DÁIL ÉIREANN

AN COMHCHOISTE UM SHLÁINTE

JOINT COMMITTEE ON HEALTH

Dé Céadaoin, 23 Márta 2022

Wednesday, 23 March 2022

Tháinig an Comhchoiste le chéile ag 9.30 a.m.

The Joint Committee met at 9.30 a.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Colm Burke,	Frances Black,
David Cullinane,	Martin Conway,
Bernard J. Durkan,	Seán Kyne.
Gino Kenny,	
John Lahart,	
Róisín Shortall.	

Teachta / Deputy Seán Crowe sa Chathaoir / in the Chair.

Business of Joint Committee

Chairman: Apologies have been received from Deputy Cathal Crowe and Senator Hoey. I have one housekeeping matter to deal with before I introduce the witnesses. Members have been circulated with a draft copy of the minutes of the public meetings of 16 February 2022 and 9 March 2022. Are these agreed? Agreed.

Hospital Doctor Retention and Motivation Project: Discussion

Chairman: Today, the committee will meet witnesses to discuss the hospital doctor retention and motivation project. I welcome from the graduate school of healthcare management at the Royal College of Surgeons in Ireland, RCSI, Dr. Niamh Humphries, senior lecturer, and Dr. John-Paul Byrne, postdoctoral researcher. Appearing virtually is Dr. Jennifer Creese, lecturer, SAPPHIRE group, department of health sciences at the University of Leicester in the UK. The witnesses are all very welcome. I invite Dr. Humphries to deliver her opening statement.

Dr. Niamh Humphries: I thank the committee for the opportunity to present our research to it this morning. The hospital doctor retention and motivation project, HDRM, is a research project that is funded by the Health Research Board, HRB, and is based at the RCSI graduate school of healthcare management. The HDRM team comprises Dr. John-Paul Byrne, Dr. Jennifer Creese and me. We are all present this morning. We have submitted a briefing statement, which contains additional detail on each component of the HDRM project.

For the past four years, the HDRM team has researched doctor retention and the working lives of hospital doctors in Ireland. We have interviewed emigrant Irish-trained hospital doctors in Australia and have surveyed and interviewed hospital doctors in Ireland about their working conditions. Over the past two years, we have undertaken research on how the pandemic altered the working conditions, well-being and work-life balance of Ireland's hospital doctors.

A key aim of the HDRM project is to connect policymakers and hospital doctors. We want to provide policymakers and medical workforce planners with the organisational intelligence they need to inform improvements to medical workforce policy and practice. In doing so, we want to help them to see the everyday work, as is done by hospital doctors, rather than the work as is imagined.

Policymakers are often surprised at our research findings and are unaware of the many challenges faced by hospital doctors. One reason for this is that hospital doctors are rarely asked about their working conditions. Another reason is that hospital doctors, like many health workers, do not always feel safe to speak up about the challenges they face at work. They have told us that sometimes they do not speak up because they fear it might damage their career or cause further deterioration in their working conditions. Others do not speak up at work because they feel it would not change anything.

Among emigrant doctors in Australia, there was a sense that exit via emigration was a less risky option than speaking up. It is difficult to see how change will happen in a situation where policymakers are unaware of the challenges that are faced by hospital doctors, hospital doctors feel powerless to improve their working conditions or the system and emigration remains a viable option for those hospital doctors who are seeking to improve their working conditions.

The HDRM project has sought to bridge the gap between policy and the front line by inviting hospital doctors of all grades to speak to us in confidence about their experiences of working in the Irish health system and for us to then share these anonymised insights with policymakers. We are delighted to have the opportunity to present our findings to the Joint Oireachtas Committee on Health.

Since 2018, we have surveyed and interviewed almost 1,200 hospital doctors about their experiences of working in the Irish health system. We have interviewed 51 Irish-trained doctors in Australia about their decision to emigrate. We have surveyed 1,070 hospital doctors in Ireland about their working conditions. We have interviewed 48 hospital doctors about working through the first wave of the pandemic. Most recently, from July to December 2021, we conducted a remote ethnography with 28 hospital doctors. This involved interviewing each doctor twice and engaging them in a WhatsApp conversation about their working conditions over a 12-week period. This is what we learned about their experiences of working in the Irish health system in 2021.

We found that the hospital doctors we spoke to are really struggling. Both non-consultant hospital doctors, NCHDs, and consultants are finding it hard to manage long working hours and a work-life balance that is heavily skewed in favour of work. The pandemic appears to have intensified already difficult working conditions. Respondents spoke to us about the challenge of working in a health system that feels understaffed and under-resourced. Although they occasionally worked on adequately staffed teams, this was a rare occurrence. Having too few staff to meet the demand for care impeded their well-being, but also restricted their ability to plan and improve services. Doctor 6 said: "It's like we're in a constant state of crisis now which makes it very hard to take a breath or plan for the future." Doctor 11 said: "We're all burned out ... I have gone from someone who was happily jumping out of bed to work to dreading it." The hospital doctors we spoke to felt they could provide better patient care if they were better supported at work, that is, if the health system was better staffed and better resourced. Doctor 7 said: "I find myself apologising to patients on behalf of the system for their poor care. It's draining." Doctor 5 said: "What keeps me up at night is ... people not having access to timely care." Respondents found it difficult to see their patients struggle to access the care that they needed.

Doctors also spoke to us about challenging relationships at work, particularly with hospital administration, HR and hospital management. For NCHDs, this related to their vulnerability as temporary employees who regularly move hospitals. NCHDs spoke about being underpaid for their work, either in being placed on an incorrect pay scale or in being underpaid for the overtime they have worked. As temporary employees, NCHDs found it difficult to resolve these issues, as this respondent explained:

> NCHDs ... are never around long enough to implement change. Only there for 1 to 2 years max and moved to new hospital. Just very easy for management not to listen.

For consultants, there was a feeling that interacting with hospital management was a frustrating experience and was of limited value in bringing about change. This dissuaded them from initiating change in their hospitals, as these doctors explain. Respondent 1 said:

> I've said all that before. No one would listen. Nothing changes. So that leads to disengagement ... just say nothing because, you know, saying stuff gets you nowhere ... and it just makes you feel bad. You don't change anything but you just get all het up about it and that's really exhausting.

Respondent 16 said:

> Having spent my first [number of] years as a consultant as someone who innovates/sets up services/improves/pushes/advocates. I am now resigned to simply doing the job and keeping away from management as much as I can. It's too damaging having any interaction with them.

Both NCHDs and consultants felt under-valued by the HSE and held out very little hope for health system improvement. While they were deeply unhappy with many aspects of the health system, they also appeared resigned to it. Although they recognised that they could provide better care if better resourced to do so, they had accepted that this was unlikely to happen. Instead, they resolved to do their best for the patient in front of them. As doctor 4 explained: "Being facilitated to do the job well and efficiently is the type of recognition I would like."

Respondent hospital doctors appeared to waste considerable time and energy struggling with difficult working conditions, inefficient systems and challenging workplace relationships. Gaining access to appropriate care for their patients or initiating even minor improvements at hospital level involved engaging in ''hand-to-hand" combat with the system. Should it really be this difficult?

Overall, HDRM research findings across four years of research reveal a medical workforce that is struggling rather than thriving. They describe a health system in which both hospital doctors and their patients are upset and frustrated, disappointed that the system is failing them both. If the health system is to recover from the pandemic, reduce hospital waiting lists, ensure timely access to healthcare and deliver on Sláintecare reforms, it will need to strengthen its medical workforce. Recruitment, retention and return emigration are all critical to medical workforce strengthening and they will all require substantial improvements to the working conditions of Ireland's hospital doctors.

Chairman: We move to questions. I call Deputy Colm Burke.

Deputy Colm Burke: I thank Dr. Humphries for her presentation. The first question I want to deal with is recommendations going forward and looking at the long-term. How does she see this changing over the next ten years? Does she believe there is not an appetite for change in the system?

Dr. Niamh Humphries: It is a big question. I think we can improve doctor retention. If the Deputy looks at the briefing document that we sent through, in the last two pages we outline six steps to improve doctor retention. The most important thing, before we begin any of those steps, is to acknowledge the need to improve doctor retention. We have high emigration, a high rate of consultant vacancy and a high reliance on non-EU doctors to staff the health system. It is really important that we recognise how much of a problem this is and how urgent it is to address doctor retention. If we want to improve doctor retention, we need to improve the working conditions of hospital doctors, improve staffing levels, reduce working hours and improve the work-life balance. Unless we do that, I am not sure that anything else will work. We need to encourage the retention and return of Irish-trained doctors, improve the retention of non-EU doctors and provide better flexibility in contracts and working hours for doctors. We need to set out a vision for health workforce improvement as well as establishing a health workforce research centre. This is a huge issue for the health system and it needs to be acknowledged and addressed.

On the plus side, it is incredible what we have achieved in four years with some Health Research Board funding. If the equivalent effort and funding went into this from a policy point of view, we would be in a different place in a couple of years.

Deputy Colm Burke: Going back 20 years, I know someone who worked as a junior doctor and who was on-call 136 hours one week and 76 hours the following week. They were on what we call a "one in two" call. They worked every day from 8 a.m. until 5 p.m. and they were on call every second night and every second weekend. There has been a move away from that and there has been some change. The number of junior doctors has increased substantially. The overall workforce in the HSE has gone from 103,000 staff to 131,000, with an increase of approximately 27% in both the number of consultants and the number of junior doctors.

The problem I find in the feedback I get from junior doctors and consultants is the resistance to change. The best example I can give is of someone who worked in the UK. A new problem arrived at their door in regard to the type of patients they were dealing with, and they were able to get funding within six months to set up a particular clinic to deal with this new problem. When they come back to Ireland, something hit them about a particular core group of patients. They suggested that a special clinic be set up to deal with that but it took ten years for that to happen. That summarises the position. There seems to be huge resistance to change. When junior doctors or consultants come up with proposals, there is resistance. How can that issue be dealt with? It has been in the health system for the past 25, 30 or 40 years and it has not changed in any way.

There is another issue. In one of the major hospitals in Ireland, something like 14 highly specialised consultants have walked away and have gone totally into the private sector because they just could not cope with the fact they could not get their job done and they could not access beds and theatres. Even as recently as last night, I was talking to someone who was trying to get their first access to theatre in five weeks and was told yesterday morning they would have to cancel their theatre list. That is the kind of frustration that has resulted. In the end, that consultant fought their corner and was able to go ahead with the operations. It is that kind of resistance. How can that kind of issue be dealt with? How can the way administrators seem to be managing the care that doctors want to provide be changed, given there seems to be a resistance to that kind of change?

Dr. John-Paul Byrne: I think there is an appetite for change among the doctors we deal with. A lot of the findings we have chime with what the Deputy is talking about - long hours, business case after business case and not getting anywhere with change. Engagement with our project highlights the doctors' appetite for change. What our project wants to do is fill the gap between the management level and the front-line level. Many of the doctors we have spoken to say there is not enough information going from the front line to hospital management and the HSE regarding what change and resources are required. We have spoken to doctors, especially during Covid, when people have been dropping out through isolation or contracting Covid themselves. It can take a long time to get the staff that are required and it can take months to resource a team, but it is that kind of speed of response that is required. Our project wants to fill a gap that is there and that gap needs to be filled. That is what we would call organisational intelligence, which is what is happening on the ground, so the hospital management and HSE management know what is going on.

Deputy Colm Burke: Can I go back to the issue of employment of junior doctors who are on six-month or 12-month contracts? Could we work towards a system? I remember doing a lot of work on this in 2012 or 2013, when I did a report on it. Could we go back to a situation

whereby instead of being given a 12-month contract or a six-month contract, a doctor is given a three-year contract, for example, and is able to rotate between hospitals? I know that is part of the training scheme, but if a doctor is not on the training scheme, he or she cannot get such a contract. What can we do to make sure people can plan ahead?

Another issue that is arising for junior doctors involves getting accommodation when they are moving from one place to another. That was not an issue five or six years ago, but it is now a huge problem. A doctor who is working in Cork today might be required to go to Dublin next year and to Galway after that. They can have problems trying to get accommodation and trying to work around that. Is there now a need to have many more junior doctors on two-year, three-year and four-year contracts, even if they are not on a training scheme?

Dr. Niamh Humphries: It is great to hire more doctors, but I am not sure that more junior doctors are what the system needs. We need to be moving towards a consultant-delivered service, as set out by the Hanly report. Although we have hired many more NCHDs, we probably need more consultants, some more trainers, more senior doctors and more senior decision-makers in the system. It is important to design a system that is focused on the doctor. The situation the Deputy described, with frequent moves and long working hours for NCHDs, is not really doctor-centred. It is difficult to see how one can change that. Going forward, our workforce policy-----

Deputy Colm Burke: Dr. Humphries is suggesting that we go into the issue by employing more consultants, but I hear big arguments from consultants. For instance, I spoke to a consultant who I think works in Galway or in the north west. She came back from the United States, where she had two days of operating time per week. Now she has a half day per week. She tries to get three operations done within her session, which is after lunchtime. She has been advised that if she does not have a patient into theatre by 4 p.m., that operation must be cancelled. In that scenario, she ends up doing two operations per week. She was doing up to 12 or 14 operations per week when she worked in the United States. If we employ more consultants, we have to be able to get access to theatre space in order that they can keep up their skills. That is one of the other challenges. How would the witnesses deal with that issue?

Dr. John-Paul Byrne: It is about resourcing the work environment in total, not just staff, although that is obviously one part of it. ICT systems must also be resourced. The efficiency through which patient information can pass through the system is a huge issue. It is a matter of resourcing the work environments of hospital doctors. We can talk about staffing, which is probably the major issue, but we must also focus on IT infrastructure, physical infrastructure and medical equipment. An holistic and resourced work environment is required to push the system towards quicker throughput and quicker efficiency.

Dr. Niamh Humphries: It is a matter of supporting them to be the best that they can be at work. If you do not have access to theatre time, you cannot be the best that you can be, if your specialty involves theatre. It is about supporting them to be the best that they can be at work. That will retain them in the system and attract them back from abroad.

Deputy Colm Burke: It appears that when we were dealing with the pandemic, hospital doctors took over the management of hospitals, to a large extent. They did a very good job while they were in charge, but that seems to have gone back again. They now seem to have very little say in when they can get a space in theatre and when they can get access to beds. There seems to be a huge clawback on the progress that was made in very difficult times. I am wondering how we now learn from that period of time. What are the lessons that can be

learned? There was a huge interaction by junior doctors, nurses and consultants in managing that particular challenge.

Dr. Niamh Humphries: We found after the first wave of the pandemic that some of the doctors were quite positive about their work environments during that first wave. They felt better staffed and better resourced. It felt like all hands were on deck. We definitely found that there was positive feedback from doctors after the first wave. We do not hear that in more recent-----

Deputy Colm Burke: Is it not the case that there was positive feedback from the doctors because they were in charge, rather than someone else dictating the terms?

Dr. Niamh Humphries: I am not sure why there was positive feedback, but definitely there were good examples of things that went well during the first wave. It was probably the most positive feedback we have received when interviewing doctors in the health system. Part of that was that non-essential care was cancelled. There were huge dynamic changes in the system. There was some positivity and there are definitely lessons to be learned from the first wave. The main thing is to talk to hospital doctors, find out what those positive examples were and attempt to resource them going forward.

Deputy Colm Burke: Does Dr. Humphries believe we can do a lot more to get administration and management to work in a far more co-ordinated way to assist doctors? The standard answer seems to be, "I'll come back to you next week about that issue you've raised". Next week goes to next month, and next month goes to next year. That is one of the complaints.

Dr. Niamh Humphries: When we talk to doctors, it sounds really convoluted and complicated. Consultants will say that they were really understaffed this week. When we ask them who they can call to say that they will need more staff next week, they explain that they need to make a business case and they need to forward that through. It might take a year to get an extra member of staff, even though staffing levels are urgent now. It sounds very slow and not agile. The system is slow to respond to the need for more staffing and the need for better resourcing. We need to shrink the distance between the policymakers who make decisions on recruitment and staffing and those on the front line who know what is needed. That distance needs to be shrunk.

Dr. John-Paul Byrne: I would like to go back to the Covid-19 example. We have published a paper that shows that most of the junior doctors to whom we spoke had a positive experience during the first wave, because of the all-hands-on-deck attitude. There were three reasons for this. The distance between the front line and hospital management shrunk. Morale improved because all hands were needed on deck. The closure of services meant that acute services shrunk, in and of themselves, within hospitals. There was simply less to do. There were fewer patients coming in. That was part of their experience as well. In addition, there were simply more staff on the floor all the time during the first wave of Covid-19. If they were going on sick leave, or if they needed cover for a day or two, they had a team of reserves that did not exist before. I am not sure whether it exists now. However, it existed during the first wave of Covid-19. Doctors could be called in to cover people who were out on sick leave or had to isolate. There was an agility within the staffing of the teams there. The general point here is the shrinking of the distance between hospital management and the front line.

Deputy Colm Burke: I think we now have over 6,000 NCHDs within the hospital system. What number of those are on training schemes and what numbers are not on any training scheme? Have we any breakdown of that number?

Dr. John-Paul Byrne: According to the 2021 national doctors training and planning report, there are 4,849 trainees.

Dr. Niamh Humphries: In addition, there are 2,593 non-trainees.

Deputy Colm Burke: There are over 2,500 doctors who are moving every six months or every 12 months. That is a huge number.

Finally, did the witnesses find in their research that junior doctors face more challenges while they working in smaller hospitals outside of the main centres of population, such as Galway, Limerick, Dublin and Cork?

Dr. John-Paul Byrne: I think that there are more challenges in such hospitals. We studied eight level 3 hospitals and specialist hospitals, and seven level 4 hospitals. The interesting thing in comparing the hospitals - we do not look at hospital-level data; we focus on the individual doctor's experience - is that the doctors in the smaller hospitals tend to have better interpersonal relationships with much of their team and closer relationships with HR and with administration, by comparison with the level 4 hospitals or the bigger hospitals. This is the case even though they face many resource gaps in terms of the care they want to provide. There is a mixed picture when hospitals are compared. It is not something we would do. However, based on the experience, we would say that there are pros and cons to working in smaller hospitals compared to the larger hospitals.

Deputy David Cullinane: I thank the witnesses for their opening statement. Towards the end of my contribution, I may ask about some solutions and how we can address some of these issues, but I first wish to pose some questions concerning the opening statement and some of the research findings. One of those findings is that one of the reasons doctors give for not speaking out about the challenges they face at work is because they fear it might damage their careers and there being a sense that repercussions might follow if they speak out in this regard. Is that anecdotal? Is it a rational fear, in the sense of there being examples in the research of circumstances where doctors did speak out and damaged their careers as a result? We know about whistleblowers in some areas, and this topic came to the fore recently and we discussed it at this committee. Regarding what is happening in healthcare generally, however, if one of the key findings emerging from the witnesses' research is that doctors are fearful of talking about the challenges they face because they fear the impact that doing so might have on their job or further career opportunities, are there examples of where something like that did happen?

Dr. Niamh Humphries: I will hand over to my colleague, Dr. Jennifer Creese, shortly because she led on the paper about voice. One thing we noticed, however, all the way through our research was that people were nervous speaking to us, despite responses being anonymous and identities protected. They were nervous about sharing information with us, never mind speaking up in the workplace. There is a great deal of nervousness at all levels, from the most junior NCHD to the most senior consultant. The respondents were nervous that what they said might be linked back to them and that speaks to a kind of general fear among the medical workforce.

Deputy David Cullinane: Referring to the experience of hospital doctors, the opening statement states: "They have told us that sometimes they do not speak up because they fear it might damage their career". Obviously, that is the case and I have spoken to many doctors who fear doing that might damage their career. Is that because they have seen it happen to themselves or to other people? During the research, was it clearly established that there were explicit examples of this type of impact occurring to show that this fear is a rational one and that this

accounts for why doctors do not speak up, or is it the case that doctors just have a fear that it may or might happen? There is a distinction between those two scenarios. I ask the witnesses to address this aspect.

Dr. Jennifer Creese: I thank the Deputy for the question. When we surveyed hospital doctors, a quarter of them said they would not speak up if they had issues at work. Probably about half of those respondents spoke about fear. The kinds of things they said they were worried about included, and particularly for junior doctors, repercussions emanating from the consultants who were going to be giving them references, grading and pushing them through their higher specialist training, HST, and then progressing them through their careers. Much of this aspect, then, probably has to do with the culture of medicine as a profession, and the specific culture of medicine in Ireland, in what is a relatively small community. In some respects, therefore, it does not really matter for these doctors whether they do have anecdotal evidence or a direct example of someone having spoken out and having been punished for doing so. It is more so that a kind of fear is built in throughout the culture about what would happen because that is the way the hierarchy works.

There are always stories about someone having heard something said about someone else's experience, but those stories perpetuate themselves and are very much bred into the culture. This is challenging to address at a policy level. What can be done is to have a framework reference system in place that can act as a kind of a safety net behind that so that-----

Deputy David Cullinane: To follow up, I think what Dr. Creese is saying is that this is more about culture and the culture of the relationship between doctors and hospital or HSE management. The opening statement goes on to state that "Doctors also spoke ... about challenging relationships at work, particularly with hospital administration, HR and hospital management." I ask Dr. Creese to explain what those challenging relationships and issues are.

Dr. Jennifer Creese: Some evidence we found spoke to a cultural rift between different types of professionals working in the healthcare system. For example, there is a cultural rift between junior doctors and nurses, or doctors and nurses, and between those who work in the clinical aspects of the health profession and those who work in the administrative side of the system. Basically, they are almost on two different islands in the stream. Patient care flows around both but the crossing of the gulf between one island and the other seems to involve a lot of personality and cultural clashes, and not everybody seems to be on the same page.

Deputy David Cullinane: Okay.

Dr. John-Paul Byrne: Regarding the specifics doctors may have talked about encountering when dealing with administration and HR, those included never getting responses to queries about pay, regularly having to pay emergency tax when they change hospitals, having to supply details to every hospital as part of their changeover every six months, providing employment details, not being paid correctly and overtime not being paid. They have to make constant efforts to sort out basic employment aspects that we would take for granted, but which these doctors regularly seem to have to struggle for. This situation leads to challenging relationships, with many of the respondents saying they just avoid HR or administration, if possible.

Deputy David Cullinane: Okay. It is more about pay and working conditions.

Dr. John-Paul Byrne: That is just one aspect in the context of the challenging relationships between the front line and HR and administration.

Dr. Niamh Humphries: An example is calling in sick and the caller needing to find a replacement. It is hard to think of any other job where the people who ring in sick need to find their own replacements before they can take a sick leave day. In general, the whole system appears to be under a great deal of strain, so antagonistic relationships between all sorts of groups within the hospital are par for the course.

Deputy David Cullinane: The next part I took from the opening statement concerned where it was stated that: "Respondent hospital doctors appeared to waste considerable time and energy struggling with difficult working conditions, inefficient systems and challenging workplace relationships." It went on to refer to one respondent speaking of "hand-to-hand' combat with the system. I again ask for examples of those difficult working conditions and the inefficient systems. Capacity is one of the issues, but are we talking in this context about hospital equipment, having the equipment needed to do the job, resources, support or oversight, or is it all those factors? I ask the witnesses to give us some examples of the inefficiencies referred to and the difficult working conditions, aside from the issue of pay, that have been encountered and related issues in that context. I also ask them to comment on the challenging workplace relationships.

Dr. Niamh Humphries: As we were interviewing and talking to hospital doctors, we would have expected them to have been talking about it being a tough job and the difficulties and challenges of delivering care and of being front-line healthcare workers. What actually gets to these doctors, though, is the kind of everyday inefficiencies found in the system, such as having to battle for care for their patients, there not being enough of them to staff the system properly and of there being too much work but insufficient numbers of healthcare workers. Those were the issues people tended to talk about when they spoke to us about their working lives, which is not really the first thing that would strike us when we think about in the context of talking to hospital doctors about their experiences. We would tend to think they would talk about trauma or the difficult situations they face with patients, but instead their responses focused very much on the organisational level, inefficiencies, poorly organised rotas, long working hours and the difficulties of just finding somewhere to take a rest, have food out of hours and sit and sleep while at work. They do not appear to be fully supported to do their jobs.

Deputy David Cullinane: I have a minute and a half left and I wish to ask one more question. I thank the witnesses for their responses. The answer I got to a parliamentary question I posed on vacant consultant posts stated 837 posts were unfilled or filled temporarily, which means that 22% of all hospital consultant posts are not permanently filled. In the minute and a half of my time left, will the witnesses outline to me what they would do differently if they were in the HSE to attract more consultants into the system? What needs to change to attract more consultants in and to start filling those vacant posts?

Dr. Niamh Humphries: We need to improve the working conditions. We will not retain the doctors we have or attract people back unless we start to improve the working conditions for hospital doctors. The fact there are 837 vacant posts is horrific. What happens where there is no consultant? What happens to the junior doctors who are meant to be supervised by the consultant? What happens to the patients who are meant to be seen by the consultant? There is a real need to make these posts more attractive to the individual doctors, either abroad or here, who are eligible to apply for them. We need to improve the working conditions considerably so they are attractive posts for people to apply for.

Dr. John-Paul Byrne: "Working conditions" is quite a general term. The experience of the doctors we have spoken to on a day-to-day basis is that they do not get to spend enough time

being doctors. To go back to the previous question, I have spoken to a doctor who is asked to fix a printer fairly regularly. When doctors are asked to do such things they ask themselves why are they fixing a printer. We have doctors who have PCs that are slower than those of many of the students in universities. They are fighting these systemic inefficiencies on a day-to-day basis and this takes away from their time being a doctor. This, along with work-life balance, are two of the major issues causing these recruitment and retention issues. Something we want to get across is that recruitment, retention and the return of doctors are all related to working conditions.

Dr. Niamh Humphries: As it stands, that is not an attractive prospect for which to return from abroad.

Deputy Róisín Shortall: I welcome our guests and thank them for the work they are doing. Their work is very important. The committee has spoken several times about the fact that it is all very well to speak about a reform programme and making funding available but if we cannot retain staff, the health service will continue to deteriorate. The frustration the witnesses have spoken about is particularly pertinent given that we are speaking about very bright and highly qualified and trained people doing very responsible jobs for which they have spent huge amounts of time training, and that training is very expensive. Then they find themselves in situations that are utterly frustrating. The most frustrating situation for people to be in job-wise is where they are doing a very responsible job but they do not have control. It seems to be like this for many of our hospital doctors. The committee should take this up in a very serious way with regard to policy and pursue it with the Minister. I raised it in the Dáil recently. The Minister did not seem to be aware of the project but certainly wanted details on it. We have a role in pursuing this.

I would like to identify what exactly are the roadblocks to successful careers for doctors. Are we speaking about two separate areas of difficulty? The first is general administration in a hospital and basic issues such as not being paid for overtime, not being rostered properly and not having the necessary supports. The second is whether there also internal problems in the career structure. Dr. Creese spoke about a hierarchical system that is very difficult. Junior doctors are dependent on their seniors for good references. Will the witnesses speak about these two elements? Are there problems clinically and career-wise and in the administration of hospitals?

Dr. Jennifer Creese: In medical culture the medical hierarchies and the way doctors function with one another on a professional level are standard throughout the world. It is the same in the UK, Australia, the US and Ireland. All doctors go through it but other countries do not have the same retention issues as the Irish system. There is something else going on as well as the professional issues. These are separate issues to address. It is more important at this stage to address the first part of what the Deputy spoke about. While changing medical culture is something that is very difficult to do, changing the health system and the structures in which doctors will function is much more in the remit of what is possible to do in Ireland to improve things. The working conditions and working hours are the most important matters to get a handle on first. Then the situation would be brought up to the same footing as everywhere else in the world. It would then not be a question of people asking whether they could be a doctor in Australia or Ireland. It would be about being a doctor in a person's own country and being the best they can be in that professional framework.

Deputy Róisín Shortall: Is the principal problem with administrators and the administrative system in the hospital or is it in the career structure of hospital doctors?

Dr. Jennifer Creese: The principal problem is probably in the way going to work works, with the types of challenges people face when they go in and the battles they have to fight when they are in there. Most of them seem to be about whether they have the right kind of resources and the right types of structures in terms of how long people work, the way they work, the way they are called on to do things and whether their time is being used to do the one thing they have signed up for.

Deputy Róisín Shortall: What I am trying to get at is what needs to happen to change this.

Dr. John-Paul Byrne: The Deputy is right there are issues at the administrative level. There are also issues in the career structure. Our research has found issues in both. The problem we find from the experience of our doctors is the professional issues, whether they be hierarchy, competitiveness or the idea that doctors cannot be patients and must be invulnerable, are organisationally reinforced when there are so many gaps in the system. Part of the medical culture is that doctors tend not to be sick and try to be in as much as possible. This is part of medical culture throughout the world. We have spoken to many doctors who feel guilt at having to be out sick. They know that because of the lack of resources in their team, if they are out for one day it completely changes the workload and there is overload for their team. The guilt might be a particularly Irish issue. From our experience, many doctors speak about the guilt of being out. This is an administrative issue and a professional issue.

Deputy Róisín Shortall: Is Ireland out of line with most other western countries in terms of the career structure for hospital doctors?

Dr. Niamh Humphries: The medical workforce is heavily focused on temporary employees. This is not the norm in other countries. I do not have the figures from other countries to hand. We have a situation where we have many more non-consultant hospital doctors than we have consultants. It is out of line with what we set out to do in the Irish health system in 2003 with the Hanly report. We are striving for a consultant-delivered service. We do not have this. Many of the problems in the system stem from this. We have a very junior workforce. They are all on very short-term contracts. I cannot think of a company that would run on temporary staff. That is what we have. We have a huge number of non-consultant hospital doctors on very short-term contracts and they are highly mobile geographically. It is not how the system would be run if we were to design it from scratch. We would have many more senior decision makers relative to the number of junior doctors. Even in terms of the numbers of trainees per consultant, we have too few consultants and perhaps too many non-consultant hospital doctors relative to the number of consultants in the workforce.

Deputy Róisín Shortall: Given the fact that there are 837 vacancies, the jobs are there. The difficulty is getting people to apply for them, is it not?

Dr. Niamh Humphries: We need to come back to the individual doctors again. We do not have a shortage of doctors; we train plenty of doctors. We fail to retain them and offer them terms and conditions that are attractive to them. We are talking a great deal about poor working conditions, but it is not attractive to work in a situation where you have a very poor work-life balance. It is not attractive to hospital doctors to return from somewhere like Australia, where they have a very good work-life balance, to a situation in Ireland where they know they will struggle to get the resources they need to be the best that they can be and struggle to do their job as best as they can for themselves and their patients. It is just out of sync with what is on offer in other countries. Until we start to meet what Australia and other countries offer, we will continue to struggle to get people to apply for the posts that are vacant.

Deputy Róisín Shortall: What about the role of pay in all of this?

Dr. Niamh Humphries: During our time speaking to doctors last year, the Sláintecare contracts were leaked. They spoke about it in our study. What came across from respondents is that appeared that the kind of geographic mobility, uncertainty and long working hours of NCHD life might continue into consultancy. That was something our respondents did not want. NCHDs put up with much uncertainty, high mobility and long working hours during their training but presume that, as they reach consultancy, this will come to an end and they will have the opportunity to put down roots, know where they are going to work and be kind of geographically stable. One of our respondents talked about planting plants, just having a garden and somewhere they know they will be. The fear with the Sláintecare contract is that the long working hours, uncertainty and instability will follow them into consultancy. Our respondents just want a normal job with normal working hours. Few of them have interest in private practice. They are very interested in stability, security, predictability and work-life balance. That is the Holy Grail and what we need to be moving towards for hospital doctors.

Deputy Róisín Shortall: Does the Sláintecare contract not offer that, in terms of a high level of pay and stability?

Dr. Niamh Humphries: They do not feel that it does. All that matters is the NCHDs who become eligible to apply for these posts feel that it does not offer them the geographic certainty or stability they really want at that stage in their careers. I am not sure what is or is not in the Sláintecare contract. However, they fear that it is a continuation of the uncertainty they experience as NCHDs, which they are not in any great rush to continue after their training. They want to settle, work and be the best they can be. The fear is that the Sláintecare contract does not offer that.

Deputy Róisín Shortall: Is it a factor that people are looking for a cap on the number of hours they want to work, in other words, a regular week?

Dr. Niamh Humphries: Yes, I think so. That is what people enjoyed about working in Australia. They had set working hours and time to have a life outside work, which is very appealing to a new generation of doctors. That has been coming for some time; I wrote about it about it eight years ago. This is what doctors want. They want to do their job and be the best they can be, but they also want a life outside work.

Dr. John-Paul Byrne: We did not ask specifically about the Sláintecare contract but it came up in our conversations. Where the respondents brought up the contract, the issues they had were not about pay but about autonomy over their own time, so again getting back to the work-life balance and that sense of stability. One participant said they did not want to move around for their rest of their life and just wanted to be at home, and by a reasonable hour. This sense of stability and autonomy over their own lives and working times was a huge issue. From their perspective of the Sláintecare contract, it felt like they were being confined to uncertainty for longer.

Deputy Gino Kenny: I thank all of the witnesses for their views on doctor retention in the public health service, which is a very important issue. I will ask some very practical questions. How many students qualify as doctors every year in Ireland? I had to look up the term "NCHD". It means non-consultant hospital doctor, just for clarity.

Dr. Niamh Humphries: After doctors finish medical school, they do internship. We have

about 725 intern places for Irish and EU doctors. There were a few more last year due to Covid, but in general 725 doctors would graduate each year. They would be the ones who have come through the Central Applications Office/Centra Admissions Service, CAO/CAS.

Deputy Gino Kenny: Is that the figure every year? Would the mean per year for the past decade be around that?

Dr. Niamh Humphries: It has increased because we introduced - I do not have this in my notes - graduate entry medicine in 2012, I believe. The figure was much lower at around 300 until then. It has been increasing steadily since then to reach the 725 mark.

Deputy Gino Kenny: Of the 725 graduates, how many would stay in the Irish health system?

Dr. Niamh Humphries: This is where we hit a problem because we do not actually have proper data on that. Ireland does not collect proper data on that. I have been looking to other countries to see how many of our doctors land there and try to figure out from there how many stay and leave. However, it is quite difficult to do. There is a real need for better data. We need to track the 725 as they exit. We need keep an eye on them and find out whether they leave and return. At the moment, we do not generate data like those. However, in 2021, 391 Irish doctors obtained work visas for Australia. Of those, about 350 were very junior doctors and would have graduated a year or two ago. That is quite a lot relative to the number we train.

Deputy Gino Kenny: Therefore, there could be a circumstance where 35% or 40% of newly qualified doctors would emigrate? That would be possible.

Dr. Niamh Humphries: Yes. We train 735 each year, and last year 391 doctors left for Australia. That would probably be after their intern year or during their basic specialist training, BST. Therefore, within a couple of years of graduating, they would have moved to Australia.

Deputy Gino Kenny: It is more than 50%.

Dr. Niamh Humphries: I do not know that it is the same doctors who are moving. I know how many graduate here and I know how many land in Australia. We are not able to join those dots, which is something that Ireland needs to start doing. We train these doctors who are highly skilled, talented and needed, yet we have only a vague idea of where they go after graduation. We need much more than a vague idea. We need to know how many leave and if they return, when they return, and whether they return to work in the Irish health system - public or private. We need that type of information.

Dr. John-Paul Byrne: It is worth reiterating that the 391 figure is only for Australia. There are doctors emigrating to other primarily English-speaking countries as well. That is something else to consider.

Deputy Gino Kenny: On yearly pay for a newly qualified doctor, what is the average pay for a doctor who goes into the Irish public health system?

Dr. Niamh Humphries: I do not have those figures.

Dr. John-Paul Byrne: I do not have those figures either. I would be guessing roughly what it is. I know there is a general scale that goes up very quickly, but I do not know what the starting rate is for a new salary.

Deputy Gino Kenny: In relation to the medical profession, when one hears stories on newly qualified doctors and long hours, work conditions that are extremely challenging and the responsibility of being a doctor, it is kind difficult to comprehend that a doctor - a human being - is sometimes working more than 100 hours per week. This is a very challenging position. To take the example of another job, which is probably not a great example, a truck driver can only drive a certain number of hours per week. If the driver goes above that, he or she is a danger not only to himself or herself but also to the public. Obviously, we are human beings and we can make mistakes if we are tired and burnt out during a working day or working week. It is incredible that the public health system, and probably the private health system, have allowed this to happen. Doctors are working these colossal numbers of hours. It is no wonder they want to emigrate or are burnt out. It is ridiculous in this day and age that people are working that number of hours. I am interested in the system in Australia where there is a set number of hours. If a newly-qualified doctor was told that he or she will not be working 100 or 80 hours per week but 45 hours per week, I believe that would have a good effect on keeping doctors in the Irish health system. What is Dr. Humphries' opinion on that?

Dr. Niamh Humphries: The doctors who are in Australia are doing the same job. They are still hospital doctors, they are still working in a health system and they are still delivering healthcare, but they are doing so in a much more sustainable way. They are working reasonable hours at approximately 40 hours per week and that frees them to have a work-life balance. That is something that is denied to many doctors in the Irish health system, unfortunately. The working hours should be restricted in the same way they are for truck drivers or any other worker. Under the European working time directive, they are supposed to be restricted to 48 hours per week, but very few of the hospital doctors we spoke to are working 48 hours per week in the health system.

Deputy Gino Kenny: Obviously, they are working much more than that.

Dr. Niamh Humphries: Yes, they are working much longer hours and longer shifts. They are not taking breaks. They struggle to have time to go to the toilet during shifts and struggle to find time to drink water and eat meals. They are not minding themselves at all. They cannot, because there is so much work for them to do and too few of them to do it. It is important to compare hospital doctors and their working conditions with other professions, where this just would not be acceptable. It should not be acceptable for hospital doctors either. Ultimately, they have to care for us and none of us wants to go into the hospital knowing that the hospital doctor seeing us is exhausted and hungry. We can do better.

Deputy Gino Kenny: As I said, a doctor is in a very responsible position, but he or she is forced to work much more than 48 hours per week. Why is it allowed to happen? That is the question. I am sure Dr. Humphries and the doctors' union have an answer to that. This seems to be a continuous situation where doctors are burnt out. I know that a newly-qualified doctor needs experience, but there is experience and then experience where somebody is pushed to the limits. Any human being who is pushed to the limits can make mistakes and get burnt out. Why is it allowed to happen in this profession?

Dr. Niamh Humphries: It should not be allowed to happen in this profession or any profession, to be honest. Some of the people I interviewed in Australia had been about to quit medicine. They had worked for a couple of years in the Irish health system. They had burnt out and were just about to give up. They went to Australia and realised that they actually love being a doctor. They just do not love the conditions that come with being a doctor. We need to improve their conditions so that they stay in the Irish health system and are encouraged and

supported to do so in a sustainable way.

Dr. John-Paul Byrne: Doctors spoke to us about loving their job and profession, but feeling like the enemy while being in a hospital and feeling punished by their working conditions. As to why this is happening, we can only speak from our data. I believe it is the combination of the negative aspects of the medical profession generally and an under-resourced organisation, when those two come together. I would also add that the sense of professionalism doctors have and the responsibility they have for their patients mean they will take on as much burden as they can, often at a personal cost to their lives and well-being.

Deputy Gino Kenny: I have a final question. If the Australian system of a set number of hours was implemented in the Irish public health system, I believe we all agree that would be a very good thing for doctors. However, what knock-on effect would it have if it was implemented in the next six months?

Dr. Niamh Humphries: That is a very difficult question to answer. We have to look at how we are spending money in the health system. Although we are spending a lot of money on health and recruitment, a lot of that is going to agency and locum staff who are more expensive. It is necessary to look at the inefficiencies in the health system and look at how that money could be used in better ways to better support the doctors to do their jobs.

Deputy Gino Kenny: I thank the witnesses. That was very informative.

Deputy Bernard J. Durkan: I welcome our guests and thank them for their useful information. A few questions come to mind. Reference was made to 750 graduates being available annually. It is 750 because 75 was mentioned as well and I presume that was a mistake. I assume we are talking about 750. With regard to emigration, I am aware that people at various levels in the health service will emigrate for experience and so forth. It is part and parcel of the job. I am also hearing of pressure in Australia, London, Canada and the US. Is that so? Have the witnesses monitored that, and to what extent? Can they also speak to the rate of emigration to the US, Canada and the UK as well as other locations? For example, in the Middle East salaries can be tax free for a limited period. Do we know the level of emigration to those locations?

Dr. Niamh Humphries: On the Deputy's first point, after the pandemic all countries will seek to strengthen their medical workforces. Ireland needs to pay attention to that. Whether it is Australia, New Zealand, the UK or the US, all of them will looking to recruit more hospital doctors and we must make sure that we work harder to retain the hospital doctors we train, especially post Covid, because Ireland will need to strengthen its medical workforce as well.

In terms of how many emigrate to each country, I do not have that data available. At one stage I looked at the data for a number of different countries to see how many emigrated from Ireland relative to the number we trained and it was terrifying. Those figures were from 2014. It is one thing for me as a researcher to look for and gather that data, but the health system needs to be doing this. We need to know how many of the 750 doctors who graduate stay in Ireland, how many emigrate and, of those who emigrate, how many return. Until we have that data it is really just guesswork about presuming they will all return or will not all return. We need hard data to back that.

In 2018, I went to Australia to talk to 51 Irish-trained doctors who had left. Of those I interviewed, only 16 planned to return, and they planned to return for personal rather than professional reasons. It is important for us to be a little fearful of our widespread doctor emigration

figures. Some 391 doctors last year leaving for Australia is a large number of doctors relative to the number we train. Not all of them plan to stay in Australia forever. Many of those I interviewed in Australia had not planned to stay there. They had emigrated with the intention of returning, but while they were in Australia opportunities came up, they enjoyed work and they enjoyed the work-life balance on offer there, so they decided to stay. We cannot just assume that those who leave will definitely return. We need to start taking emigration more seriously, especially post Covid, when there is going to be increasing competition for doctors from all the countries the Deputy listed. Doctors who were trained in Ireland and who speak English are going to be in demand worldwide post-Covid.

Deputy Bernard J. Durkan: We do not have any figures for the US, Canada or London at present.

Dr. Niamh Humphries: No, but I really-----

Deputy Bernard J. Durkan: Dr. Humphries is back. I was missing the sound. Sound is a help in this business.

Dr. Niamh Humphries: I can collect data. We can go and look for the data but gathering information about its medical graduates and where they go after graduation should really be part and parcel of what the health system does.

Deputy Bernard J. Durkan: It is alarming that 55% or thereabouts go to Australia. If other locations are included, that figure must increase to an alarmingly high level. I cannot understand how we can keep our health services going with that level of emigration. We need to find out, if we can, exact and precise numbers in respect of emigration. We must ask ourselves whether we can continue like this. I know that we are accused of having one of the most expensive health services in the OECD. People on either side of the argument will talk about that. However, if, having educated and preparing doctors, we are losing them to the extent we are, it will be virtually impossible to provide a health service at home. There is a danger that the health service at home in Ireland will degenerate. This problem is multiplying annually. The service will degenerate to a great extent, making it impossible to have a level playing field insofar as working conditions are concerned. I wanted to make that point. Do any of the witnesses wish to comment on that or do they have any particular views as to how to challenge that issue? It must be challenged one way or the other. Pay is one way, perhaps in the short term. I do not know. If somebody would like to talk about that, they should by all means do so.

Dr. John-Paul Byrne: From our experience, pay was not a major issue for the participants we spoke to. It was not a reason for going or for coming back. It was not something they were majorly focused on when they discussed the Sláintecare contract. One of the issues we need to talk about is that, when doctors emigrate, we often hear that they will probably come back in a year but we are not sure whether they do. However, in going abroad, they are often going to systems that have better work-life balance and better conditions where they can spend their time being a doctor and getting satisfaction from that. Medicine is a competitive sector. The labour market is competitive. All of these countries are looking for highly specialised doctors in different specialties. Doctors experiencing these better systems, better experiences and better work-life balance is a risk to our health system because they will obviously make comparisons. We have written about this. They compare the working conditions and work-life balance in Australia and Ireland and, for the majority, Australia comes out on top. Australia obviously has its own issues but, with regard to doctors' own working life, participants had a better experience over there. As Dr. Humphries has said, a lot of the time it is the personal family pull back to

Ireland that brings them back but we have to be concerned about how long that can continue to happen.

Deputy Bernard J. Durkan: If pay is not an issue, that reinforces my earlier point that work-life conditions and so on are a determining factor at home. That will lead more and more qualified doctors to emigrate, which in turn will create a further problem at home. It will multiply annually. The problem will only get worse. We need to look at ways and means of identifying how to break the cycle because, if we do not find out what can be done in that regard in the short term, the problem will only get worse. We have heard about the hours per week. Do we have any evidence to indicate the number of hours worked per day in some extreme cases? We know what the average in most cases is. Averages are just that - averages. The long and the short of it is that somewhere in the middle lies the tale. Do the witnesses have any information on that?

Dr. John-Paul Byrne: Most of our approach is based on qualitative research, so I can avoid the averages and talk about the extremes, which can range from 60 to 100 hours a week. During our study, doctors were texting us on their 18th hour working on a Saturday, having worked 15 hours per day that week. The level of hours is incredible. This is an extreme example but in one case a number of doctors left a team due to Covid or having to isolate and one doctor was left doing a one in three call rota for two weeks, which means a 24-hour call every third day. Those hours are incredible. When it comes to the hours, it is not just a matter of the length of the work day but, as has been discussed, the intensity of work when the doctors are in there. This means that, when they leave work, they have no time to do anything other than rest, recuperate, eat and sleep. That is all they have time to do.

On another point that came up in our research, we did a survey in 2019 and 83% of respondents agreed that they often or always worked beyond their rostered hours. Most of-----

Deputy Bernard J. Durkan: Can the witnesses give me a picture of the agency costs? We know about this. We have been through it many times before. We need to identify the extra costs involved in providing doctors, nursing staff and general hospital staff through agencies. Why should this be? Why do hospitals rely on agency staff? The staff must be there. Why not make them permanent staff of the hospitals? They are in the country. They are not in Australia. We are not going to depend on agency staff from Australia in any event, unless they come home. What is the difference in respect of cost? Why have we traditionally relied so heavily on agency staff?

Dr. Niamh Humphries: We do not have any figures on the cost of agency staff but, as to why agency staff are used, they are used where there are gaps in the system and where there is a need to fill a post on a temporary basis. I would imagine they are more expensive than regular staff. From speaking to doctors, we know that agency or locum staff are less familiar with their work environment and are less likely to do as much on-call work as a permanent colleague. They are not a like-for-like replacement for a permanent staff member. It is important to use agency staff as sparingly as possible, which involves workforce planning and making sure that there are as few gaps in the workforce as possible.

To come back to another thing the Deputy said, which related to the high rate of doctor emigration, the only reason the Irish health system has not collapsed as a result of this high level of doctor emigration is that those doctors have been replaced with non-EU doctors, who comprise 42% of our medical workforce and keep the show on the road.

Deputy Bernard J. Durkan: I understand. My last question is simple. If the witnesses were to select two measures that might address the problems we face in the health services at the present time, what would they be?

Dr. John-Paul Byrne: I would say staffing and work-life balance, which are related.

Deputy Bernard J. Durkan: They are. Does anybody else wish to answer?

Chairman: I thank Deputy Durkan. We are going to move onto Deputy Lahart.

Deputy John Lahart: I thank the Chair. I was actually just writing a note to say that I will have to depart. A group from the Huntington's Disease Association of Ireland is coming in at 11 a.m. and I am hosting them. I am really thrilled to have an opportunity to speak. I will only use five minutes of my time. I thank the witnesses. I am really concerned about some aspects of their presentation. I am very taken aback and surprised. I will just focus on one aspect, that of the HR relationship in hospitals. The witnesses' evidence certainly took me by surprise with regard to the conditions. The average layperson would probably think that doctors are highly respected and very influential in the day-to-day running and management of a hospital and in the decisions that are made, although they may just think that about consultants. What I read and hear is of a powerless group of people who do not seem to be represented or have a representative voice and who are afraid of speaking for upsetting the apple cart, but not just that, of endangering their career prospects. This is the kind of stuff that we as politicians hear from low-wage and low-income workers who are on zero-hour contracts working in the retail setting. It is really shocking for me, certainly, and I can only speak personally, to read about this.

I thank the witnesses for this body of evidence they have brought forward. I think the health world should be very shocked by this. The doctors are the oil in the engine of the hospital system. I am also really taken aback and minded by the witnesses saying that it is not all about money. Often, in the public mind, people think doctors earn so much and want more money. On the well-being piece and all of that kind of stuff, I am really struck by the idea that non-consultant hospital doctors, NCHDs, and consultants feel undervalued by the HSE. I was driving in the car listening to all the contributions remotely before I arrived. What struck me is that an awful lot of stuff in the witnesses' presentation is very fixable. There are some complicated bits and pieces in terms of contracts and that kind of stuff but what really struck me is how much of this is fixable and quick fixes are available.

I have one question in the very little time I have available. We interact with hospital management groups all the time. What can we as politicians do with regard to the management structures in hospitals? I refer to this idea of having to replace a doctor. A teacher does not have to find a substitute if he or she calls in sick. Panels are in place for this kind of situation and the principal, that is, the boss, has to ring around the panel. The Department of Education facilitates this in its own way. I think we will be coming back to this topic. I am sorry for ranting on; this is my question. Do the witnesses think some of the power structures in some of the hospitals are out of control in terms of the respect in which hospital doctors are held?

Dr. Niamh Humphries: That is a very difficult question to answer. What we can speak to is our own experience. Where I struggle at the moment is knowing where to go with our findings. Obviously, this morning has been a wonderful opportunity but we are really eager to use our findings to inform policy change. It is very difficult to know who in the system we should be speaking to, however.

I recently presented to a group of medical manpower managers, which was incredible, but it is very difficult to identify who the right people are within policy circles or hospital circles to whom we should be speaking. It would be really helpful if people could direct us to whom in the system we should be speaking in order that they hear our findings and can use them to inform policy change. That does not answer the Deputy's question at all but that is something I wanted to raise.

Dr. John-Paul Byrne: I think it goes back again to that piece about organisational intelligence. Based on our participants' experiences and thoughts, there seems to be a significant gap between the stressors they face on the front line and in terms of their working lives and how they are supported by management, HR, colleges or whatever it might be. It is shrinking that gap between management and the front line with information, intelligence and awareness of what is happening on the ground and being agile enough to respond to organisational issues as they arise.

We have ourselves discussed the idea that, particularly for NCHDs, it is almost like talking about a peripheral workforce from another industry. There are basic aspects of employment that seem to be missing. Time, rest and food seem like basic things but they are the things with which they have issues and that are major stressors for them on a day-to-day basis.

Deputy John Lahart: I have to depart. Shrinking the gap is a very good way of describing it. It certainly speaks to me. It speaks of a big gap between administration and the day-to-day role of the hospital doctors. Clearly, the chief executive of the HSE and the Minister have a role here. When we go into private session at some stage later in the week, certainly, I think the witnesses have exercised our minds greatly on that. I know talk is easy but I think they have. The Joint Committee on Health produces the occasional paper. All the information the witnesses presented is just so accessible. There is simply nothing complicated about any of it. This is not a complex issue. I will repeat that I have been taken aback by many of the issues and the extent and breadth of the situation.

I commend the witnesses on their very deep and credible research. They did not go once, but twice in some cases. Research and evidence always interests us. I think we will be returning to this. I feel a sense that they have highlighted something and the word that is coming into my head is "abandoned".

To answer the last point that was made about how the witnesses do not know who to go to; they come to us now. We cannot ignore them. It is at our peril that we ignore them. Their words are not lost on us. This is a cross-party committee. I can only speak for myself but the witnesses made a very deep impression. They certainly educated my with regard to the reality of the day-to-day lives of NCHDs in our hospitals. I thank them for that and apologise for my departure.

Senator Frances Black: I have to agree with Deputy Lahart. I was quite shocked to hear the witnesses' very informative contributions and findings today. I also agree with Deputy Shortall when she said this is an extremely important issue, which this committee certainly should take up, in terms of policy. The healthcare system has evidently not only failed patients with waiting lists etc., but also hospital doctors who are bearing the brunt of our under-resourced health sector. It is really shocking.

I have a couple of questions. I missed out on a little bit this morning so apologies if I ask the same questions again. In her opening statement, Dr. Humphries mentioned that some doc-

tors feel unable to raise issues or make criticisms. Would the introduction of something like an independent complaint process across the HSE help with this or would that make it worse?

Dr. Niamh Humphries: In the UK, the National Health Service, NHS, has a speak up guardian model, which Dr. Creese might be able to speak to a little bit more, that aims to facilitate health workers more generally to speak up about issues they encounter in the workplace. Does Dr. Creese want to take that question?

Dr. Jennifer Creese: The guardian initiative is a national framework in the UK across all the public sector areas. Each NHS trust is mandated to have a speak up guardian within the staff. Sometimes it is a member of staff and sometimes it is a member of the public who has been trained and comes in to serve as an employee of the hospital trust.

Doctors, nurses and any staff of the hospital can, therefore, raise any issues they feel are about patient safety, in particular. That link between working conditions and patient safety is a really important one that many people and even many doctors overlook. As was mentioned before, a doctor working really long hours is a patient safety issue. A doctor not being able to be off sick is a patient safety issue.

All these are recognised by the NHS as things it needs to hear about because then they can be actioned appropriately and keep patients safe. So, yes, the speak up guardian model within the NHS frameworks and the UK public sector generally is a great model about which it would be very easy to find out more and look towards implementing.

Senator Frances Black: I thank Dr. Creese.

To follow on a little bit with regard to the Sláintecare reforms, is Dr. Humphries aware of what could help alleviate the issues raised in the findings of her research? Is there anything in Sláintecare that would be very helpful and really pertain to the conditions of well-being of hospital doctors?

Dr. Niamh Humphries: That is another difficult question. I am not sure. It would be interesting from a Sláintecare perspective if the hospital doctors knew what Sláintecare would change for them. Sláintecare, other than the contracts, did not come up as much as one might think it would, considering it is the reform programme for the health system. There is a job of communicating to the hospital doctors what exactly Sláintecare will change for them. That would be useful because it does not come up as much as one would think it should.

Senator Frances Black: Are there enough positions available on training schemes for NCHDs who want them? Is this impacting motivation and retention with regard to training schemes?

Dr. Niamh Humphries: There are still 2,593 non-trainees in the system and based on research I did a number of years ago on non-EU doctors, many of whom are also non-trainees, one would have to question having so many doctors in the system for whom career progression is almost impossible. I am not sure how that should be resolved but there should not be doctors in the medical workforce who cannot access career progression and find it difficult to access training. That needs to be addressed.

Dr. John-Paul Byrne: Added to that is the impact of the working conditions we have discussed. It sounds like a simple point but trainees want to have protected time for being trained and to have access to trainers who are available as much as possible. Essentially, they want to

spend their time being a doctor and being trained to be a doctor in their specialty. Many doctors would point to that being a major issue at the moment because of the strain on them and the service delivery pressures. Covid has intensified those pressures.

Dr. Niamh Humphries: If there are 837 consultant vacancies, that means a shortage of trainers. That is fewer trainers than are needed in the system, putting strain on the available trainers and consultants and perhaps meaning that trainees are not getting the optimal trainee experience while there are so many vacancies among senior doctors and trainers in the system.

Senator Frances Black: The witnesses have touched on it, but will they comment on how doctors can be incentivised? What is the one thing we could do to incentivise return emigration?

Dr. Niamh Humphries: It needs to be a policy choice. We need to focus on doctor retention and return. I do not think we do anything to encourage emigrant doctors to return. We work off the assumption that those who leave will inevitably return. I do not think that is evidence-based. It is a risky strategy. There is a need to encourage them back and provide them with the working conditions and resourcing needed to encourage them back into the Irish health system. There are a number of reasons that they leave but I do not think we have addressed doctor emigration in any way. We need to look at what they want. They want good working conditions and a reasonable work-life balance.

We need to provide professional reasons for them to want to return. The doctors in Australia who returned were doing so for family reasons, not professional reasons. They were returning to work in Ireland despite the HSE, rather than because of it. They knew they would be taking a step down in their career progression and working life but returned for family reasons.

Ireland needs to give them something to return for. It needs to start trying to encourage them back. They are a huge resource. The 51 doctors I spoke to in Australia were incredibly senior and good at what they do but I was the first person who had asked them why they had left. That is insane. We seem to allow them to drift away and pay no heed to them until they return. Many are considering returning after Covid but Ireland does little to incentivise, encourage or support that return. Ireland could do better. One could see them as a diaspora. All the emigrant doctors around the world are a potential workforce for the health system. We need to actively engage with them and encourage them to return or consider returning by offering terms and conditions that are attractive.

Senator Frances Black: And that are manageable and liveable. The work-life balance is vital and needs to be made a priority. I thank the witnesses. I knew it was bad. We all know doctors and healthcare workers are overworked but I was not aware of how bad it was until this morning's presentations and contributions. I commend the witnesses on this work. I would push for the committee to do a report on this issue. I hope the committee will stay engaged with the witnesses and the work they are doing.

Chairman: According to the research, what was the single greatest driver for qualified doctors and consultants to go abroad when they had completed their study? A number have been mentioned but what was number one?

Dr. Niamh Humphries: I can give you three. I cannot give you one.

Chairman: You cannot give me one.

Dr. Niamh Humphries: I will not give you one. There are different reasons they go. One is a culture of medical emigration. They would be hard pushed to get a consultant post in the Irish health system unless they have international experience and an international fellowship. Two is poor workforce planning. Many of them come to the end of their higher specialist training and there are no jobs for them in the system. It seems crazy. It takes a long time to train as a doctor and do postgraduate medical training. Then they come to the end and have the option of staying in Ireland as a locum or emigrating. Needing a break from the working conditions is another reason they go. That can be very early in their careers. A year or two into the system they feel they really need a break from it, so they go to Australia *en masse*. They go to places like Perth and have a great time working as doctors in a health system that enables them to do that and have a life outside work. They are the three main reasons they go. To meet them and encourage them back, each of those issues needs to be addressed.

Chairman: We talk to senior people from the HSE and Department of Health and to the Minister. They all say it is a policy to retain staff and encourage people back to Ireland. Dr. Humphries is saying from the research that it is not really happening or that there is no evidence of that.

Dr. Niamh Humphries: What was tough about the interviews last year for me, Dr. Creese and Dr. Byrne was how little hope there is in the system. There is very little hope of change and, for that reason, those who left because of the health system will not return. They have already tried it. They have worked here and seen how difficult it is. If nothing changes, they are coming back to the same thing they left. It does not make sense when they have a better work-life balance and better working conditions in countries such as Australia.

Dr. John-Paul Byrne: There is a huge risk of future workforce issues in that registrars and SpRs are looking up at consultants and their working conditions and thinking it may not be for them. There is a progression of junior doctors towards consultancy but they are looking at consultancy and working conditions at the moment in the health system and that could be a further driver of emigration for more senior doctors. Working conditions are an issue for doctors now and there may be a future workforce planning issue for potential consultants who move because they do not want to face the conditions that are there. It is about looking ahead as well as at the right now.

Chairman: The majority of people you talk to who are planning to emigrate, and it is the dream of most emigrants, think they will return home but that does not necessarily happen. People settle down and the quality of life can be better. It can be worse and they miss family and so on. The pandemic highlighted for many people the importance of being close to loved ones. It was very difficult for those in Australia to leave. There were all those challenges.

The most disturbing thing coming from the research was the reluctance to speak out because of the impact on careers and people being seen as troublesome and so on. The suggestion of the speak up guardian that Dr. Creese talked about is certainly something that needs to be looked at. However, it does not tie in with my understanding of those doctors and consultants who are in the system that they are people who are frightened and nervous about speaking out. The representatives were asked whether there was any evidence of impacts on career. The evidence is slim, if it is there at all, regarding that but it was said there is a culture in the system. That is something we can raise the powers that be that the committee deals with.

The fact that the representatives talked about low self-worth, not being listened to and not being asked about anything makes sense in the context of poor conditions. I was surprised

about the pay conditions. We have heard from various representatives from different unions, including consultant groups and so on, and they all talk about the two-tier pay structure, which adds to the lack of self-worth. If a colleague earns more than someone who is doing the same job, that undermines self-worth. People before the committee a number of weeks ago talked about the impact that had on pensions. As people get older, they look at this two-tier system.

How would the representatives address the difficulties consultants are having with hospital management? What structure do consultants and doctors want? Would the guardian structure be enough? Is something else needed? It was clearly outlined that people need to be asked how they are getting on and so on, which is something that is lacking in the system. Is there anything else in the system or structures the witnesses are aware of that they can forward to the committee? We will try to use whatever knowledge we have of the system to push forward some of the issues raised.

We need data on doctors who have been trained, which was mentioned, and a tracking system for where they go and their career progression. That makes sense. That is something the committee could recommend.

The HR issue seems crazy. It appears to be something that would be easy to address. People are being underpaid, they are not paid being overtime, and there is the issue of emergency tax. If it is known someone is moving to a hospital in Munster, Ulster or wherever it is, those systems should be in place. There are possibly recommendations the committee can make in that regard.

Is there anything else the representatives believe is outstanding in the system? I am conscious that Dr. Creese has been taking part but has not been fully involved in the meeting. Is there anything more in the research that she would like to outline to the committee? I will then bring in Deputy Shortall. Deputy Durkan is also indicating he would like to contribute. Does Dr. Creese want to address any of the issues I raised?

Dr. Jennifer Creese: It is really important to bear in mind that the health system is only as strong as its workforce. We can put in as many extra beds, extra hospitals and extra machines as we want but without the people to staff them, and without staff at their full functional capacity who are able to staff them, we cannot strengthen the health system unless we have the support of those health workers. That means recruiting and retaining the right people and getting the right people to return. That all means making sure they are returning to somewhere that is a good place to work, and not just returning to fill a job but to build a life as a doctor.

Deputy Róisín Shortall: I will pick up on how the committee might pursue this. Senator Black's suggestion that we produce a report, and publish and go public with it, is a very good one. I endorse that completely.

I will return to the question Deputy Gino Kenny raised regarding the absence of any tracking system. It seems ridiculous that we do not know where trained doctors are going. There are major issues for the health service in that but from a taxpayer perspective, and value for money and so on, the State is spending a fortune on training doctors and we do not know how many of them we can retain. It is ludicrous. It was stated more than 50% of the annual number of 725 went to Australia and there are then all the other countries. It seems we are probably talking about losing approximately 75%, at least. That does make any sense on any level.

I will ask about hospital doctors being expected to have experience abroad. Is that essential

in all cases and in all branches of medicine? What is that period? Are we talking about a requirement for two years' experience abroad or how long? When could we expect to see people returning, all else being equal? When should we look for them to return? Does anybody have a figure on that? How essential is it, career-wise, to spend some time abroad?

Dr. Niamh Humphries: It is expected that hospital doctors have international experience. I do not have figures. There was a figure that 90% of consultants have international experience. It stemmed from the situation where Ireland could not provide training in certain fields. It has continued as a tradition and it is expected now. The international fellowship is usually 12 to 18 months. Doctors tend to do that after higher specialist training, HST. In Australia, I found that people would come for the international fellowship and within that 12- or 18-month period they would be offered a consultancy there. The international fellowship is what people do after they complete their HST in Ireland and before they get a consultancy.

The reason for going abroad for an international fellowship is to wait for vacancies to arise in the Irish health system. Even though someone may be fully trained as a specialist doctor, there is no vacancy to match that person. In terms of workforce planning, it is hard to get your head around the fact that we have people who put so much time, energy and effort into training in a particular specialty and there is not necessarily a job for them at the end of it. They go abroad, wait to see what consultant posts come up in the Irish health system and then apply for them. In the meantime, however, they may well get offers from the country they are resident in at the time for their fellowship, be that America, Australia or any other country.

Deputy Róisín Shortall: I had a chance to look at the further documentation provided and its six recommendations, which are very worthwhile. It is almost a year to the day since the representatives met officials from the Department of Health on 25 March last year. With what level in the Department did they meet? Have they had any meetings with the Minister at all? Since that meeting, a year ago, has there been any response in respect of activating any of those recommendations?

Dr. Niamh Humphries: No, we have not heard back from the Department. I do not have the details of who we met to hand but it was senior people. I will forward the details to the Deputy. We have not heard anything since.

Deputy Róisín Shortall: Was it a Secretary General-level meeting?

Dr. John-Paul Byrne: No, it was lower than that.

Dr. Niamh Humphries: It was lower than that.

Dr. John-Paul Byrne: It was not a ministerial or Secretary General-level meeting.

Deputy Róisín Shortall: I think it is essential that our guests have a meeting at the highest level in the Department. We will do everything we can in that regard. In terms of solutions, how feasible is it to give a guarantee of a Sláintecare contract to people who are in training in order that they know there is a clear, secure and viable pathway to a career?

Dr. Niamh Humphries: That would make a lot of sense. We could offer people who have emigrated a contract to come home to and tell them that after their emigration, we have a contract for them here. That would mean those who emigrate would know there is a limit to the time they need to remain abroad. That would be well received by the medical workforce who are looking for stability and security. If Sláintecare contracts were available to those who are

nearing the end of their training, it would be a good offer to encourage retention and encouraging professionals to return after a fellowship.

Deputy Róisín Shortall: Dr. Humphries quoted a figure relating to non-trainee doctors, who would, in the main, I take it, be non-EU people. Did Dr. Humphries say there are 2,593 of those in the health service at the moment?

Dr. Niamh Humphries: Yes, according to the national doctors training and planning, NDTP, unit report from last year.

Deputy Róisín Shortall: There are approximately 2,500 people without access to training programmes.

Dr. Niamh Humphries: Yes.

Deputy Róisín Shortall: Am I right in thinking those people do not have the option of a long-term career in the Irish health service?

Dr. Niamh Humphries: That is right. They would be on short-term contracts.

Deputy Róisín Shortall: It seems like a chicken and egg situation at the moment. There are a vast number of vacancies and the aforementioned 837 vacancies does not include the promised 1,000 Sláintecare contract posts. There are an enormous number of vacancies and yet people cannot get jobs. The higher the number of vacancies, the less attractive the Irish health service is to work in because the workload is heavier. Can there be any meeting of minds at all? Are our guests aware of anybody in the Department who actually understands this problem and is in a position to do something about it?

Dr. Niamh Humphries: We would love to know the whereabouts of the policy equivalent of us. To whom do we hand this information over? We want to hand it over to someone who can then run with it and ensure that doctor retention and return becomes a policy priority for the next few years. We have not been able to find that group or person yet. We would love any steer that the committee could give us in that regard.

Dr. John-Paul Byrne: The Deputy made an interesting point about breaking the cycle of understaffing, heavy workloads and high emigration, which leads to heavier workloads and further understaffing. We discussed that in one of our papers. It is almost like a closed loop of deterioration. We need to break that loop through heavy investment in all sorts of resources in the health system. We need to invest in staffing and physical and information infrastructures, ICT systems. Many doctors have talked to us about the frustrations they face in chasing information. It takes up a lot of their time and leaves them pressed for time, which results in work-life balance issues. It is a big problem. There is scope for investment. A range of resources is required, some of which might be expensive, but some of which is not. I am thinking of things such as canteens being open after 4 p.m. Doctors do not have access to hot food on a Saturday and yet are being asked to work for 18 hours. Those seem like simple fixes. There are, of course, also more complicated problems. We need a more holistic approach to what a resourced work environment looks like for hospital doctors.

Deputy Róisín Shortall: I thank our guests for shining a light on an essential part of the health service and coming forward with real and practical solutions. We will do everything we can to pursue those recommendations with the Minister. I thank them again for their work.

Senator Martin Conway: To follow up on what Deputy Shortall has just said, I acknowledge that this meeting has been a learning experience for the committee. I have been following the meeting from my office all morning. I listened to our guests' answers to questions asked by a couple of my colleagues, particularly those asked by Deputy Colm Burke. The Deputy outlined striking examples where theatre access was pulled from people at the last minute. That is totally unprofessional and should not happen except in extreme emergencies. I must ask our guests if they have confidence in hospital management at this stage. In my view, hospital management is bulging at the seams. Massive money seems to be spent on all sorts of management streams and so on. From the work they have done, have our guests confidence in hospital management? When they were doing their research, was there resistance from hospital management to the work they were doing? Did they get co-operation from management? What was the input from management like? Were there any learnings from the input or was it confrontational and difficult? What was the experience like?

Dr. Niamh Humphries: Our research was different than intended because of the pandemic. We had planned to do ethnographic research in a number of different hospitals. We had scoped it out a little and the hospitals were quite supportive. Unfortunately, the pandemic put paid to all of that and we had to do all our data collection remotely. We have not linked in with hospital management as much as we would have done in non-Covid times. As the focus of our research has been on the individual doctor, we have sidestepped hospital management. We have a lot of findings on how hospital doctors and management relate to one another and it is not very positive. There is a lot of frustration. There is a feeling that change and initiatives just stop and do not translate into change on the ground because of hospital management or because of the structures of the hospitals. We have not engaged with hospital management as much as we would have in non-Covid times. We would like to do so again and I hope we get an opportunity to do so.

Senator Martin Conway: That leads me to another question. Unfortunately, management is, to a large extent, an important cog in the structure. There is a significant amount of hostility. I have spoken to junior doctors and there is an enormous amount of resentment and hostility because doctors are working 18 hours a day. As Dr. Byrne said in response to Deputy Shortall, canteens are not open beyond 4 p.m. even though the doctors are expected to work for 18 hours. These are management issues. It is important to challenge management. It would be important for our guests, in their engagement with managers, to challenge them to explain why the relationship is so hostile because it should not be. In most environments, there is a healthy respect between people and their management. In some cases, there is a hostile relationship. I never hear a hospital consultant speak well of management. That is a major problem. It would enhance the work our guests have done, which is superb, if they were able to get the perspective of managers and challenge them on it.

I would also like to hear our guests' perspective on the unions. Did they engage with the unions? How was that engagement? Do they feel the unions help the situation in this country? Do unions make any difference or is their influence negligible? As part of the guests' body of work, was there much engagement with unions?

Dr. John-Paul Byrne: On the Senator's first question, because we have not engaged with hospital management as much as we would have liked, a better version of the question would be whether the doctors we spoke to have confidence in hospital management. The answer is certainly "No". They do not have confidence in feeling supported or valued by hospital management. That is a huge issue in and of itself. I have confidence in the doctors we spoke to as

clinicians and their sense of professionalism. They are willing to put their work–life balance at risk just to follow through on patient care. It is something we would like to engage on further with those in hospital management. Obviously, they are a big part of the machine. It is a matter we will have to examine further.

I do not have exact numbers on the question on unions, but many of the participants we spoke to were members. They said some issues could not be raised unless there are many members in the one hospital or place. Individuals with particular issues did not feel like the support was available, although, at the same time, they felt it was valuable to be part of the union.

On our engagement with unions, we have presented to them and discussed their findings.

Senator Martin Conway: I am speaking about clinical management. The people Dr. Byrne spoke to did not have confidence in hospital management. What is their level of confidence in clinical management in hospitals?

Dr. John-Paul Byrne: That was not a major part of our research. However, where it did come up, there was confidence in the trainers' expertise.

Dr. Niamh Humphries: On the frustration of unions with clinical management, maybe they are as lost as we are regarding who fixes junior doctors' working conditions, who improves their work–life balance and where they go to fix their everyday frustrations with work. Since the affected doctors' working conditions are so poor, as we have described, it is hard to see how much support they have from any group and where they should go to initiate change that will make a genuine difference to their everyday working lives.

Senator Martin Conway: Sure. I support what Deputy Shortall said about engagement at the highest level. It is a question of at least trying to achieve quick wins. In this day and age, it is hard to believe that a canteen would close at 4 p.m. I would consider addressing a number of these kinds of issues to involve quick wins. They will not solve the problem but they should happen in the short term. For the medium and long term, it is important to glean the lessons from what has been done to ensure we retain and, hopefully in the future, attract back those who have left. I thank the delegates for their engagement, time and the work they have done.

Deputy Colm Burke: I just wanted to ask about the doctors interviewed. Did the delegates not find that doctors working here believe they are doing a lot of work that really should not be under their remit, or that other staff in the hospital should be doing much of the work general doctors in Ireland do by comparison with those in other jurisdictions? As a result of their doing that work, we are overworking general doctors and underutilising their qualifications and expertise.

Dr. John-Paul Byrne: I wholeheartedly agree with that based on our findings. Overworking and underutilising comprise a perfect way to encapsulate many of the experiences of our NCHDs, in particular. Many of them felt they had no defined job specification in that anything nobody else wanted to do or for which they did not feel they had responsibility fell to them. That would certainly be the experience we have-----

Deputy Colm Burke: The one example I have is of a student from the US who qualified as a doctor here. They worked in a smaller hospital initially and got great opportunities to work in theatre and everywhere else. They went to a bigger hospital for the second six months of their first year and found all they were doing was going for this or that, without getting access to many of the areas they wanted to deal with. When the delegates talked to junior doctors in

Australia, did they find there was a difference in approach in their workload, such that they could focus their expertise on their job rather than on many other tasks for which they should not be responsible?

Dr. Niamh Humphries: If each junior doctor in Australia works a 40-hour week, the hours are valuable. One has to be very careful about how to ration them. If we have junior hospital doctors doing 100-hour weeks, their time is not considered valuable. The work is unstructured and kind of a dumping ground for what others have not done. It comes back to valuing our doctors and making sure the work they do is the work they need to be doing, not just work that nobody else has picked up on.

In Australia, there was scope at consultant level to specialise a little more than here. That was really interesting. Consultants could drop their clinical hours and take on a leadership or education role. That enabled them to get a lot more job satisfaction because they could craft their job to best suit their skills, experience and interests at a given time. At consultant level, that was really interesting. They would take on a different role that took up 20% of their time and reduce the clinical proportion to 80%. Overall, it still amounts to 100% but the doctors could steer their careers in directions in which they were interested and also reduce their hours or take on a greater role in education coming up to retirement. It just seemed there was less of a one-size-fits-all model in Australia at consultant level. That was really interesting. It was not just a question of adding to their jobs but of focusing their hours and specialising a little more.

Deputy Colm Burke: May I return to the issues of consultants in the hospitals outside the major centres of population? Many of them are on a rotation whereby they work every day from 8 a.m. until 5 p.m. and are on call every third or fourth night and every third or fourth weekend. If you are on call at the weekend, you will have worked for the entire preceding week. You will be on call from 5 p.m. on Friday evening right through until 9 a.m. on Monday morning. Have the delegates come across any hospital that has changed that system such that there would be a consultant on call on Friday night and Saturday, with someone else taking over on Saturday night, Sunday and Sunday night, instead of doing a stint of three full days on call?

Dr. John-Paul Byrne: I cannot say we have. Many of our data are based on individual doctors' experiences. It is hard for us to talk at hospital level because we try to examine the matter from a health system perspective. However-----

Deputy Colm Burke: Would Dr. Byrne not agree that a system that requires one to work all week and then go on call from 5 o'clock on a Friday evening right through until 9 o'clock on a Monday morning is not a good one to have in place?

Dr. John-Paul Byrne: I absolutely agree. That relates to the work–life balance issue we talked about. I am aware that work–life balance was brought up at various meetings of the committee in respect of different healthcare professions. However, it is not just about the number of hours; it is also about the intensity of the work when at work. The doctors are working harder and faster than ever before, yet still do not feel they are getting on top of anything. It goes back to the rota system, whereby doctors cannot predict when their day will end. It also goes back to the mobility of NCHDs, who have to move to a new place every few months, leaving behind family, friends and support networks. When we talk about work–life balance, we often say it is about really long hours. Yes the hours are long and exhausting, but it is the quantity of the hours and the intensity of the work time. It is the unpredictability of their work time. They do not know when they are going to finish so they cannot dedicate any specific time to something outside of work such as hobbies or social life. On top of that they have the mobility of mov-

ing around. When those things are added together it has huge impacts on their mental, social and physical well-being, on their relationships with families and friends, and also on their career decisions which underlines many of the retention issues. We have had doctors tell us that sometimes it felt like a choice between pursuing their profession or being a functioning, normal human being. It is a really stark thing and it is something that cannot be said but it is a huge issue. Those hours are a huge issue.

Deputy Colm Burke: Following on from that, is that not a challenge as to why you cannot even get an applicant for some posts that are advertised, because of the requirement to work one in three weekends or one in four? As a result people are saying they do not want to take on that job, they can get a job where they will have at least five or six weekends off completely, and they might work one in six or one in seven weekends. Therefore the smaller hospitals are going to have that challenge of trying to get staff while the present structure of their employment is as it is now.

Dr. Niamh Humphries: Ireland probably has a rural remote retention problem but we have never really spoken about it in those terms. If you look at countries such as Australia and Canada, they talk a great deal about the challenges of getting people to work in rural and remote areas. Ireland is starting to have a problem with that in terms of GPs and hospital doctors and these two issues are connected. There is very much a need to look at how we can retain and attract doctors to rural and remote places, as well as how to retain and attract them to Ireland generally.

Deputy Colm Burke: Some of the areas I am talking about are not very remote. Sligo is not remote in real terms. Neither is Mayo but all of those hospitals, whether it is Letterkenny, Castlebar, all of those have challenges in regard to getting people even to apply for jobs.

Dr. Niamh Humphries: Because Ireland is a small country we think we do not have the same challenges as Australia or Canada, but I think they sound very like the type of challenges faced by countries like Australia and Canada in encouraging people into and retaining people in posts like this. It is definitely an issue that needs more attention.

Deputy Bernard J. Durkan: I want to ask our witnesses if they might like to share with us their own concerns and opinions in regard to overcrowding in accident and emergency, A&E, units throughout the country. Some A&Es seem to cope with it well, others not so well. I wish to ask the same in regard to long waiting lists. Apart from the staff there must be a link somewhere, for example looking at the private health service and the public health service and the waiting lists that accrued to each. Have they any opinion?

Dr. Niamh Humphries: What we can speak to is how it feels for the hospital doctors to whom we have spoken to work in overcrowded contexts and to work with patients that they know are just going to enter a long waiting list and that makes their jobs all the more difficult, every day. We cannot really speak to these issues generally but what we can say is all of these things make it very much more difficult to be a hospital doctor in the Irish hospital system.

Dr. John-Paul Byrne: As an example of the impact that has on the public and therefore on the hospital doctors we spoke to is - it was particularly striking in the past six months - the level of public anger that they have to face on a day-to-day basis particularly in emergency departments. The doctors talked about being perceived as the face of the healthcare system so if a patient or a family has an issue with the healthcare system it is directed at that doctor, and that doctor has no control over those issues. That was a huge stressor for many of the doctors we

spoke to and that is how the overcrowding and the waiting list issues impact on their working conditions.

Deputy Bernard J. Durkan: If I might put the focus back on the patient again. If you have a crowded A&E anywhere in the country that is crowded in the morning, in the afternoon and in the evening, and sometimes has to restart again the following day or overnight, very often overnight, public confidence in the system is not helped by that and it is therefore important to identify the precise reasons. The numbers have to be dealt with in any event, it is just that it takes longer to deal with them if there are certain conditions in place. What are those conditions that are impeding the progress? Is it too few hospital doctors? Is it too few doctors on duty at a time? Is it too few doctors available? Are there are any other reasons why the patient should not be dealt with much more speedily?

Dr. Niamh Humphries: I do not think we can speak to emergency department overcrowding or even the patient experience. Our focus is very much on the medical workforce. That is the research we have done, the research that we have been funded to do. There is definitely a need for other research to find out what it is like within the health system for a patient or for anybody else who interacts with the system but that is really not the scope of our research project.

Dr. John-Paul Byrne: By way of example one of the emergency department doctors we spoke to compared their experiences in Australia and Ireland working in similar sized emergency departments with similar patient numbers. They said that in Australia there were ten consultants, ten registrars and ten senior house officers. In Ireland in a similar sized emergency department there was one consultant, three or four registrars and three or four senior house officers. If the patient numbers are the same and they are the staffing numbers that are dealing with similar volumes of demands, of course that is going to lead to higher strain, workload stress and burn-out. We can only speak from the doctors' experience. Going back to the question about comparing Ireland and Australia, they are the experiences they are comparing. One was staffed appropriately but I have no idea of the efficiency of the emergency department system in Australia but from the doctors' experience it was a much more efficient system in Australia.

Chairman: The witnesses' opening statement stated that respondents found it difficult to see their patients struggle to access the care that they needed. There is a quote where Doctor 7 said: "I find myself apologising to patients on behalf of the system for their poor care. It's draining." Doctor 5 said: "What keeps me up at night is ... people not having access to timely care." This is a follow-on from Deputy Durkan's question. We had doctors before this committee who were dealing with the issue of scoliosis and one of the people who came in made that point about the difficulty of trying to explain to families whose child is in severe pain that there is a queue and a waiting list and there is no access to care for that child. The point made at that meeting was if it is the best use of a consultant to deal with families on a daily basis given the amount of time it takes to explain to those families that within the current system there is not space for resolving their child's condition. Dr. Byrne spoke of frustration and that is clearly something that keeps people up at night. They are dealing face-to-face with those families and those children on a personal basis and that has an impact and it is hard to walk away from and switch off from after work.

Dr. John-Paul Byrne: The constant apologising was a major stressor for many of the doctors to whom we spoke last year. One of them described the primary cause of burnout for that particular individual was having to face the anger of patients and families and apologise on behalf of a system over which they have no control. That was a huge stressor.

Dr. Niamh Humphries: They know what their patients need but they cannot necessarily get their patients the care that they need. That is heart-breaking.

Chairman: Knowing that if the system was tweaked or there was a system, the outcomes would be much better. It goes back, presumably, to the people who are coming from abroad with the experience of what they have seen working there, knowing this but facing the "that is not how it is done here" type of attitude.

Dr. Niamh Humphries: They know that they could deliver better care if the resources were there and they know that when they worked in Australia, America or Canada they could get X, Y and Z for a patient within a certain amount of time whereas here, they are just joining the end of a waiting list. While they wait, they know their patients will get worse. It is very difficult to be the public face of that health system, which is very much under strain at the moment.

Chairman: I am conscious I cut Deputy Durkan off earlier. Is the Deputy finished?

Deputy Bernard J. Durkan: Unless we get to the bottom of the particular issues of patient confidence and dealing with people on waiting lists for long periods of time, and do something about it very quickly, we will reach a situation where the level of anger from these patients is going to increase and the level of care is going to decrease because of the gap that exists in the system. For whatever reason, there are gaps in the system and they need to be filled quickly and we need to restore the health sector to some level of confidence. We have a larger population and many more young people. People say we have a high proportion of older people, but we have a high proportion of younger people also. The younger people look at the system and see what is happening and make their decisions accordingly.

If we are to presume that it will take another four to five years before we have the system up and running, that is going to be a problem. We have to do something that is in line, as has been said previously, with Sláintecare and put in place the various parts of the jigsaw that will deal with this and electrify that system to the extent that is necessary to create public confidence in it from the points of view of the patient and the management. If the management system does not work, then we need to find a way around that, to be able to pinpoint that, and to say that this particular hospital, for one reason or another, has handled a certain number of patients over a period of time, elective or emergency patients or whatever it is, and we need to ensure we have a high level of care, confidence and reliability. That, in itself, will restore some level of confidence in so far as patients are concerned. Otherwise, people will seek out the private system and deal with it because it will produce for them.

Chairman: I thank the Deputy very much. We have covered everyone who indicated a wish to ask questions. On behalf of our committee, I thank all of our guests for their contributions which were very helpful and will be useful to the work of the committee. We will try our best to progress their research. A number of suggestions were made by members, including the possibility of a report. We can certainly put many of the recommendations made by our guests into the system and, hopefully, arrive at some positive outcomes on them.

The joint committee adjourned at 11.54 a.m. *sine die.*