centres at Galway and Cork.

With regard to the development of other specialist areas within dermatology, as previously mentioned, some hospitals have developed as referral centres for the rest of the country for specialised treatments based on the particular expertise of individual consultants. The committee accepts that this situation will continue. Inevitably as consultant numbers increase, specialty interests within dermatology will emerge and this is already happening. At present, the overwhelming requirement is that consultant dermatology services should be provided on a regional, equitable basis to provide a comprehensive service to patients throughout the country in regionally self-sufficient centres. In the long-term, following the implementation of all of the recommendations cited above, the development of designated special interests within dermatology and the designation of such sub-specialties to particular centres should be re-visited.

6.6 ACADEMIC POSTS

The committee suggests that as the specialty develops, medical schools and relevant employing authorities should consider the inclusion of formal academic sessions in certain posts of consultant dermatologist.

6.7 NURSE-LED DERMATOLOGY CLINICS

As mentioned in section 5.3.4 of this report, nurse-led dermatology clinics are currently in operation in a number of hospitals in Ireland. During its visit to Ninewells Hospital, the committee was informed of the success in Scotland of such nurse-led clinics, with appropriate consultant back-up. It was clear from the committee's site visits to the Mater and Beaumont Hospitals that the role of specialist nurses in the provision of dermatology services was substantial. The committee believes that nurse-led clinics have an important role to play in the future development of dermatology services in Ireland and should be developed accordingly to complement the work of the consultant dermatologists. The related area of liaison nurses in dermatology should also be explored. There are currently no dermatology liaison nurses in Ireland but such a service could provide a seamless progression of care between the primary and secondary sectors, act as an interface with the community, as well as provide community-based care e.g. follow-up management of leg ulcers.

7 CONCLUDING REMARKS

It is clear that dermatology is a specialty of medicine that has not been prioritised by hospital authorities and medical boards for development, despite the considerable proportion of people that suffer from dermatological conditions.

This report aims to ensure an equitable distribution of dermatology services and consultant dermatologist posts nationally, to develop self-sufficient regional dermatology centres located in major regional hospitals and to develop a network of out-patient clinics in each acute general hospital throughout the country in line with advice and international best practice. The committee has identified twelve priority consultant posts, followed by a further seven, to give a total of 38 permanent consultant dermatologist posts and a consultant/population ratio of approximately 1/100,000.

The committee acknowledges the service currently in place and has taken this into consideration in the formulation of its recommendations. The committee believes that its recommendations, when implemented, will address the large waiting lists and long waiting times experienced by dermatology patients in this country and will result in a significantly enhanced dermatology service for the people of Ireland.

November 2003

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9 APPENDICES

APPENDIX A – LIST OF QUESTIONS POSED TO ALL HEALTH BOARDS AND RELEVANT PUBLIC VOLUNTARY HOSPITALS

- (a) The level of implementation of the Comhairle na nOspidéal Report on Dermatology Services (July 1988) in your hospital / health board;
- (b) The views of the hospital / health board on the recommendations contained in the submission from the Irish Association of Dermatologists;
- (c) The location, number and frequency of out-patient clinics plus the number of attendances (new and return) in each of the last three years;
- (d) The number of in-patients and average duration of stay in each of the last three years;
- (e) List of dermatology procedures (number and type) performed during the past year. Please indicate whether in-patient or day case; identify type of anaesthesia used as appropriate;
- (f) Total number of dermatology procedures performed in each of the last three years;
- (g) The number of patients on the waiting list and the waiting times, if any, for both in-patient and out-patients;
- (h) Access to beds and out-patient facilities;
- (i) The number of (i) permanent and (ii) non-permanent Consultant Dermatologists. Please include names and sessional commitments;
- (j) Sub-specialty interests of current consultants (if any) and level of activity in each;
- (k) Number and grades of NCHDs in dermatology and whether the posts are recognised for training, and if so, to what level and by which body;
- (l) Future plans in terms of staffing and resources.

APPENDIX B – SUBMISSIONS RECEIVED BY COMMITTEE AND MEETINGS HELD

The committee met with representatives of and received written submissions from the following:

Beaumont Hospital
East Coast Area Health Board
Eastern Regional Health Authority
Hume Street Hospital
Irish Association of Dermatologists, Southern Group
Mater Hospital
Midland Health Board
Mid-Western Health Board
North Eastern Health Board
Northern Area Health Board
North Western Health Board
Our Lady's Hospital for Sick Children, Crumlin
Southern Health Board
South Infirmary-Victoria Hospital
South Western Area Health Board
St James's Hospital
St John's Hospital, Limerick
St Vincent's Hospital
Tallaght Hospital
The Children's Hospital, Temple Street
Western Health Board

Site visits were carried out at

Beaumont Hospital, Dublin
Mater Hospital, Dublin
Ninewells Hospital, Dundee, Scotland.

APPENDIX C – INFORMATION SUPPLIED BY HOSPITALS TO COMMITTEE**Out Patient Waiting Lists**

Health Board Area	Hospital	Total Number on Out-patient Waiting List (where available)	Out-Patient Waiting Time
Eastern Region - East Coast area	St Vincent's/ St Michael's	St Vincent's: 450 St Michael's: 210	St V: 7 mths St M: 5 mths
	Hume Street	800	Urgent: 1-2 weeks Routine: 7 months
Eastern region - Northern area	Mater	49	8-14 months Months: 0-3 3-6 6-12 12-24 24-36 36-48 48+ No. Waiting 2 3 8 11 8 8 9
	Beaumont	208	Urgent: 2 weeks Routine: 3½ months
	JCM	N/A	8 months
	Temple Street	358	27 wks
	St James's	795	Days waiting 30 60 90 180 365 >365 No. waiting 18 34 144 377 222 0
Eastern region - South Western area	Tallaght	0	No waiting list (patients are seen within 2 weeks)
	Crumlin	790	New patient: 1 year; Return patient: 3½ months
	Mullingar	Service not established for long enough.	No data available
Midland	Limerick Regional	958	Urgent: 3 weeks Routine: 14 months
North East	Drogheda	N/A	Urgent: 2 weeks Routine: 4 mths/1.5 yrs
	Dundalk	N/A	Urgent: max 1 month Routine: 2.5 yrs
	Cavan	401	76 patients waiting < 12 mths; 325 patients waiting 12mths
North West	Letterkenny	548	Months: 3 3-6 6-12 >12 No. Waiting 224 140 151 33
	Sligo	1005	Months: 3 3-6 6-12 >12 No. Waiting 9 11 48 937
South East	Waterford Regional	Adults: 2894 Children: 263	Adults: 2.5 - 3 years Children: 6-8 wks
South	South Infirmary -Victoria	1206	11 weeks
West	UCHG	3367 (including skin cancer triage waiting list figures)	N/A
	Mayo General	936	
	Roscommon	596	
	Portlincula	378	

N/A: data not available

Frequency of Out Patient Clinics: Number of attendances (new & return); Total number of dermatology Procedures performed in each of last three years

Health Board Area	Location of OP Clinics	No. OP Clinics & Frequency	Attendances at OP Clinic / Year (2000 or 2001)			Total Dermatology Procedures			
			New	Return	Total	1999	2000	2001	
Eastern Region - East Coast area	St Vincent's	2 / week	826	1829	2655	1049	1256	Not available	
	St Michael's	1 / week	210	525	735	Not available	210	Not available	
	Hume Street	6 / week	1297	4612	5909	17,987	17,241	18,741	
Eastern Region - Northern area	Mater	Ave. 10/wk	2836	3505	6341	1376	1748	Not available	
	Beaumont	3-4 / week	1118	2600	3718	Not available	Not available	1125	
	JCMBlancharstown	2 / week	582	518	1100		Not available		
	Temple St	4 / week	316	643	959	57	32	45	
Eastern Region - South Western area	St James's	Ave. 4.75/wk	2181	2006 + 2865 laser clinic		9287		Not available	
	Tallaght	Ave. 5 / week	1110	1682	2792	469	595	254	
	Crumlin	4 / week	1023	2086	3109	639	531	657	
Midland	Mullingar	2 / month ¹	8	-	8	-	-	84	
Mid West	Limerick Reg.	3 / week	1073	572	1645	-	-	1060	
North East	Drogheda	Ave. 3/month	316	209	525			Not available	
	Dundalk	Ave. 1/month	44	152	196				
	Cavan	1/month	87	98	185				
North West	Letterkenny	1/week ²	590	528	1118	-	-	151	
	Sligo	2/month ⁴	107	260	367	N/a	N/a	N/a	
South East	Waterford	Ave 3/week	1133	1987	3030	2743	2753	3908	
	Wexford	2/month	230	314	544				
	St Luke's Kilkenny	2/month	137	212	349				
	St Joseph's Clonmel	2/month	138	221	359				
	St Vincent's	9 / week	2160	5370	7530	5790	6206	5176	
South	CUH	Ave. 1 / week					Not available		
	West	UCHG	Ave 2/week	579	1063	1642			
		Castlebar	1/month	110	268	378		Not available	
		Ballina	1-2/month	195	215	410			
		Roscommon	1/month	127	274	322			
		Portlincula	1-2/month	112	122	234			

Notes:

1. gap in service. Procedures based on number of samples sent for histopathology.
2. Service started in November 2001. Only three sessions held from Nov 2001 to May 2002.
3. Provided by visiting consultant from Altnagelvin
4. Provided by visiting consultant from WHB until July 2001. Temporary consultant dermatologist in place since May 2002.

APPENDIX D – REVIEW OF THE COMHAIRLE NA NOSPIDÉAL REPORT ON DERMATOLOGY SERVICES (JULY 1988)

CONTEXT OF REPORT

Following an announcement by the Minister for Health on 19th May 1987, a major review of acute hospital services in the country was undertaken by the Department of Health with the assistance of Comhairle na nOspidéal. Subsequently, Comhairle was requested to undertake, *inter alia*, a review of dermatology services. The report of the Comhairle committee on dermatology services was published in July 1988.

The committee began its work in October 1987 and immediately identified inequity in the provision of dermatology services nationally. The concentration of dermatology services in the Dublin region identified in the 1988 report reflects a situation that prevails today.

THE PRINCIPLES FOR FUTURE DEVELOPMENT

The principles for future development detailed in the 1988 report can be summarised as follows,

- Dermatology services should be based in and be an integral part of a major regional hospital providing a comprehensive range of specialist services,
- For minimum viability, consultant appointments should only be created in centres where there is potential for at least a two-consultant team,
- As a low-technology and relatively inexpensive specialty, dermatology services, consistent with minimum viability, should be based as close as possible to the population being served,
- Sub-specialisation is not a requirement within dermatology in present circumstances,
- Every major general hospital (of the scale of 500 to 700 beds) should have consultant dermatologists with major commitments to it,
- A limited number of regional dermatology centres should be developed as the focal point(s) for the organisation of the specialty at regional level,
- A norm of one consultant per 150,000 to 200,000 population is recommended as a reasonable guideline for the future,
- The major emphasis in the future development of dermatology services should be on out-patient clinics and day-care services rather than in-patient activity
- A network of peripheral clinics should be developed and maintained within each region to provide a local diagnostic and therapeutic service.

REGIONALISATION

Four regional centres were recommended as follows,

- (a) North Dublin Service (North Dublin, the North Eastern Health board area, half of the Midland Health Board and part of Kildare);
- (b) South Dublin Service (South Dublin, half of the Midland Health Board, Wicklow and part of Kildare and the South East);
- (c) Munster Service (i.e. SHB and MWHB areas);
- (d) Connacht Service (i.e. WHB, NWHB and part of MHB area).

Clinics would be provided to the other general hospitals within each region and the major emphasis in the future development of dermatology services would be on out-patient clinics and day-care services rather than in-patient activity.

RECOMMENDATIONS

Specifically, the recommendations of the 1988 report were as follows,

North Dublin

- Total population for the region 900,000 in 1988
- Regional centre to be based at the Mater Hospital
- Five Consultant Dermatologists in the region servicing the Mater, Beaumont and Temple Street Hospitals
- All five consultants would be involved in providing clinics at JCM Hospital Blanchardstown, Cavan, Monaghan, Dundalk, Navan, Drogheda, Longford and Mullingar

South Dublin

- Total population for the region 813,000 in 1988
- Regional centre to be based at St Vincent's Hospital
- Five consultants in the region, servicing the St Vincent's/Hume Street Hospitals, St James's Hospital, Tallaght Hospital and Our Lady's Hospital for Sick Children, Crumlin
- Hume Street Hospital to be transferred to the St Vincent's site as soon as possible
- Dermatology services at St Anne's Hospital to cease
- Clinics to be provided at Tullamore and Portlaoise Hospitals

The South East

- Total population of 385,000
- The establishment of a locally-based dermatology service with two consultants, based at Waterford Regional Hospital, with clinics, as appropriate, in the region
- The establishment of formal links with St Vincent's/Hume Street Hospitals

Munster

- Total population of 851,000
- Regional centre to be based at Cork University Hospital
- Five consultants, three of which would be based in Cork (CUH) with out-patient clinics and ward consultations at the Mercy Hospital and the South Infirmary-Victoria Hospital. The remaining two posts would be based at Limerick Regional Hospital, with formal links to the regional centre

The West

- Total population of 347,000
- Regional centre to be based at University College Hospital, Galway
- Clinics to be continued at Sligo General Hospital and clinics to be initiated at Portiuncula Hospital, Ballinasloe and at Athlone by the Galway-based consultants

The North West

- Total population 212,000, thereby not warranting the establishment of a regional centre
- Dermatology links with Northern Ireland to be developed in the provision of dermatology services in Donegal
- The establishment of a post of Consultant Dermatologist based at Sligo General Hospital was recommended and the consultant would provide clinics in appropriate centres in the region
- The existing clinic at Sligo run by the Galway-based consultant should continue pending the provision of a locally based consultant service.

APPENDIX E – SUMMARY OF RECOMMENDATIONS FOR NORTHERN AREA HEALTH BOARD

The following is the committee's model for the revised sessional configuration (consultant sessions per week) for the hospitals in the Northern Area Health Board area:

Post (current & recommended structure)	Beaumont Hospital	James Connolly Memorial Hospital	Mater Hospital	Temple Street Hospital	Other
Sessions per week					
Post 1-current	6		3		2 (NEHB)
Post 1-rec.	8		3		
Post 2-current		3	8		Service to NEHB
Post 2-rec.		3	8		
Post 3-current	3	1	7		
Post 3-rec.			7	4	
Post 4*-current			3	6	2 (MHB)
Post 4 - rec.			5	6	
Post 5 - current	3		1		7 (NEHB)
Post 5 - rec.	2				9 (NEHB)
Post 6 - NEW	8	3			
Total -current	12	4	22	6	11
Total - recommended	18	6	23	10	9

* Consultant Dermatologist s.i. paediatric dermatology

