Irish Medical Organisation Submission to the Public Service Pay Commission – Consultants

Introduction

Recruiting doctors into the Irish public healthcare system, and retaining those doctors once they are appointed has rarely, if ever, been more challenging. At present, when analysed comparatively, Ireland is already precariously short of doctors with only 2.9 practising physicians per 1,000 population, compared with an EU average of approximately 3.4.[1]

One part of this shortage that is worrying indeed is that it represents a break from the historical pattern of doctors going abroad to enhance their skills before then returning home. In recent years however, there has been a radical alteration to this pattern of emigration, as research conducted by the Royal College of Surgeons in Ireland (RCSI) confirms:

> “there has been a change in the pattern of emigration in recent years, with more doctors leaving at an earlier stage in their training (many within one or two years of graduation), and more doctors staying abroad rather than returning. Research on health professional emigration in the Irish context indicates that much recent emigration has been driven by dissatisfaction with working conditions in the health system and uncertain career progression opportunities, aggravated by austerity-related staff reductions, salary reductions and taxation increases.”[2]

It is worth reminding ourselves that the role of the doctor cannot be replicated by other professionals within the health system. The practice of medicine has entered an era of unprecedented complexity. Patients, and their doctors, are today faced with an array of disease classifications, diagnostic assessments, and treatment regimes far in excess of those available just a generation ago. As the understanding of human physiology and disease pathology advances, the provision of healthcare requires an ever more detailed understanding of the myriad clinical factors and scientific principles that constitute disease. The medical practitioner is uniquely educated and trained to manage this complexity and to translate its nuances into an accurate diagnosis and effective treatment of the patient’s disease.

The centrality of the doctor’s role as both a scientist and central to the provision of high quality healthcare was well described by the New Zealand Medical Association’s *Consensus Statement on*

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[1] Organisation for Economic Co-operation and Development, *OECD Health Statistics 2017*, Health Care Resources, Physicians, available at: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

[2] A.M. Walsh and R.F. Brugha, *Brain Drain to Brain Gain: Ireland's Two-Way Flow of Doctors*, Royal College of Surgeons in Ireland, Dublin, 2017, p. 13.

the Role of the Doctor in New Zealand. Here, in agreement with other medical bodies,[3] the Association wrote that:

> "[d]octors have the ability to access, interpret and assimilate new knowledge critically, have strong intellectual skills and grasp of scientific principles, and are capable of effectively managing uncertainty, ambiguity and complexity. They have the capacity to work out solutions from first principles when patterns do not fit, and the ability to work outside guidelines when circumstances demand."[4]

The importance of strong medical workforce within the hospital system is reinforced by the overwhelming evidence available to demonstrate that consultant-delivered care, care which is provided by comprehensively trained medical experts with extensive experience, is the best model by which to organise hospital services; immediate steps should be taken to ensure its implementation in Ireland. While there has been a gradual increase in the number of consultants and NCHDs employed in the HSE, NCHDs still outnumber consultants by two-to-one and one in eight consultant posts currently remain unfilled.[5] Working conditions in over-crowded hospitals have led to unprecedented recruitment and retention issues, and many of our newly trained doctors are emigrating or planning to emigrate while we, in turn, are becoming increasingly reliant on foreign-trained physicians. This practice of recruiting physicians from outside of the European Union risks contravening Article 5 of the World Health Organisation Global Code of Practice on the International Recruitment of Health Personnel, which sets out that "Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers".[6] Staffing our hospital system in a manner that provides for real consultant-delivered services, ensures NCHDs' time for training is maximised, and enables faster access for patients must be afforded high priority in public policy planning.

Additionally, Public Health Medicine is one of the core medical specialties of any functioning health service and this is true in Ireland as elsewhere. Uniquely amongst medical specialties, a substantial part of the Public Health Medicine function is mandated by national and international legislation. The Sláintecare report calls for strengthening of Public Health as a major aspect of reforming the health service and describes it as an essential enabler in the reconfiguration of the health services over the next 10 years. Accordingly there is an imminent and urgent need to address the current terms and conditions that prevail in Public Health Medicine, as it is a key enabler in designing and

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[3] The *Consensus Statement on the Role of the Doctor in New Zealand* is endorsed by: the New Zealand Medical Association; the Cardiac Society of Australia and New Zealand (New Zealand Branch); the Royal Australian and New Zealand College of Psychiatrists; the Royal College of Pathologists of Australasia; the Royal Australian New Zealand College of Radiologists; the Royal Australian New Zealand College of Obstetrics and Gynaecologists; the Council of Medical Colleges; the New Zealand College of Public Health Medicine; the Australasian College for Emergency Medicine; the Australian and New Zealand College of Anaesthetists; the New Zealand Rural General Practice Network; and the Royal New Zealand College of General Practitioners.

[4] New Zealand Medical Association, *Consensus Statement on the Role of the Doctor in New Zealand*, Wellington, 2011, p.

[5] The latest HSE census report shows that there are currently 2,764 consultants and 5,762 NCHDs employed in the HSE. HSE Census Report May 2016 downloaded from http://www.hse.ie/eng/staff/Resources/Employment_Reports/Census-Report-May-2016.pdf.

[6] World Health Organisation, *WHO Global Code of Practice on the International Recruitment of Health Personnel*, Geneva, 2010, p. 7.

delivering a health service that adequately meets the needs of our population in a structured and coherent way.

A factor contributing to the low number of doctors working in Ireland are unattractive working conditions and levels of remunerations that both drive emigration of doctors from Ireland, and inhibit the return of doctors who have already emigrated. This affect all levels of current and aspirant medical practitioners. A Medical Workforce Analysis, published by the Department of Public Expenditure and Reform from 2015 highlighted that 87% of medical students are either intending to emigrate or contemplating it,[7] while a Medical Council examination of the retention intentions of Irish trainee doctors revealed that just 58% of trainees see themselves practising in Ireland for the foreseeable future.[8] Last year a quarter of all advertisements for consultant posts had to be closed due to the lack of a suitable applicant, while around one-in-ten advertisements failed to attract a single application.[9]

Unless radical action is taken to resolve the recruitment and retention crisis within the medical professional in Ireland, we will be unable to deliver the kind of specialist and specialised medical care taken as a right in other jurisdictions. The IMO welcomes the opportunity to make the following submission to the Public Services Pay Commission, and urges the Commission to make recommendations that can act to mitigate the scale of this crisis within the Irish public health service.

Part I - 1 - *Are there currently recruitment issues for this sector? Please indicate which grades are experiencing the most significant difficulties.*

Yes, there are serious issues with regard to consultant recruitment in Ireland. Evidence of the nature of these recruitment difficulties is set out below.

Part I - 2 - *Please provide evidence to support the recruitment difficulties identified?*

The Public Appointment Service

Consultant recruitment has proved highly problematic in Ireland. Figures obtained by the IMO from the Public Appointments Service (PAS) has revealed that, of the 84 consultant posts that were advertised and closed in 2016 by the PAS, one-quarter (22) received just one application, while another quarter (21) received just two applications. One-in-ten (8) advertisements were closed without a single application being lodged for the position.[10] The PAS was unable to identify a suitable applicant for 22 of these 84 posts.[11] These statistics demonstrate that 60% of advertisements for consultant posts in the Irish health service last year attracted two applications or fewer. This highlights the deep unattractiveness with which the Irish health service is viewed by those seeking consultant posts.

[7] T. Campbell, *Medical Workforce Analysis: Ireland and the European Union compared*, Dublin, Department of Public Expenditure and Reform, 2016, p. 1.

[8] Medical Council, *Your Training Counts: Spotlight on Trainee Career and Retention Intentions*, Dublin, 2016, p. 6.

[9] Public Appointments Service (business correspondence, 21 November 2017).

[10] Ibid.

[11] S. Mitchell (business correspondence, 10 November 2017).

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Recruitment efforts this year have proved no better, and of the 38 consultant positions currently being advertised by the PAS, 16 have been open for over twelve months. Additionally, 128 consultant positions are currently being occupied by practitioners who are not on the specialist register.[12] It is a condition of the consultant contract that persons occupying these roles must have achieved specialist qualification and be listed on the specialist register of the Medical Council.

While the exact level of consultant vacancies within the Irish health system is somewhat ambiguous, due to a paucity in accurate staffing records, it is generally accepted that 400 such posts are either vacant, or are filled on a temporary basis.[13]

These figures offer a stark illustration that there exists minimal competition for most consultant vacancies in Ireland. Accordingly, health services management has little choice in the personnel it employs, frequently having to appoint qualified consultants from extremely small pools of applicants. In some cases the high number of vacancies has led to the health service appointing practitioners who have not achieved specialist qualification to consultant roles on an interim basis. Appointing practitioners who have not achieve specialist qualification to consultant positions, even temporarily, is both an illegal and dangerous practice that creates patient safety and clinical risks.

Opinions of Overseas Doctors

The IMO has canvassed opinions from a group of 77 consultants and NCHDs currently working in other jurisdictions. This group's responses to a number of questions on the subjects of recruitment and retention illustrate the difficulties inherent in attracting these doctors back to Ireland to fill consultant posts.

- Approximately half (56%) stated that their pay was improved by moving abroad.
- 71% stated that improved pay would prove useful in recruiting them, and their peers, to posts within the Irish health service.
- 87% stated that the pay disparity between existing consultants and their future colleagues since the 2012 consultant pay cut had impacted on their decision to return to a medical post in Ireland.
- 97% stated that they were not aware of any initiatives by the HSE or Department of Health that aim to recruit and retain doctors in Ireland.

Towards Successful Consultant Recruitment, Appointment and Retention

In December 2016 the HSE published the report of a Committee appointed by the HSE regarding reform of the processes for creation, approval recruitment and appointment to Consultant posts. This report, entitled *Towards Successful Consultant Recruitment, Appointment and Retention*, sought to outline key findings on the difficulties in retaining and recruiting consultants.[14] This report, despite its stated objective, specifically excluded the examination of contractual issues related to the terms and conditions of consultants in its terms of reference.[15] Notwithstanding this significant omission, the report nevertheless made a number of useful observations. In this report "the

[12] L. O'Reilly, Dáil Éireann Debates, Parliamentary Question No. 210, 29 June 2017.
[13] C. Burke and R. Bruton, Seanad Éireann Debates, 22 June 2017.

[14] Health Service Executive, *Towards Successful Consultant Recruitment, Appointment and Retention*, Dublin, 2016.
[15] Ibid, p. 9.

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Committee took the view that a key driver of the large number of vacant posts was a Consultant recruitment and retention crisis", to which there are a number of contributing factors.[16] These include a failure to link additional consultant posts to the availability of candidates, poor quality and protracted recruitment practices, lack of detailed job descriptions or information, and the limited resources available to new consultants.[17]

The report does, however, go on to specifically outline how income "is an important determinant of successful recruitment and retention".[18] Several paragraphs from the report are worth quoting as they provide a reasonably succinct description of the problem.

> "A key concern for many potential candidates for Consultant posts in recent years has been income. Starting salary, progression through points on the salary scale, how new appointees compare to colleagues appointed in earlier years and access to private practice all influence decisions by potential candidates to apply or to accept an offer of a post.
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> In October 2012, during Ireland's financial crisis and following negotiations with medical representative organisations on the implementation of the Public Service Agreement, the Minister for Health unilaterally reduced new entrant Consultant salary rates by 30%. While this reduced the cost of Consultant posts to the health service, it resulted in significant challenges to successful recruitment in a range of settings."

The decision to unilaterally impose such a swingeing cut to new entrant consultant pay has played a substantial part in the present recruitment crisis, by not only creating a pay disparity between practitioners who perform the same work, but by further dismantling what little trust practitioners had in the government to uphold their terms and conditions. In addition, a side effect of this decision has been to ensure that, on balance, female Consultants, who tend to be younger than their male colleagues, will earn considerably less than those male colleagues.[19] While, through negotiations at the Labour Relations Commission the IMO was able to achieve some mitigation of the extent of this cut in 2015, this did not amount to a full restoration in pay. As the report goes on to note:

> "The 2015 salary rates represent a partial restoration of pre-October 2012 rates, albeit Consultants appointed under these rates take longer to progress to the final point on the scale and the final point is below that paid to Consultants appointed prior to 1st October 2012."

While the 2008 Consultant Contract provided a Type A Contract that offered increased payment for consultants who work exclusively in the public system, rather than Type B and C contracts which permitted a mix of public and private work, the report found that, since 2008 "changes to Consultant remuneration have reduced the difference between Type A and other contract types."[20]

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[16] Ibid, p. 24.
[17] Ibid.
[18] Ibid, at 25.
[19] Medical Council of Ireland, *Medical Workforce Intelligence Report: A Report on the 2015 Annual Registration Retention Survey*, Dublin, August 2016, p. 38. In 2015, 737 Doctors were registered for the first time on the Specialist Register, of these 354 were female and 383 were male.
[20] Ibid.

Changing Demographics within the Consultant Workforce

The difficulties in attracting Irish-trained doctors into the consultant workforce has led to changing demographics in this sector. In 2015 only half (53%) of newly registered specialists in Ireland were graduates of Irish medical schools. The remainder were graduates of non-Irish EU medical school (30%), and non-EU medical schools (17%).[21] A continuation of this trend would create a significant alteration in the demographics of the specialist register in Ireland, where at present approximately 80% of those on the specialist register were trained at an Irish medical school.[22]

Ireland is a signatory of the World Health Organisation (WHO) Global Code of Practice on the International Recruitment of Health Personnel, however it has been in consistent and increasing contravention of one of the Code's central tenets: "all Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible", rather than seeking to recruit medical practitioners from developing states, and thus denying those nations the benefit of the practitioners they have trained.[23]

Poor Resourcing and Supports

Several studies have noted that a myriad of factors have led to the creation of the present recruitment and retention crisis for consultant positions. The Royal College of Physicians of Ireland report, *Training 21st Century Clinical Leaders* (The Imrie Report), noted that "[l]eading factors in the increased difficulties in the recruitment and retention of consultants include a 30% cut in pay for new consultants and an increased pressure on clinicians to maintain a high level of service with reducing resources."[24] *Towards Successful Consultant Recruitment, Appointment and Retention* also noted that "in a number of cases Consultants have commenced posts in the absence of / with severely limited access to key resources or facilities to deliver services. Additionally, Consultants have commenced without administrative support, access to office space or appropriate clinical supports."[25] The absence of many of these resources, and access to clinical facilities appropriate to a consultant's field of practice, operates as a serious barrier to recruitment. Furthermore, hospital medical staffing is extremely poor in Ireland, which poses severe difficulties to working in Ireland, and detracts from the HSE's attractiveness as a prospective employer for medical practitioners.[26]

Operationally, and once consultants are in post, low levels of bed capacity have resulted in widespread surgery cancellations across the hospital groups, with staff shortages in Beaumont Hospital leading to one-in-four theatre lists being cancelled on an ongoing basis.[27] The IMO's recent quarterly survey on consultants revealed that 58% of consultants stated that there were medical vacancies on their team, and of these 38% stated that these vacancies had led to the cancellation of appointments or procedures during the last six months.

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[21] Ibid.

[22] Ibid, p. 68.

[23] Article 5, *WHO Global Code of Practice on the International Recruitment of Health Personnel*, Geneva, 2010.

[24] K. Imrie, *Training 21st Century Clinical Leaders: A review of the Royal College of Physicians of Ireland training programmes by Professor Kevin Imrie*, Royal College of Physicians of Ireland, p. 22.

[25] Health Service Executive, *Towards Successful Consultant Recruitment, Appointment and Retention*, Dublin, 2016, p. 13.

[26] N. Humphries *et al.*, ''Emigration is a matter of self-preservation. The working conditions . . . are killing us slowly': qualitative insights into health professional emigration from Ireland', *Human Resources for Health*, 13:35, May 2015, doi.org/10.1186/s12960-015-0022-6.

[27] M. Wall, 'Ireland's ailing health service: What consultants say', *The Irish Times*, 18 September 2017.

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Bed occupancy rates published in 2016 found that bed occupancy in Ireland had risen to 97%, and sat at an average of 104% in Model 4 hospitals.[28] This far exceeds the recommended 85% bed occupancy, and is well above the identified 92.5% tipping point that has been shown to result in significantly higher patient mortality, due to rationing of resources and elevated stress levels.[29]

We are finding it difficult to recruit consultants, and when they are recruited, they are finding it ever more challenging to do their job.

Part I - 3 - *Please provide evidence of any relevant initiatives to address these difficulties (if applicable)?*

The IMO is aware of no initiatives that seriously attempt to address the recruitment difficulties within consultant posts in the Irish health service. Similarly, of the surveyed group of doctors working overseas, approximately 97% stated that they were not aware of any HSE or Department of Health initiatives that aim to recruit doctors to Ireland.

It is therefore evident that no concerted effort has been made by the HSE, or other relevant bodies, to put in place initiatives designed to alleviate the medical recruitment crisis in Ireland.

Additionally, please see the answer to Part II – 3.

Part I - 4 - Please provide evidence of the outcomes of the initiatives described in part I-Q.3

As aforementioned, the IMO, and the medical profession generally, is unaware of the existence of any such initiatives.

Part I - 5 - *Please supply any relevant data, including trend data (from 2007 to 2017), that you may have; such as staff numbers, turnover rates*, staff vacancies**, age profiles and details of recruitment campaigns, etc. from 2007 onwards.*

Any statistics relevant to medical recruitment in Ireland, which the IMO has to present, are contained within the response to Part I – 2.

Part II - 1 - *Are there currently retention issues for this sector? Please indicate which grades are experiencing the most significant difficulties.*

Yes, consultant positions are currently experiencing severe retention difficulties. The evidence supporting the existence and extent of these difficulties is outlined below.

Part II - 2 - *Please supply evidence to support the retention difficulties identified?*

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[28] Department of Health, *Interim Report and Recommendations by the Taskforce on Staffing and Skill Mix for Nursing*, Dublin, February 2016, p. 27.

[29] L. Kuntz, R. Mennicken, and S. Scholtes, 'Stress on the ward: evidence of safety tipping points in hospitals', *Management Science*, Vol. 61, pp. 754-771.

Consultant Turnover

Staff turnover figures collected by the HSE for 2016 show that 39% of those who left consultant posts during that year resigned their positions, while 46% had their contracts expire.[30] Just 13% of those who left consultant posts did so due to retirement. This means that only 36 of the 279 consultant posts that were vacated in 2016 could be said to be as a result of retirement. The overall turnover rate for consultants in the HSE was 8.9% last year, while the corresponding figure for NHS England sat at just 6.1%.[31] Consultant emigration from Ireland is poorly studied, however these statistics shed light on the considerable problems that exist for consultant retention in the HSE, and show that leaver rates are substantially higher for this class of doctor in Ireland than in the UK's National Health Service. Of the replacement consultant posts that have become available within the HSE since 2015, 73 have arisen from consultant resignations.[32]

IMO Consultant Survey Recruitment and Retention Issues

The outcomes of the IMO Consultant Survey on Recruitment and Retention Issues obtained the responses of 111 consultants working in Ireland, which give some indication of the issues driving consultants away from positions within the Irish public health service.

27% of consultants indicated that they were considering taking up a post abroad in the foreseeable future. Of the consultants considering taking up a post abroad in the foreseeable future the four most frequently cited factors leading them to consider a move were:

- better workplace atmosphere, culture, and supports elsewhere (76.7%);
- higher levels of remuneration elsewhere (73.3%);
- higher doctor staffing levels (70%); and
- better opportunities to avail of education, training and continuous professional development elsewhere (60%).[33]

Focussing specifically on pay, it becomes clear that it was considered to be an important recruitment and retention issue throughout the survey responses.

- 76.6% of all consultants believed that their remuneration would be increased, were they to move abroad;
- 68.5% stated that improved levels of remuneration would prove useful in ensuring their retention, and that of their peers, within the Irish health service;
- 99.1% believe the pay disparity between existing consultants and their future colleagues since the 2012 consultant pay cut has impacted on recruitment to consultant posts in the public system;
- 93.7% believe the failure of government to fully honour the 2008 Consultant Contract has been an impediment to consultant recruitment.

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[30] Health Service Executive, *Staff Turnover Report 2016*, Dublin, 2016, p. 7.
[31] NHS Digital, *NHS Hospital & Community Health Service (HCHS) workforce statistics*, July 2017.
[32] Figures derived from Consultant Appointments Advisory Committee data.
[33] IMO Consultant Survey on Recruitment and Retention Issues, November 2017.

Additionally, 89.2% said that they have been approached by an agency or employer seeking to recruit them to a medical post in another jurisdiction, demonstrating the intense recruitment efforts being employed by health services in other jurisdictions to attract consultants working in Ireland to posts abroad.[34]

Indeed, some Consultants shared with the IMO some of the offers that had been made to them which include salaries of up to AUD400,000 offered to Emergency Department Consultants in Queensland, while similarly qualified Consultants could command up to USD280,000 in the United Arab Emirates which could be augmented by incentive payments and other benefits. These terms and conditions are far in excess of those offered in Ireland. Yet, in the coming shortage of medical specialists highlighted by the WHO, this is the competition that the Irish health service will face.

Working Conditions

International research demonstrates that poor working conditions constitute a major driver of medical workforce migration, and that the likelihood of a practitioner returning to his or her source country is heavily dependent on improvements in working conditions.[35] This is mirrored in Irish research on health professional emigration, which indicates that a significant portion of emigration has been driven by dissatisfaction with working conditions in the health system and uncertain career progression opportunities, aggravated by austerity-related staff reductions, salary reductions and taxation increases.[36] Consultants are heavily concerned about the quality of healthcare management and the quality of care they can provide amidst resource constraints.[37] They also feel undervalued within the negative sociocultural environment in which they work.[38]

The poor resource and staffing levels under which consultants routinely work contributes to a high risk of burnout. Though little research has been done in this area, a study of urologists in Ireland and the UK found that the highest levels (and statistically significant) of burnout were seen in the Republic of Ireland (63.5%) followed by England (58.6%). Four-fifths of respondents were consultants, with the remainder being NCHDs.[39] These study results, while here specific to one specialty, are indicative of the experience of consultants working across a health service in which medical staffing is amongst the lowest in the EU. Ireland possesses a mere 2.9 practising physicians per 1,000 population, compared with an EU average of approximately 3.4.[40]

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[34] Ibid.

[35] A. Sharma, T.W. Lambert, and M.J. Goldacre, 'Why UK-trained doctors leave the UK: cross-sectional survey of doctors in New Zealand', *Journal of the Royal Society of Medicine*, 105(1), 2012, pp. 25-34. doi: 10.1258/jrsm.2011.110146.

[36] R. Brugha, S. McAleese, and N. Humphries, *Ireland: A Destination and Source Country for Health Professional Migration*, Royal College of Surgeons in Ireland, Nov 2015, p. 3.

[37] B. Hayes *et al.*, 'Quality care, public perception and quick-fix service management: a Delphi study on stressors of hospital doctors in Ireland', *BMJ Open*, Vol. 5, No. 12, December 2015, doi: 10.1136/bmjopen-2015-009564

[38] Ibid.

[39] F. O'Kelly *et al.*, 'Rates of self-reported 'burnout' and causative factors amongst urologists in Ireland and the UK: a comparative cross-sectional study', *British Journal of Urology International*, Vol. 117, No. 2, February 2016, pp. 363-372.

[40] Organisation for Economic Co-operation and Development, *OECD Health Statistics 2017*, Health Care Resources, Physicians, available at: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

Part II - 3 - *Please provide evidence of any relevant initiatives to address these difficulties (if applicable)?*

The IMO is aware of no initiatives that seriously attempt to address the retention difficulties within consultant posts in the Irish health service. When consultants in Ireland were asked if they were aware of any initiatives by the HSE or Department of Health that aim to retain doctors in Ireland, 91% consultants replied “no”.

Quite apart from making no serious effort to launch effective recruitment and retention initiatives, the HSE has actively failed to tackle many serious barriers to recruitment and retention.

Dr. Rhona Mahony, current Master of the National Maternity Hospital, Holles Street, in her presentation at the IMO’s Doolin Memorial Lecture noted that “the HSE is perceived to be a toxic employer – a damning indictment of a body that is meant to facilitate the delivery of healthcare in Ireland. . . and the current policies of the HSE surrounding recruitment and retention of doctors in Ireland are failing.”[41]

Numerous cultural issues that act as a barrier to recruitment and retention within the HSE have often failed to be meaningfully addressed by the organisation’s initiatives. Bullying, harassment, and sexual harassment appear to remain common features of medical practice in Ireland, despite efforts to curtail their impact and prevalence. The Medical Council’s *Your Training Counts: Trainee Experiences of Clinical Learning Environments in Ireland 2015* shows that 35% of trainee doctors working in Ireland reported that they had been victims of bullying and harassment, while 46% said they had been the victims of undermining behaviour, at least once, as a result of the actions of a consultant or general practitioner.[42] There appears, from this research to be an inverse correlation between the clinical experience or seniority of the trainee and the probability of him or her being a victim of bullying, as 48% of interns, 34% of those in basic specialist training, and 28% of those in higher specialist training, report being bullied at least once in their posts.[43]

Research conducted by the Irish Medical Organisation shows that 27.7% of female NCHDs, 13.2% of female consultants, 10.4% of GPs, and 5% of community health and public health doctors surveyed report being bullied on the basis of their gender during the last two years, while 21% of female NCHDs reported being sexually harassed in the workplace in the same time period.[44]

Discrepancies in specialty choice is a core issue that has not been adequately addressed. Approximately 41% of all doctors practising within the state are female,[45] and 39% of consultants within the public health service are female.[46] This headline figure, however, belies considerable nuance within the overall structure of medical leadership in hospitals and the disparities that exist between the ratios of male to female consultants across various specialities. Dermatology, geriatric medicine, medical oncology, obstetrics and gynaecology, paediatrics, pathology, psychiatry, and ophthalmology, for example, are some of the areas of specialisation in which there is approximately equal gender representation or, in some areas, female dominance in terms of representation in

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[41] R. Mahony, *Presentation to the Irish Medical Organisation Doolin Memorial Lecture*, 2 December 2017.

[42] Medical Council, Your Training Counts: Trainee Experiences of Clinical Learning Environments in Ireland 2015, Dublin, 2015, p. 29.

[43] Ibid.

[44] IMO Survey on Gender Issues in Irish Medicine, December 2016.

[45] Medical Council, *Medical Workforce Intelligence Report 2016*, Dublin, 2016, p. 58

[46] Health Service Executive, *Consultants by Specialty (HSE & S38 Agencies): December 2016*, 2016, p. 1

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consultant posts, relative to the percentage of female doctors in practice generally. Other areas, however, such as cardiology, endocrinology, nephrology, neurology and most of the surgical specialties exhibit disproportionately high male representation.[47] In fact, only about one-in-ten consultant surgeons in Ireland are female.

Dr. Mahony's presentation at the IMO's Doolin Memorial Lecture also pointed to the lack of flexibility in medical training that inhibits the balancing of family commitments and the pursuit of a career in medicine. She noted that:

> "at no time have discussions surrounding our supports for parents been more relevant and this is not just politically correct but this is a political imperative. And this conversation is particularly needed in medicine. . . women are deferring childbirth to accommodate training demands. And many fathers are deeply involved in parenting but how do we facilitate parents to rear their children healthily but still pursue demanding careers? Flexible working structures and robust affordable childcare would be a good start."

She furthermore remarked on the need to:

> "honestly appraise training locations and ensure that trainees are circulated around the country for real training purposes and not for service. The ritual annual circulation of obstetric trainees to hospitals all over Ireland creates real stress for young families on registrar salaries, who spend time separated from their families and with the financial burden of relocation."

Our health services ensure that all medical practitioners are protected from discrimination on the basis of their gender, and that harmful behaviours that undermine the dignity and welfare of those providing care to patients are eliminated from the workplace. Similarly, significant gender disparities within individual fields of medical practice should not be permitted to continue unchallenged, as predominance of one gender over another in leadership risks producing cultural barriers to practice in specific areas, and can lead to the perception of bias. Improved efforts must also be made to better the work-life balance experienced by medical practitioners and their abilities to comfortably meet their family commitments, through extended supports and revised management practices.

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Part II - 4 - Please provide evidence of the outcomes of the initiatives described in part II-Q.3

As aforementioned, the IMO, and the medical profession generally, is unaware of the existence of any such initiatives.

Part III - 1 - Evidence of any impact of recruitment and retention difficulties on service provision:

1993's *Medical Manpower in Acute Hospitals: A Discussion Document* (The Tierney Report); 2003's *Report of the National Task Force on Medical Staffing* (The Hanly Report); and 2006's *Preparing*

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[47] Medical Council, *Medical Workforce Intelligence Report 2016*, Dublin, 2016, p. 60.

Ireland's Doctors to Meet the Health Needs of the 21st Century (The Buttimer Report) all placed a focus on significantly reducing the ratio of NCHDs to consultants and employing greater numbers of consultants to provide a consultant-delivered, rather than led, health service.[48] Regrettably, however, there has been little change in the NCHD to consultant ratio which has stood at roughly 2:1 for the past 25 years, despite consistent calls throughout that period for a move to a consultant-delivered service and a reduction in the NCHD to consultant ratio. Consultant-delivered care been widely accepted as the most effective and appropriate method of providing health services in a hospital setting, resulting in improved quality of care and patient safety as important clinical decisions would be made faster and at a higher level. Accordingly, a failure to recruit and employ a sufficient number of consultants to deliver services to patients has resulted in the suboptimal delivery of care in Ireland. According to ratios provided in The Hanly Report, based on population the Irish health service should employ approximately 4,400 consultants,[49] however at present only around 3,000 consultant posts have been approved, while just 2,427 have been permanently filled.[50]

Greater effort must be made to ensure progression of NCHDs working in Ireland to consultant posts. Ireland already possesses far fewer doctors per capita than the EU average (2.9 practising physicians per 1,000 population, compared with an EU average of approximately 3.4),[51] and accordingly the health service requires a considerable expansion of its medical workforce to ensure appropriate service provision. This expansion in hospitals should occur within the consultant workforce, with provisions emplaced to better facilitate the transition of doctors-in-training in Ireland into these roles.

The inadequacy of medical staffing in Ireland has contributed to high profile service failings across numerous specialties, which have been highlighted in recent months. For example, in late 2016 staffing inadequacies at the Mater Misericordiae University Hospital's cardiology unit garnered national media and parliamentary attention, where Prof. Kevin Walsh, a consultant cardiologist at the hospital, noted that a failure to employ adequate numbers of staff was leading to severe restrictions. He pointed out that UK NHS recommendations state that there should be four full-time consultants at the Mater Hospital's cardiology unit for the number of patients being treated, however instead there were just two part-time consultants filling those essential roles.[52] He also added that lives were being risked by the failure to staff the service in the correct manner. Throughout this hospital 240 consultant posts have been approved but only 144 (60%) have been permanently filled. Similarly, the report of the Ombudsman for Children on the standard of paediatric scoliosis treatment identified a lack of qualified consultant orthopaedic surgeons in Ireland as a core reason for the unacceptably long waiting lists in this area.[53] Again, recently, the

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[48] Department of Health, *Medical Manpower in Acute Hospitals: A Discussion Document*, Dublin, 1993; National Task Force on Medical Staffing, *Report of the National Task Force on Medical Staffing*, Dublin, 2003; The Postgraduate Medical Education and Training Group, *Preparing Ireland's Doctors to meet the Health Needs of the 21st Century: Report of the Postgraduate Medical Education and Training Group*, Dublin, 2006.

[49] National Task Force on Medical Staffing, *Report of the National Task Force on Medical Staffing*, Dublin, 2003, p. 14.

[50] R. Bruton, Seanad Éireann Debates, 22 June 2017.

[51] Organisation for Economic Co-operation and Development, *OECD Health Statistics 2017*, Health Care Resources, Physicians, available at: http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT.

[52] D. Buckley, 'Top role in cardiology at Mater Hospital 'had no applicants'', *The Irish Examiner*, 20 October 2016.

[53] Ombudsman for Children, *Waiting for Scoliosis Treatment: A Children's Rights Issue*, Dublin, March 2017, p. 8.

Seanad Éireann Public Consultation Committee Report on Children's Mental Health Services recognised the "HSE's chronic inability to recruit nurses and child psychiatrists to commission" children and adolescent mental health service in-patient beds, and to "to operate the existing bed compliment in Ireland".[54] Many aspects of these psychiatric services operate far below even their approved medical staffing complement. For example Dublin South's child and adolescent mental health services have six consultant psychiatrist posts approved, however this service currently operates with a single part-time consultants. This report specifically referenced consultant pay disparity between equally qualified colleagues due to the 2012 consultant pay cut as a barrier to consultant recruitment in Ireland,[55] and that "[h]ealth staff ought to be remunerated at an internationally competitive level".[56]

These examples do not serve as evidence of particular difficulties within these individual specialties, but rather as evidence that the problems arising from insufficient medical staffing span across the entire health service and touch all areas of practice. Even a cursory glance at hospital waiting lists produced by the National Treatment Purchase Fund reveals excessive in-patient and outpatient waiting lists across all specialties, which have approximately trebled over the past two years in terms of the number of patients waiting longer than 12 months for treatment.[57]

Part III - 2 - *Please provide evidence of labour market pressures from the private sector domestically or international organisations (if applicable)?*

Intense competition exists to recruit trained medical practitioners globally. In 2013 the WHO estimated that there existed a global shortage of approximately 2.6 million doctors.[58] Across Europe considerable deficits in the healthcare workforce exist, with 21 of 29 European countries reporting vacancies in their healthcare workforce in a recent European Commission study, including Ireland where difficulties in the recruitment of doctors was specifically noted.[59]

The majority of doctors working in Ireland have been specifically contacted by agencies or employers from other jurisdictions, seeking to recruit them to medical posts abroad. In a recent IMO survey 89.2% of consultants said that they have been approached by an agency or employer seeking to recruit them to a medical post in another jurisdiction. Various media reports in recent years have established the concerted recruitment efforts being made by employers in other English-speaking jurisdictions to lure Irish-trained doctors to posts within their states.[60]

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[54] Seanad Éireann Public Consultation Committee, *Seanad Éireann Public Consultation Committee Report on Children's Mental Health Services*, Dublin, Oct 2017, p. 8

[55] Ibid, p. 16

[56] Ibid, p . 38.

[57] National Treatment Purchase Fund, National Waiting List Data.

[58] World Health Organisation, *Global strategy on human resources for health: Workforce 2030*, Geneva, 2016, Annex 1.

[59] European Commission, *Mapping and Analysing Bottleneck Vacancies in EU Labour Markets: Overview report Final*, Brussels, 2014, p. 68-69.

[60] B. Heffernan, 'Canada offering €380,000 carrot to Irish GPs', *Irish Independent*, 3 March 2012; G. Culliton, 'Entry to Canada has been streamlined for Irish doctors', *Irish Medical Times*, 29 October 2015; C. Kenny, 'An Irish welcome: how Australia recruits doctors and nurses', *The Irish Times*, 14 October 2014; C. Kenny, 'Why has Ireland lost so many doctors and nurses?', *The Irish Times*, 7 September 2015.

Pay Comparisons with Other English-speaking Jurisdictions

In its submission to this Commission earlier this year, the IMO set out a pay comparison between the salaries of consultants working in other, major English-speaking jurisdictions. This pay comparison established that, when rates of taxation and purchasing power parity is taken into account, salaries offered in Ireland often fall below that available in comparator health systems. The pay comparison from that submission is set out below, for the Commission's consideration.

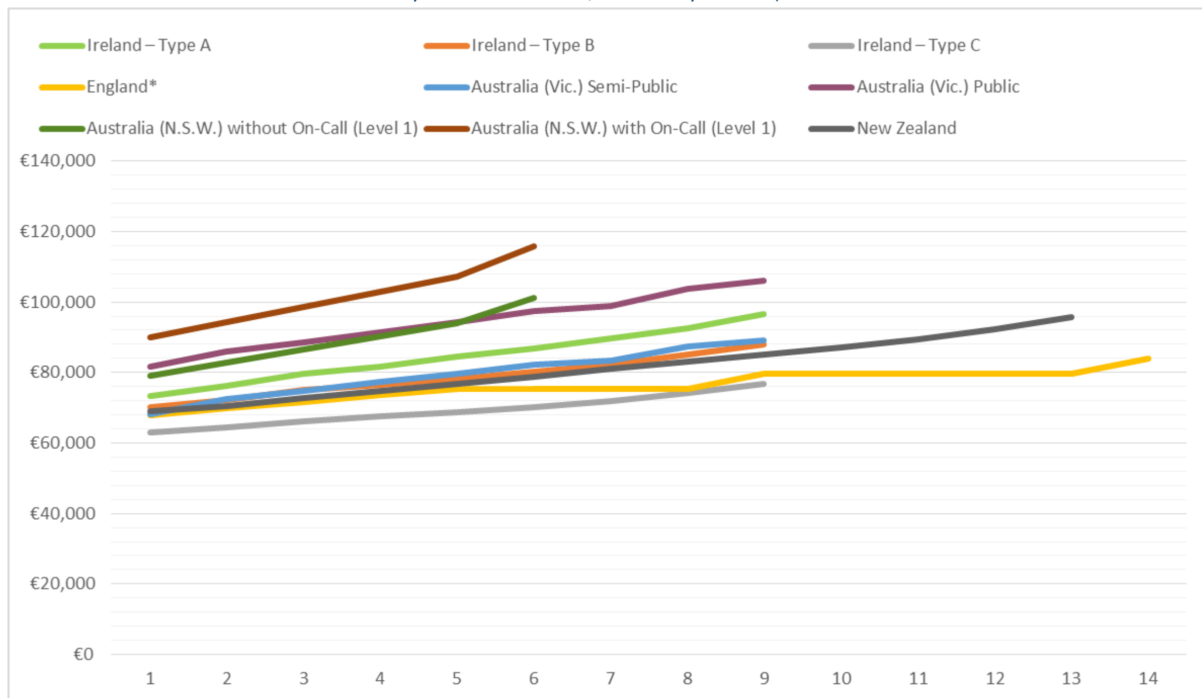
Consultants' Pay – An International Comparison

As previously discussed, three types of consultant contract are currently offered in Ireland: Type A, which requires thirty-nine hours of service to the public health system and precludes private practice; Types B and C are similar to Type A but permit private practice on the basis that it does not exceed more than 20% of the consultant's clinical workload and differ on the basis of where such private practice may be carried out.

Many comparable English-speaking jurisdictions offer alternative contracts to consultants. In England, publicly-employed consultants may carry out private practice on the basis that it does not conflict with their commitments to their public contracts, but sets no express limit on the clinical workload that can be devoted to private practice; in Victoria, like Ireland, separate contracts are offered for consultants who wish to work exclusively for the public system or those who wish to hold private practice in addition to their public contract; in New South Wales contracts do not preclude private work, however Level 1 contracts, in return for the assignment of the billings from the Staff Specialist's private practice to the Public Health Organisation, grant the consultant a 20% salary bonus; and in New Zealand, consultant contracts permit private practice, which again must not impinge on the performance of the public contract. The comparison of consultant salaries revealed in the IMO's submission to this Commission in January revealed that consultant salaries in Ireland, when taxation and cost of living considerations are taken into account, often lag behind those available in other jurisdictions.

The best reflection of consultant earnings may be obtained by aligning salaries for 'Purchasing Power Parity'. Such an alignment is shown in the graph below.

Consultants' Net Pay in Euro (Post Tax), 'Purchasing Power Parity' Adjusted (From IMO Submission to Public Service Pay Commission, January 2017)



* Figures from England do not take into account monies received from Clinical Excellence Awards. These are performance-related pay bonuses. On average, each consultant in England receives a bonus to the value of €11,847 (gross, PPP adjusted) annually, in addition to the basic pay listed in this table.

The only contracts that may be easily compared with the Irish Type A contract are the Victoria 'public only' contract and the New South Wales Level 1 contracts. It is evident that the remuneration provided by Type A Irish consultant contracts, when compared to those available in Australia, is low. At the median point in the Irish salary scale (point 5), salaries from these Australian territories are between 11% and 27% higher, in net terms, than those available under the Type A contract in Ireland.

It should also be borne in mind, when assessing this comparison, that a relatively long time is spent in postgraduate training by Irish-trained doctors before becoming a consultant, which ordinarily ranges between ten and fifteen years of practice. By contrast, medical residency (or post-graduate training) often ranges between three and seven years in Canada or the USA before taking up a specialist post. This can mean that Irish-trained doctors often spend longer in training before obtaining a consultant post than international comparators, and so remain on lower pay scales for longer, thus resulting in lower earning capacity.

Part of the challenge in recruiting consultants also relates to the increase in the number of salary points to reach the top of the Consultant salary scale coupled with a freeze in increments which has the impact of reducing life time earnings for consultants and in turn will impact on their future pension. This coupled with numerous failures to honour consultant contracts by the employers' side, reductions in terms and conditions, reductions in excess of all other workers in the context of the additional 30% salary cut for all new entrants superimposed on an in excess of 20% cut and reduced or no access to private practice and the lack of parity between existing and newly appointed consultants with regards to pay has led to difficulties in recruitment and an unprecedented number of consultant resignations from the public hospital system in Ireland.

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The salary scale for the Type B contract in Ireland can be viewed as, initially, broadly-similar to comparable contracts in England, Victoria, and New Zealand. There are key differences, between these contracts however. The English salaries listed in Table 4 do not contain monies paid through Clinical Excellence Awards which amount to, on average, a payment of €11,847 (gross, PPP adjusted) to each consultant annually. In Victoria, contracts of employment carry with them an allowance of up to 25,077AUD for approved expenses incurred in connection with continuing medical education, while in New Zealand bonus payments for the performance of on-call duties are available to the value of between 1% and 8% of salary, depending on the number of hours devoted to on-call responsibilities. None of these contracts, unlike Type B and C contracts in Ireland, contain an express restriction on the workload that a consultant can undertake privately at the same time as she performs her public contract.

In view of such restrictions, Type B and C contracts may be viewed as relatively unattractive. With the scope for private practice limited, they contain neither performance-related bonus payments, nor the strong support or additional payments contained in other contracts. An unwinding of FEMPI and a reversal of the 30% pay cut imposed unilaterally on consultants in 2012 would be required to render the remuneration available under the Irish Type B and C contracts as sufficiently attractive in an international marketplace.

Part III - 3 Other information relevant to the submission

In the Irish public health system, the relationship between doctors and their employers has been marked by protracted disputes that have fed into a lingering sense of alienation among the medical profession. While one must accept that there are few industrial relations issues that lend themselves to speedy resolution, the length of time taken in resolving some issues in the medical profession has, all too often, resulted in those issues being brought before the courts. Quite aside from the expenses incurred, the perception that it is only through the courts that issues can be resolved, has served to foster disaffection among those Doctors whose skills and expertise we need to recruit and to retain.

Some examples may serve to illustrate the point.

The current consultant contractual arrangements are set out in the 2008 Consultant Contract. This Contract itself was the culmination of a five year long process of negotiations. The Contract is a complex document, but the length of time taken in bringing the negotiations to a conclusion was attributable, in the main, to prevarication, delay and obfuscation on the part of the employer. Notwithstanding the delays, the employer has still failed to implement the Contract in its entirety. This can most clearly be seen in the decision of the employer to unilaterally set aside certain pay elements that had been previously agreed. The current legal proceedings that have been taken by some seven hundred consultants is emblematic of the frustration felt by senior doctors at the unilateral actions taken by an employer who cares little for the consequences of their actions, and repeatedly acts in bad faith.

The IMO recently surveyed consultant members and discovered that a majority of consultant respondents are working up to twenty hours a week above their contractual commitment. This work is often done without any additional remuneration and is, in many cases, the glue that holds an overstretched service together. However, the IMO has increasingly found that we are forced to seek third party intervention to secure contractual entitlements, such as Sunday and other premium payments, and access to compensatory rest provisions for consultants.

Resource issues are an ongoing concern for consultants, as managers attempt to have consultants provide professional medical services without the necessary supports or resources in an overcrowded, unsafe environment. Consultants are committed to delivering the highest standard of patient care, but are all too often prevented from doing so by a system wherein crisis management is the norm.

If we are serious about recruiting doctors into the Irish public health system and retaining them once we have them, the disingenuous disregard shown to legitimate grievances and concerns raised by doctors has to end. To this day, the IMO remains engaged in working to have contractual terms and conditions, nationally agreed, implemented. It is immensely frustrating for doctors to have to fight to have agreed terms and conditions honoured. It is also damaging and self-defeating for the health service if the intention is to retain skilled medical professionals within that service.

Protracted industrial relations disputes, all too often culminating in legal proceedings, have done dreadful reputational damage to the Irish public health service among medical professionals; if we are serious about recruitment and retention this has to end.

Conclusion

As the IMO noted in its Submission to the Commission in January, medical practitioners in Ireland have, in many cases, borne a disproportionately heavy burden from reductions in public sector pay. This has reduced the attractiveness, and thus the competitiveness, of the Irish health services as an employer within a global market for the services of highly-skilled medical practitioners. Pay ranks as a significant consideration for almost three-quarters of trainee doctors who are contemplating leaving this country, and the poor pay and conditions available in Ireland, relative to some other English-speaking jurisdictions, has unquestionably contributed the high levels of doctor emigration and low uptake in consultant posts in Ireland.

The IMO here sets out a number recommendations on doctor remuneration which it believes will reduce the flow of qualified, Irish-trained doctors from this country and better enable the Irish health services to attract medical practitioners of a high-calibre to its employment.

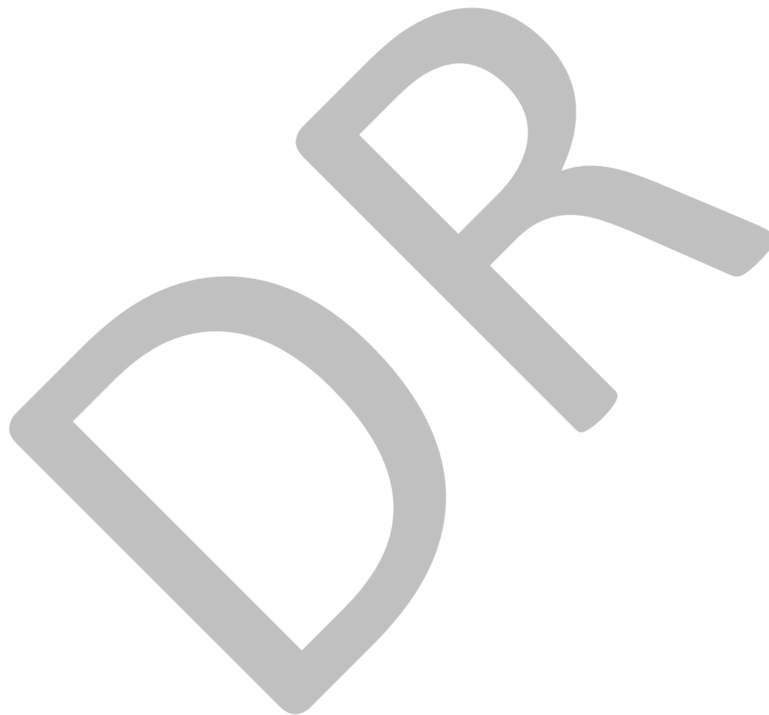
As it did in its earlier Submission, the IMO asks the Commission to adopt the following recommendations:

- The effects of the FEMPI Acts, 2009-2015, must be withdrawn, as they apply to medical practitioners.
- The 30% unilateral pay cut imposed on consultant doctors in 2012 must be completely reversed, to restore pay parity among colleagues.
- An independent review of doctors' remuneration and working conditions in Ireland should be carried out, which will include an assessment of the attractiveness of the Irish health services as an employer in terms of pay and conditions, relative to other English-speaking jurisdictions, such as Australia and Canada.
- Grants, support schemes, and tax benefits must be developed for all NCHDs to ensure that all costs associated with an NCHD's training are borne by the HSE.
- A new contract for consultants in Public Health Medicine must be drawn up and offered to new entrants and existing Specialists in Public Health Medicine, placing such physicians on par with their consultant colleagues in terms of remuneration, and with regard to out-of-hours arrangements.
- A supported recruitment and retention programme, specifically designed at attracting Irish-trained doctors back to Ireland must be developed.

- Tax relief, or similar benefit, on loan repayments for graduate entry medical students must be provided.
- A new consultant contract must be negotiated.
- A new NCHD contract must be negotiated.

As a final remark, it is worth bearing in mind the key summary point from the long-running and comprehensive doctor migration project run by the RCSI's Health Workforce Research Group:

> "The evidence points to the need for effective retention measures in order to achieve medical workforce sustainability. Strategies that will achieve this in Ireland include better working conditions (shorter and more flexible working hours), better terms and conditions of service (including equitable salary levels), better access to training and research opportunities, and clearer career paths."[61]



[61] R. Brugha, S. McAleese, and N. Humphries*, Ireland: A Destination and Source Country for Health Professional Migration*, Royal College of Surgeons in Ireland, Dublin, Nov 2015, p. 2.