IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

REPORT OF IMO AGM 2024

Valuing Patients by Valuing Doctors

Thursday 4th - Saturday 6th April 2024

Europe Hotel, Killarney

Message from IMO President

The 2024 IMO Annual General Meeting was a great success where doctors from across all specialties and all parts of the Health Service gathered to participate in a very topical and interesting programme.

The theme of our AGM was Valuing Patients by Valuing Doctors- what we are calling for is a properly resourced health service where doctors are enabled to do the job for which they are trained and deliver timely care to their patients.

Our National Meetings and General Motions sessions highlighted the very significant challenges facing our health services and, as the representative body for all doctors, we want to work with the HSE and Government to deliver and implement solutions that will make a tangible and real difference to patients and to doctors delivering care.

It is an honour for me to serve as President of the IMO and I look forward to working with you, and for you over the coming year.

Sincerely

Dr Denis McCauley
IMO President

Artificial Intelligence

The first panel discussion of the IMO AGM took place on a blustery, rainy Thursday evening in the Europe Hotel, Killarney. Given the title of the discussion was **'Artificial Intelligence – Impact on Healthcare Delivery',** it was fitting that the lights were dimmed for chair Dr Austin Byrne's introduction, a five-minute AI generated video which was created using a brief written prompt. The topic of AI has generated huge debate in several fields in recent years, so what impact will it have in healthcare?

The contributions of the panellists were as distinct as they were interesting. **Professor Barry O'Sullivan** cast a somewhat sceptical eye on AI throughout his presentation and indeed when addressing questions from the audience, at one point humorously compared generative AI to a pub bore that you would never allow to do your job. He also highlighted a study which utilised AI to detect Covid-19 in patients; out of 2,000 tests, all were deemed useless. Ironically for a digital scientist, he cautioned the room against giving up the written word to embrace digital records and got a good laugh when he said that computers are the stupidest things ever invented.

Professor Patricia Maguire initially echoed these sentiments, questioning whether deep learning AI could create new antibiotics, given pharmaceutical companies are not spending money on creating antibiotics themselves. However, she noted that of 40,000 compounds tested for activity against MRSA, only two were found to work.

She also suggested that the most telling feature of a smart AI resource assistant for mental health released by the WHO this month was the long disclaimer on accuracy.

However, the news on AI was not all bad; Professor Maguire also highlighted a personal project, in which AI was being used to help diagnose and stratify the risk of pre-eclampsia among women in three Dublin maternity hospitals. This has been named by UNESCO as one of the top 30 projects in the world using AI to solve sustainable goals, and certainly is one to watch.

Dr Conor Judge spoke about how the successful use of AI is dependent on randomised clinical trials, and emphasised the huge gap between the large number of AI publications in healthcare and the relatively low number of AI learning devices approved by the FDA. He outlined an example of the first autonomous medical device to earn a CE mark, which is required for products manufactured anywhere in the world that are then **marketed in the EU.** This device performs chest x-rays; the process remains fully autonomous if no abnormalities are found, however if abnormalities are found, a doctor is then notified to examine further.

So, what does that mean for Irish doctors with the Irish health system lagging significantly behind others in terms of digital adoption? The panellists agreed that not all written data was messy e.g. GP data is hugely informative and, indeed, more useful than typed notes.

Professor Barry O'Sullivan

Professor Patricia Maguire

Dr Conor Judge

Professor O'Sullivan made a philosophical point when he suggested that one of the drawbacks of data is that it doesn't tell you causality – as we know, causality comes from common sense e.g. we know the reason the ground is wet is because we know it has been raining. Similarly, our understanding of the world is not solely because of facts, it's also due to the relationships around us. That's what makes doctors so good at what they do.

The panellists agreed that the most practical and useful way in which AI can help is with menial administrative tasks, and the audience were particularly interested to hear GP Dr Zachary Johnson who gave an example of an AI Platform that could be used to help with paperwork and referrals.

Valuing Role and Expertise of the Doctor

On Friday afternoon, former RTE journalist Ingrid Miley chaired a lively panel discussion on **'Valuing the Role and Expertise of the Doctor'.** Only a few years ago the title of this discussion may have been taken for granted, but the audience learned over the course of the debate that recent developments posed a real risk to doctors and the profession of medicine.

After agreeing that a doctor's skills are derived from both the science of medicine and the art of patient care, the panel turned to the growing influence of both physician assistants and pharmacists in Ireland and the impact they may have on the role of doctors.

A key contribution came from **Dr Kitty Mohan,** a consultant in communicable disease control based in the UK who offered a glimpse of life in the NHS. She told the audience about the rise of physician associates (PAs) in the UK, who are not doctors but increasingly are doing jobs which do not reflect their training and experience.

PAs have been gradually introduced in the UK as a way of mitigating a pronounced falloff in doctor numbers, and in Ireland currently approximately 60 are employed, mostly in hospitals.

Dr Mohan said that PAs had been operating in the UK for approximately 20 years. PAs in the UK need to have an undergraduate degree ideally in a scientific subject, after which time they can complete a PA Master's or diploma which equates to 1,600 hours of clinical experience and teaching.

By contrast, she said that medical degrees in the UK require a minimum of 5,500 hours of clinical experience and teaching.

There are currently 4,000 PAs working in the NHS, and there are plans to increase this number to 10,000 in the next decade. But recently, there had been a number of high-profile scandals involving PAs, including one hospital using one as an on-call anaesthetist.

Dr Mohan noted that there were concerns around the title of the role itself, as it had changed from physician assistant to physician associate. She said this had created issues for patients, many of whom did not know that PAs were not doctors.

She referenced a UK study of 18,000 doctors and 2,000 patients, in which 87% of doctors said the way PAs work was always or sometimes a risk to patients. Less than 20% of doctors said that the employment of PAs had reduced their workload, and over half of patients had not heard of PAs. Just over 3% of doctors said they felt having PAs enhanced their training opportunities. This would have particular resonance in Ireland, at a time when NCHDs are continually on rotation and PAs can work in one place without moving – which in the UK has anecdotally led to them receiving better opportunities even when they are not suitably qualified.

Under the BMA safe scope of practice published this year, PAs should follow, not give medical directives. They should not see undifferentiated patients, and supervision standards must be adhered to.

Dr Kitty Mohan

Dr Peadar Gilligan

Dr Peadar Gilligan, Professor Gaye Cunnane, Dr Kitty Mohan, Professor Tadhg Crowley

Ms Ingrid Miley

Dr Tadhg Crowley said that continuity of care was critically important, and that to achieve this we need more GPs and more investment rather than other people to do a doctor's job. He brought up the example of pharmacists being offered contracts to prescribe for minor illnesses in Ireland. He said this was problematic, as pharmacists are not trained to do a GP's job, but also because it may lead to a conflict of interest for the pharmacist with regard to prescribing.

He referenced a plan suggested by the IMO, in which pharmacists would themselves join GP practices, which would better support continuity of care.

Dr Peadar Gilligan reminded the audience that a diagnostician requires a very significant breadth of knowledge and experience. This role could not be performed by someone with just two years of experience.

He said that PAs in Ireland have delegated autonomy, which means that the doctor who delegates that autonomy is responsible for a PA's decisions. So, as a doctor, you would need to be fully sure that the PA is competent and not taking on tasks that are beyond their capabilities.

Professor Gaye Cunnane agreed that the title of PA needed to be defined, and 'assistant' was preferable to 'associate' given the experience of the role. She emphasised that patients needed full clarity on who was treating them.

The panel agreed that the Irish health system doesn't currently help the doctor to provide optimal care. PAs and pharmacists have value, but the suggestion that they can take on some of the doctor's workload is the wrong answer to a pressing problem.

The Dark Side of Social Media

The final panel discussion of the AGM took place on Saturday afternoon and shone a spotlight on **'The Dark Side of Social Media'.** This discussion had particular resonance for any parents in the room, as the panellists exposed the shocking reality of some social media platforms, their harmful algorithms and the overall effect on children and adolescents.

Professor Matthew Sadlier began the discussion by highlighting research he had conducted recently among GP trainees, who by no measure could be classified as vulnerable. He said that, even among this relatively successful cohort, half of them said that "using social media makes me anxious or depressed".

He said that the problem is far more pronounced among young people, among whom there has been an epidemic of mental health problems, with girls disproportionately affected.

He highlighted a UK study from 2017 which found that over 75-year-olds were less likely to be lonely than 16–24-year-olds. He also referenced a BMJ study which stated that 20% of UK adolescents use social media at least five hours daily, adding that self-harm presentation were soaring in Ireland.

He said that there is widespread agreement that excessive social media use (more than an hour a day) has negative effects, and he noted that the US surgeon general has issued a public health advisory regarding social media. Furthermore, 42 attorneys-general in the US have taken a case against Facebook parent Meta – a rare show of bipartisan support.

Professor Debbie Ging said that social media has changed the way we live and think and that, worryingly, the technologies are not neutral but are disposed to manipulation. This has had a monumental impact on young people; she outlined how widespread access to violent pornography had changed young people's attitudes to sex, with a major rise in intimate partner abuse among young people.

She spoke of the impact of 'manfluencers' such as Andrew Tate and their red pill philosophy, namely that the world is stacked in favour of women and minorities and that men are the victims. She explained how these extreme views are exacerbated by the negative algorithmic patterns of social media platforms.

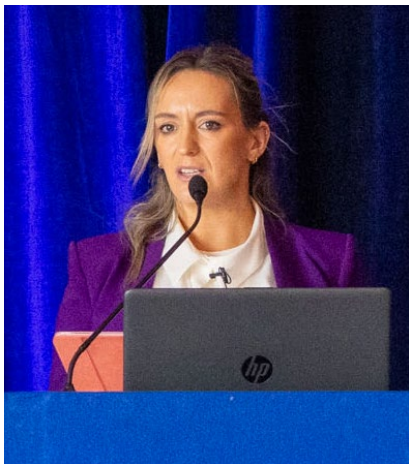
Ms Clare Daly stated that a third of all online users are children, and the online world's risks and harms often outpace regulatory change.

She referenced a CyberSafeKids survey conducted in Ireland which suggested that 95% of 8 to 12-year-olds own their own smartphone, and 45% of 10-year-olds use a smartphone in their bedrooms. Shockingly, a quarter of 6-year-olds have their own smartphone.

The panellists highlighted how a combination of the perpetuation of harmful content, the aim to keep eyes on screen, and the nature of online communication have led to a perfect storm of negativity for young people. Professor Sadlier said that social media was leading to an "explosion of distress and creating broken people".

Professor Matthew Sadlier

Professor Debbie Ging



Ms Clare Daly

He added that humans are all born with a specific temperament, and social interaction brings it to the mean. However, social media platforms never mediate temperament, but instead they reinforce our behaviour. Hence, it is no surprise that extreme behaviour and views are growing.

Ms Daly said that the Online Safety and Media Regulation Act was signed into law in Ireland in 2022 and aims to improve online safety for children. She added that there are now laws criminalising intimate image abuse.

However, it was clear that a huge amount more needs to be done to ensure our children are adequately protected from what is essentially an unregulated monster. The panellists were unanimous in their belief that self-regulation does not work and that education on its own was not sufficient.

Professor Sadlier offered the analogy of driving. After we pass our driving test, we are not given free rein to drive as we please. We have speed cameras, checkpoints, penalty points, speed ramps, and more. A similar system of enforcement should apply to social media.

Professor Ging said the solution is legislation. Recommender algorithms must be turned off and pornography cannot be available to minors.

The panel agreed that Ireland's dependence on massive social media companies' corporation tax is a concern but cannot be an excuse to let things continue as they are.

As the evening drew closer, we heard the simple but troubling truth that myopia is also now booming among young people – Professor Sadlier explained that they are not looking at the horizon any more.

Understanding Obesity

The rain continued to fall as a packed room took in the first of- Friday's 'hot topics', **'Understanding Obesity'** with **Professor Donal O'Shea.** His key point was that the old mantra of "eat less, move more" can no longer be applied to the treatment of obesity. Furthermore, he explained that weight gain was 90% irreversible for 90% of people. Obesity is essentially the reception of too much energy from the environment for your genes.

He gave an initial example of a patient weighing 157.5kg who received treatment for six weeks, including a daily diet of 1,100 calories, physiotherapy, and psychological supports. On discharge, the patient weighed exactly the same, albeit with much improved mobility and personal hygiene.

Professor O'Shea described how obesity had doubled in the last 30 years and that the marketing in shops and supermarkets had become particularly sophisticated e.g. ice creams marketed to five year-olds are always placed at their eye level.

He said that five of the seven determinants of obesity are outside a person's control. Interestingly, he cited a 2007 study which said that if a friend of yours develops obesity, your chances of getting it increase by 70%. If a friend of a friend becomes obese, your chances increase by 30%.

He said that obesity was linked to over 200 diseases, with analysis among obese people showing they have an absence of specific white cell sub-types. In particular, people with obesity have fewer iNKT cells, dubbed the "Swiss army knife" of white cells. He referenced a study of mice which showed that after removing iNKT cells, they got fatter, and when they were reintroduced the mouse lost weight.

He concluded by saying that drugs like Ozempic will soon be overtaken by new, better obesity drugs which will offer patients up to 20% weight loss. He specifically mentioned Retatrutide, a groundbreaking drug which offers every patient a 5% weight loss at a minimum.

Professor Donal O'Shea

Tackling Falling Vaccine Rates

In the second hot topic of the day, **Dr Paddy Kelly** offered some insights into **'Tackling Falling Vaccine Rates'** in Ireland. He outlined how there had been a significant fall in the uptake of childhood vaccinations in the past five years, with massive regional variation in rates.

At a national level, taking the MMR as an example, he said that uptake in the most recent recorded period, Q3 2023, was 89.9% nationwide. This compares with the highest ever rate of 93.2%, recorded in Q4 2014.

There is global context for this trend – as he noted a 3,000% increase in measles in Europe and central Asia this year compared to the same period in 2023.

Worryingly, Dr Kelly suggested that we were probably over-reporting vaccine percentage take-up, given there is a cohort of children that we do not know about e.g. some migrants. He outlined how there was no communication between public health nurses and the HSE department looking after migrants.

What are the issues that lead to falling vaccine rates? Dr Kelly referenced the fact that we have no national immunisation system, delaying tactics by parents, and difficulties accessing GP appointments. We also have reporting inconsistencies nationwide.

When it comes to those who are vaccine hesitant or resistant, he said that only a small minority will refuse a vaccine in every circumstance.

With a large GP representation in the audience, Dr Kelly encouraged those dealings with vaccine-hesitant patients to get an understanding of a patient's feeling on vaccines, ask open-ended questions, provide reassurance, and acknowledge their feelings without feeling obliged to agree with them. Always leave the door open to those who are sceptical.

He said that there was a high level of public trust in GPs. As such, he said GPs should recommend vaccinations, put up reminders and alerts in the practice itself, and use records to check uptake.

At a national level, Dr Kelly said to improve take-up rates we need a real-time digital system to record data, consistent national reporting, including refusal data; we need migrant data and we need to identify unvaccinated children.

Dr Paddy Kelly

Alcohol - Is the cost too high?

The final hot topic of Saturday morning was presented by **Dr Mary O'Mahony,** who examined the impact that alcohol has on society. She began her presentation, **'Alcohol – Is the Cost too High?'** by emphasising that Ireland has the third-highest level of foetal alcohol spectrum disorder (FASD) globally, a permanent condition that is a consequence of alcohol-induced brain damage.

She said that this shocking statistic had to be viewed in the context of the proposed introduction of the Sale of Alcohol Bill, which would extend licensing hours and, as a result, drive alcohol consumption and harm.

She outlined the impact that alcohol has, referencing WHO data which shows that the drug is responsible for 18% of suicides, 27% of traffic injuries, 26% of mouth cancers, and 48% of liver cirrhosis, among others.

In Ireland, half of people drink harmfully, and one in seven have an alcohol use disorder. Two out of three people who die in Ireland of alcohol-related causes are under 65, and the overall annual cost to the State is €3.7 billion.

Around 1,000 cancers diagnosed in Ireland per annum are caused by alcohol; for example, one in ten breast cancers is due to alcohol.

Dr O'Mahony pointed to the Public Health (Alcohol) Act 2018 which contains a number of positive aspects, including the labelling of alcohol products and a broadcast watershed – initiatives which will be introduced in Ireland shortly.

She said that among the alcohol-related policies that actually work are minimum unit pricing, drink driving measures and the restriction of availability, while some non-effective policies are school-based education and public information campaigns.

Dr O'Mahony reminded the audience that 79 organisations have requested the Minister for Justice Helen McEntee to conduct a health impact assessment on the Sale of Alcohol Bill, as there is a public health imperative to reduce our alcohol per capita rate.

Dr Mary O'Mahony

Address by Mr Stephen Donnelly, TD, Minister for Health

A packed room welcomed **Minister for Health Stephen Donnelly TD** to the AGM on Friday afternoon, with the Minister giving his evaluation of the state of the health service, focusing on all specialties and acknowledging the immense contribution of all doctors.

Importantly, Minister Donnelly confirmed that negotiations around the new NCHD contract would commence at the end of April, as he acknowledged that fundamental cultural change was needed for our NCHDs. This announcement was met with applause from the audience.

The theme of Minister Donnelly's speech was 'a lot done, more to do'. The Minister pointed to the progress that had been made in recent years with regard to investment, waiting lists and trolley numbers, new GP services, eligibility for free healthcare, and an increase in GP training places.

However, he acknowledged that there was "still a long road to travel", admitting that he believed we were roughly four years into a ten-year journey to reform the health service, with universal healthcare the ultimate goal.

He said that nearly half of consultants had signed the new Public Only Consultant Contract, and a strategic review of General Practice was well underway with the IMO.

He said he fully endorsed and supported the recommendations of the NCHD Taskforce Report, and that he is looking forward to implementing them. He confirmed that the new NCHD contract will be a key part of that implementation.

Minister for Health Stephen Donnelly

Minister for Health Stephen Donnelly and President of the IMO, Dr. Denis McCauley

Address by Mr Bernard Gloster, CEO HSE

HSE CEO Bernard Gloster took to the stage to address the AGM on Saturday morning, focusing primarily on the changing structures of the HSE.

He said these changes were coming about to maximise people's access to healthcare, and to improve both timely implementation and public confidence.

According to Mr Gloster, the new structures should facilitate better integration and timely decision making. He said they would support a local focus and, by extension, remove excessive decision-making from the "centre".

Overall, the goal is to deliver person-centred care, and to align the hospital, community and public health services as one team.

Mr Gloster introduced the new HSE regions and their leaders, and pointed to progress in recent years in terms of the advanced community care programme.

Echoing Minister Donnelly the previous day, Mr Gloster acknowledged that a lot more work was needed to improve the health service. However, he argued that the system was moving faster, specifically mentioning the decreased amount of delays to transfers of care.

Concluding on an upbeat note, he confirmed that the HSE had more money and staff than they have ever had, so now was the time for real reform.

HSE CEO Bernard Gloster

IMO Financial Services Seminar Strategies for Pension and Investment Planning

Speakers at the IMOFS seminar were Mr Francis McGrath, Business Development Manager, IMOFS and Mr Richard Temperley, Head of Investment Development Zurich. Fran gave an overview of the IMO/IMOFS Submission to the Government Review of the Standard Fund Threshold and what any changes might mean for doctors whether they be direct HSE employees or GPs. He also discussed recent changes in relation to pensions, the importance of a financial plan for a doctor's financial goals, and the steps needed to achieve those goals over a specified period. IMO FS guides doctors through the process and ensures that the plan is tailored to the doctor's needs and goal and gave advice on pre retirement financial planning.

Richard Temperley discussed the current state of investment markets with a particular emphasis on the likely direction on interest rates. His presentation also looked at the importance of holding equities in a portfolio. Finally, he also provided an overview of the area of responsible investment including ESG (Environmental, Social, Governance) funds.

For further information on all aspects of financial planning click on **imofs@imo.ie** to arrange a financial review.

Mr Francis McGrath

Mr Richard Temperley

National Specialty Meetings and General Motions

The AGM incorporated General Motions and National Meetings for all specialty groups and results of motions debated and be accessed here:

https://www.imo.ie/news-media/agm/agm-2024/motions-1/index.xml


IMO AGM 2024
Valuing Patients By Valuing Doctors
IMO MEMBER
Consultant
NCHD


THE EUROPE
HOTEL & RESORT

Address by IMO President, Dr Denis McCauley

Past Presidents, Distinguished Guests, colleagues, fellow members of the Irish Medical Organisation and friends.

Good evening to you all and thank you for your kind welcome.

I don't want to keep us all here very long this evening. We have a dinner to go to and there have been plenty of speeches already this weekend.

But I would like to give you a sense of the perspective I bring as President and my thoughts on some of the pressing issues facing the profession.

I am open to correction but I believe that I am the first person from Donegal…and without doubt, the first from Inishowen to become IMO President.

The locations in which people grow up have a huge influence on their character and that was certainly the case for me.

I came of age during the 70s and 80s growing up in the beautiful town of Moville on the Inishowen peninsula. We lived in close proximity to the border and my father had business interests in the North and we passed between the two jurisdictions as easily as the covid virus did during the recent pandemic.

My youth in Inishowen provided me with an early role-model for medicine; our local GP, Dr. Ken O'Flaherty.

Ken was remarkably innovative for his time with a superbly fitted out surgery and even a practice nurse long before these things became commonplace. The people of Moville were enormously reassured and comforted by the presence, the care and the attention of this accessible, decisive and warm doctor.

Leaving Inishowen, I was the first in my family to study at Trinity College – receiving the curious blessing to do so which was necessary at that time from the local Bishop and which my uncle had been denied 20 years earlier. And I undertook my training in the Adelaide Hospital in Dublin

My training in the Adelaide had an enormous impact on me. Most importantly it was where I met and fell in love with a smart, funny, beautiful girl …Suzanne.

Sue is the essence of that saying that "behind every saint there is a martyr" and I thank you so much, Sue, for all the help and support that you have given me.

The Adelaide was really important for another reason in that during that time social change hadn't really taken-off in Ireland. The State was interfering with healthcare at many levels, but the Adelaide was "a place apart". Its ethos was different in that it full appreciated that a person's health decisions were a matter that should be solely between their doctor and themselves.

President of the IMO, Dr. Denis McCauley

It's important to remember that this was not always the case and – if some populists and extremists have their way – it would not continue to be the case for very long. We must not take these rights for granted.

Like many people in this room, I became an activist in the IMO in response to growing exasperation with working conditions; firstly, with the unhealthy and dangerous working conditions we were forced to endure as NCHDs…something our younger colleagues spoke eloquently about this morning…and then again with the outrageous treatment of General Practice through the FEMPI cuts.

Both these experiences demonstrated very clearly to me the value and importance of the IMO in our professional lives.

Recently I was at an educational weekend in Donegal attended by a lot of GP's and GP trainees and there was such a general positivity about our union. We had a newly established, single-handed young GP giving a discussion on starting general practice and he gave a wonderful compliment to the IMO secretariat - he said that they were knowledgeable, proactive, and effective and he encouraged everybody to be a member adding that the membership fee was such good value. We might even hire him as our recruitment officer!

The unique value of the IMO is that we are the Trade Union that represents all doctors – of all ages and across all specialties. We are all doctors and as a profession we stand as one in our fight for a well-resourced health service that is capable of delivering for patients and retaining doctors.

The system itself seeks to divide us into sub-groups fighting against each other for resources instead of fighting together but I know we will continue to resist that pressure.

Looking back over the past 10 years or so, the success of the IMO is advancing the cause of each of the specialty groups is remarkable. From tackling the FEMPI cuts to negotiating the terms on which GPs supported the emergency COVID response, to the terms on which we treat young patients….. to securing consultant status for Public Health Doctors and representing the interests of consultants on their new contract, the IMO has been at the forefront of protecting the interests of all doctors in a rapidly changing world. And perhaps most importantly for the future of our profession, our **#standingUP4NCHDs** campaign. As I said I first joined the IMO as an NCHD and it genuinely saddens me that, despite some progress, they are still not treated with the value and level of respect they deserve – but more of that later.

But of course, the work of a union never ends, and this conference has again highlighted how our profession continues to face challenges and threats that demand our attention. Sometimes doctors are characterised as being against reform…even of being obstacles to reform but nothing could be further from the truth. Many doctors before me have clamored for change – shouted from the roof tops for reform. But reform must deliver real and meaningful change for the patient and the doctor. Change for change's sake or the endless pursuit of the latest great idea does not help anyone.

The theme of this year's AGM – *Valuing Patients by Valuing Doctors* - is particularly timely as it raises the growing risk of the role of the doctor being undermined … with the knock-on effects which that will have on patient care.

We have to face up to what are the core issues impacting a negative perception of our services by patients and doctors – and they are really the same things:

- Not enough doctors
- Waiting Lists that are frighteningly long
- Not enough capacity

Yesterday we heard, for example, of the growing risk to patient health posed by the sometimes-careless deployment of Physician Associates in place of – rather than in addition to – fully qualified doctors. We have seen the risks posed by this development in the NHS and we understand how concerned our colleagues in the NHS have become about this.

So let me be very clear. We are not against any new grades that will support and deliver better health services but let's be honest we need fully qualified doctors, and lots of them to treat patients. And we need to protect these new grades to ensure they are not being exploited and expected to undertake roles and tasks for which they are not trained.

It is in no-one's interest to undermine the essential role of the doctor in the patient journey and to pretend that someone else can do that role is simply misleading. So yes as health professionals we can all work together within our scope of practice to deliver best care but each role is different and brings different skills. Lets respect that rather than fool ourselves that the roles are interchangeable.

I am also concerned about what I see as a pattern where it is becoming increasingly difficult for doctors to simply get on and practice medicine here.

Increasingly obstacles are being put in our way that prevent us from doing what is best for our patients.

There are so many reasons as to why that is the case.

We don't have enough beds.

- The ESRI anticipate that we need over 5,000 new beds in public hospitals. Absent those beds, our bed occupancy rates run at 88%(11% over the recommended upper limit) and our full capacity protocols are now often operative year-round.

We don't have enough consultants.

- 1 in 5 Consultants posts aren't filled and there are gaps in key specialties across the country.
- So yes, we have a new contract and over 4,000 consultants have signed up to that contract– we have a commitment that more consultants will be hired – we need to be more ambitious with that number, but we do acknowledge it is progress.
- But we do need to build trust – we need an acknowledgement from the system that consultants already provide care 24/7 through the on-call system.
- And we have to ensure that we properly resource the consultants working on weekends so that we don't simply move work from the middle of the week to the weekend. Let's make sure that weekend work adds to the volume of work undertaken across the week rather than simply replaces the work done on other days currently.

I want to say a few words about **NCHDs.**

I mentioned earlier that it was the horrendous working conditions we faced as NCHDs which first encouraged me to become involved with the IMO.

Thanks to the efforts of the IMO and successive generations of NCHDs, we have made progress on this agenda. But the system continues to fail NCHDs and their patients and that needs to be addressed comprehensively and urgently.

Being an NCHD just means being under constant pressure, working illegal and unsafe hours and having no work/life balance. And we wonder why they emigrate in such large numbers.

My son Gordon is presently training in the NHS but his experiences mimic that of his peers in this country. He describes a situation of beginning a day with an intense workload and rushing through to the end of his shift without feeling he has achieved anything tangible.

But more importantly there's just no joy there's no fun and how can you ask a population of young doctors to stay for these experiences.

If you don't respect them, they won't stay.

There aren't enough GPs.

We need 2,600 new GPs in the next four years…but how many have we got since 2017 – 150!

My daughter Hannah, I'm really proud of her, all through her training I know she always wanted to be the best GP that she could be, and I really respect her for that, but now she has 2 young children and now she wants the best mother she can be.

We have to implement change so that they can be both.

- Supports starting up,
- New structures and educate them how to achieve.
- To be able to have a family and work as a partner and that is something that we as a union have to advocate for.

But it is not all down to under resourcing and poor working conditions.

Other obstacles arise from political interference – sometimes well-intentioned but often with unintended consequences.

Having a really a good idea on its own doesn't always make for good health policy.

Anticipating the short and medium consequences of an idea or policy especially on workload is vital.

Free access to a service is not of much use without ease of access to that service. Yet sometimes politicians focus on making things free but ignore that it is also making them scarce.

When access to a service is difficult it causes tension in a population such that paradoxically they will try and attend that service more often.

I think this point reinforces the fact that we need to consider whether any new plan allows us to retain the good things we are doing before we add new services on top.

I think from a society point of view during COVID crisis we observed how the population reacted to good communication, consistency of information and frankly a good touch of reassurance.

We must continue to the use this coordination of messaging to compete against the populism and misinformation that is ever present particularly in relation to childhood immunisation. We must coordinate or message that immunisation is not an optional extra, but it is vital for long term health of everybody.

And I would appeal to politicians and aspiring politicians not to make promises around healthcare as some kind of political football over the coming year as elections are looming.

Medical negligence litigation is having a detrimental effect on how doctors practice medicine.

Medical negligence is proven when a doctor deviates from the standard which is actually applied by competent professionals of similar specialty in an area.

But case law is moving beyond that. In *Dunne v The National Maternity Ward* 1989, it was found that even if a doctor is shown to have followed the standard practise that a competent professional would apply, negligence may still apply if a *"a plaintiff can establish that such a practice has inherent defects"*.

Legal practitioners and the judiciary which assess these cases must fully understand the models of care which each specialty follow (a screening process is not a diagnostic test etc) and they must recognise that in a hospital setting that the clinical staff are essentially working with one hand tied behind her back due to staff shortages and infrastructural deficiencies.

A failure to do this is leading to Ireland being a outlier in medical litigation, it is encouraging the exodus of well-trained competent medical staff from our shores to other health systems where this is not an issue.

More importantly it is leading to altered patterns of medical practice which is leading to increased investigations and referrals from primary care to a secondary service that will soon collapse under this legally induced demand.

These are serious issues and I hope to be able to shine some attention on them in the coming months. It is beyond time for a change to the system that pits doctors against patients and becomes a litigation nightmare for all involved. There is probably no perfect system but there are better systems and I really want us all to get behind a campaign for change.

I want to thank everyone who has spoken at the AGM. I particularly want to acknowledge and thank the Minister for Health for taking the time to join us at the AGM We don't always agree with the Minister – any Minister ! – and they do not always agree with us but when we work together, in a collaborative way, with respect and trust on all sides we can deliver progress.

But that's enough talk from me. Let me conclude by again thanking you all for your presence over these past few days and again this evening.

There are so many of our colleagues who serve on committees and give so much of their precious time away from family and life to work in the IMO in the interests of all doctors – I salute them and look forward to working with them this year.

And I want to thank our IMO Secretariat – they are there to help, support, guide us, negotiate for us – we could not do this without you so to each and every member of the team I say Thank You.

I am deeply honoured to be President of the IMO. I hope I do justice to my distinguished predecessors in this role and I look forward to working at the service of all of you over the coming months advocating on behalf of our patients, and our members to ensure that we continue to build a health service that we can be proud of.

Thank you all. I hope you enjoy the rest of the evening.

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