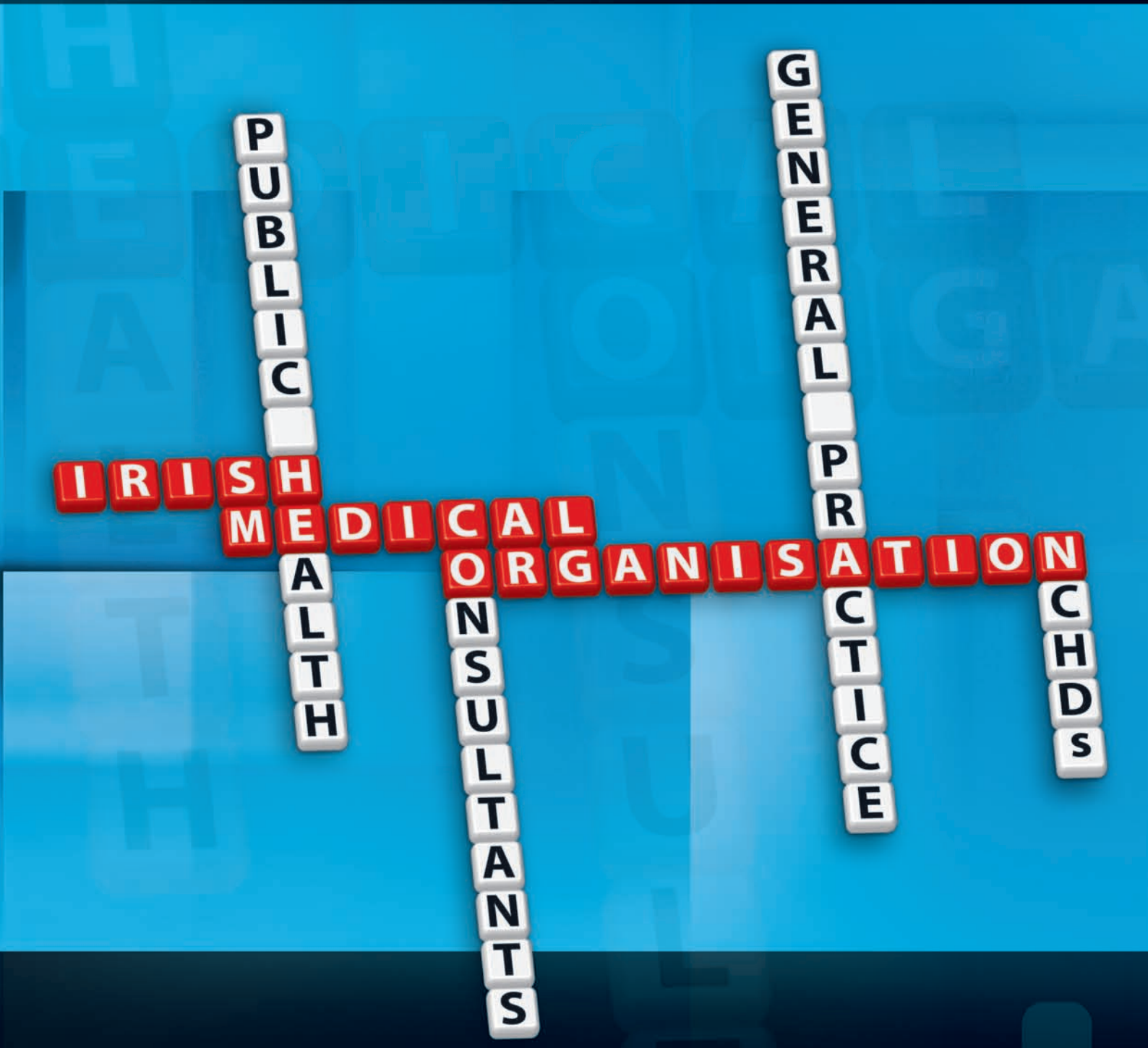
IRISH MEDICAL ORGANISATION

Ceardchumann Dochtúirí na hÉireann



2011 annual report & accounts

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

The role of the IMO is to **represent** doctors in Ireland and to **provide** them with all relevant services.

It is committed to the **development** of a caring efficient and **effective** Health Service.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Annual Report & Accounts 2011

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

IMO Organisational Structure

Annual General Meeting

Policy-making body of the Organisation.
Open to all members.

Council

Meets on a quarterly basis and is chaired by the President and has 25 members elected by the Specialty Groups. Council has the overall control over general policy implementation in accordance with the rules and policy formulated by the AGM.

Management Committee

Meets eight times a year and monitors the performance of the secretariat, receives monthly management accounts and ensures that policy is being implemented. It consists of the President, Vice President, Honorary Treasurer, Honorary Secretary, Chief Executive, Chairperson of each Specialty Group and immediate past President.

Specialty Groups

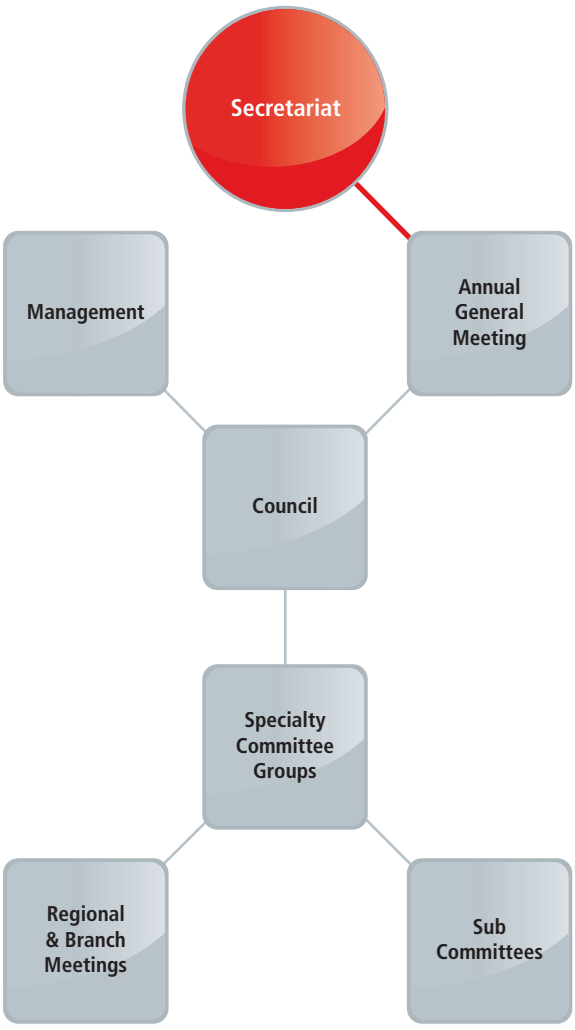
General Practitioners, Consultants, Public Health Doctors, and Non Consultant Hospital Doctors. The groups meet eight times per year and decide on action to be taken in relation to issues affecting the relevant groups. If issues arise which affect other specialty groups, those issues are referred to Management Committee for decision.
Each Specialty Group contains regional and specialty representatives.

Standing Committees

International Affairs.
Ethics.

Regional Structure

Each speciality group is sub-divided into Regional Divisions which correspond with the HSE Administrative Areas. Each Regional Division is divided into branches, where applicable, and each Branch is to have a Chairperson and Secretary, who are elected at the AGM.



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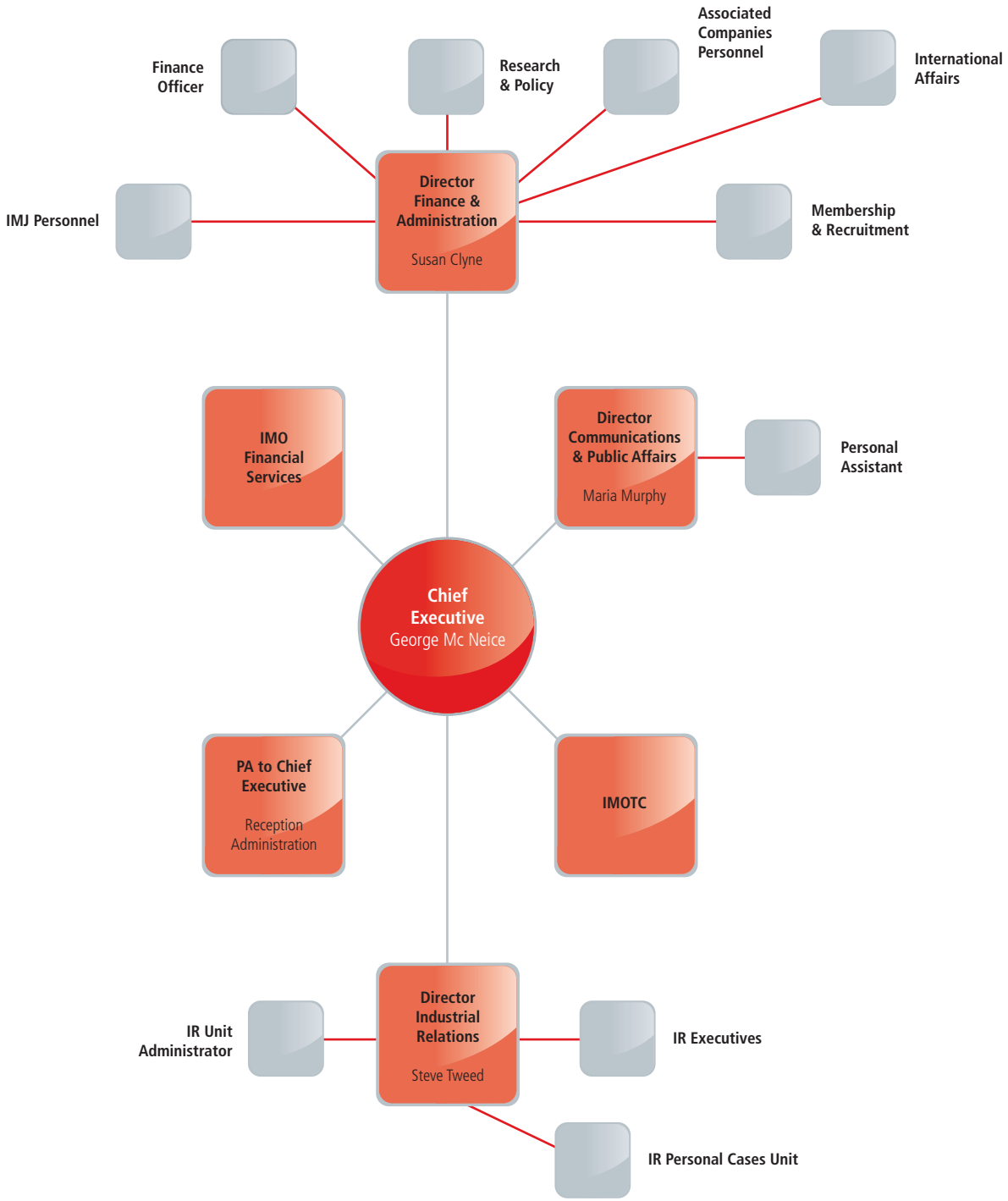
IMO Corporate Structure



IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Chief Executive Mr George McNeice

President Dr Ronan Boland

Vice-President Dr Paul McKeown

Honorary Treasurer Dr Trevor Duffy

Honorary Secretary Dr Matthew Sadlier

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Introduction

Dear Members

As President and Chief Executive of the Irish Medical Organisation, we have pleasure in presenting you with the Annual Report and Accounts for 2011. The report offers a detailed outline of IMO activities during the year.

We wish to thank our Honorary Officers who worked tirelessly for the IMO this past year; Vice President, Dr. Paul McKeown, Honorary Treasurer, Dr. Trevor Duffy and Honorary Secretary, Dr. Matthew Sadlier.

We would also like to thank the chairpersons of each of the committees, whose extensive work on behalf of members is detailed in this report.

A special word of thanks is due also to the IMO secretariat for the dedication and professionalism with which they carry out their roles. We thank all those who have contributed to the success of the Irish Medical Organisation, ensuring that the vast array of issues dealt with by the IMO are progressed in the interests of the whole medical profession.

We thank all of our members for their continued support for the IMO throughout the years.

In accordance with Paragraph 12.1 of the Constitution and Rules of the Irish Medical Organisation, we hereby give notice that the **Annual General Meeting** will be held in the **Hotel Europe, Killarney, Co. Kerry from the 12th April to 15th April 2012.**

Yours sincerely

Dr. Ronan Boland, President

Mr George McNeice, Chief Executive

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

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Mr George McNeice, Chief Executive, IMO

The IMO exists to represent, defend and promote the interests of doctors across the country and to promote the development of a caring, efficient and effective national health service. That's an ambitious agenda in times of plenty and doubly so in times of economic crisis. Inevitably therefore 2011 was a very tough year for the organisation and, more importantly, for our members, for our patients and for the wider community.

However the year also proved, if such proof was necessary, that the need for the IMO has never been greater. The organisation has negotiated a key role in the debate about transformation of the health services and in the implementation of the Croke Park Agreement. It's role as the key trade union representing doctors across the health services is undisputed, and it has played a critical role in supporting thousands of members up and down the country in respect of individual disputes and disagreements they are having in relation to their own practices. In a future as laden with risk and challenge as that facing this country, the continued importance of the IMO to represent doctors in our health services is undeniable.

This Annual Report contains a detailed review of our activities during 2011. I would like to focus however on a number of key issues we faced during the year, starting with our Strategic Plan.

Strategic Plan 2011:2014

The role of the IMO is to represent doctors in Ireland and to provide them with all relevant services. It is committed to the development of a caring, efficient and effective health service.
IMO Mission Statement

In 2011 the organisation finalised and published a Strategic Plan to cover the period up to 2014. This plan sets out a roadmap for the organisation for the coming years. It was formulated after extensive analysis of the issues facing the health profession, a review of strategies and priorities to date, and widespread consultation with members.

The plan sets out the following key principles for the organisation:

- Remain true to the IMO Mission Statement
- While industrial relations will remain the core activity of the IMO, the Organisation will build upon areas of professional representation and policy development
- IMO strategies will be rooted in realism and focused on achievable goals
- While all strategies must be robust, they must also be flexible enough to adapt to unforeseen external developments

The Strategic Plan focuses on the three pillars that are essential to the ongoing work and development of the IMO.

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Report of Chief Executive

Excellence in Industrial Relations

As a Trade Union, representing the interests of our members in their dealings with their employers and other stakeholders is a priority for the IMO.

The Personal Cases Unit [PCU] is one of the most significant developments in our Industrial Relations offering of recent years. The PCU is a dedicated service to support individual members in relation to queries they have on accessing their rights and entitlements under contract and other relevant issues. The need for this unit is highlighted by the fact that in 2011 it dealt with an extraordinary 14,000 queries from individual members.

Looking beyond personal cases, the IMO has ensured that it is centrally placed at the heart of the Health Transformation Programme under the Croke Park Deal (Public Service Agreement). The IMO is the representative organisation for doctors on the Health Implementation Body which is overseeing Health Transformation. This gives us critical influence on the shaping of policy in this area and it is critical that we remain engaged and proactive in order to best position our members to do what they do best – treating patients in a properly resourced environment.

The Croke Park Deal has been the subject of increasingly negative comment from some commentators. However, it has clearly delivered important results already and we remain committed to working with all stakeholders to achieve real and sustainable reform.

In the context of our engagement under this Agreement we have been proactive and innovative in seeking solutions and working towards a better health service that will benefit all– patients and doctors alike. Achieving this will, of course, mean intensive discussions and negotiations, and will not be without its difficulties. While we remain committed to Health Transformation that is not to say we will allow the transfer of work from one sector of the health services to another without proper planning or adequate resources. Change in the complex environment of the health services will take time. The country simply cannot afford to get it wrong and the IMO will ensure that your concerns and hopes for the future of our public health services are heard in this debate.

Chief Executive George McNeice at the Pre-Budget press conference

Sectoral Strategies:

Working with the national committees for the different specialisations within the IMO, the organisation has developed specific strategies for each of the member groups. Taking into account stated Government intentions in terms of health and the views of our membership, these strategies focus on a clear set of IR priorities, specialty specific policy initiatives and communication objectives.

GP Members

The IMO GP Strategy encompasses a body of work on a number of key issues.

Through 2011 we continued to fight for the amendment of Section 4 of the Competition Act. This amendment was agreed in 2008 and provided for in the Croke Park Agreement though it has not yet been implemented. We have not and will not waver from our position that GPs are entitled to be represented by the IMO and that no contract changes can take place without negotiation with the IMO. We remain committed to the GP Strategy and if necessary we will take legal action on the matter.

While seeking to be proactive in relation to Health Transformation we have vigorously defended the integrity of the GMS Contract particularly against unilateral actions by PCRS in respect of Phlebotomy, Out of Hours and STCs.

On the issue of Chronic Care Programmes the position is clear – the IMO has not been involved in any discussions or negotiations on these issues and no new work arrangements

Report of Chief Executive

have been agreed. Everyone recognises and acknowledges the potential for General Practice but we are adamant that before any transfer of workload from secondary care to primary care takes place there must be proper planning and a guarantee of the resources and infrastructure required to deliver on new programmes.

The FEMPI legislation has been the instrument used by Government to reduce GP fees. In 2011 we made strong submissions, particularly in relation to the devastating effects such cuts are having on rural general practice and in relation to the flu vaccine. Through the year we highlighted that GP delivered vaccination programmes have been particularly successful in Ireland and that the proposed action on the flu vaccine programme by Government had the potential to seriously undermine the successes achieved to date. In relation to the flu vaccine, we significantly mitigated the stated objective of the Department of Health in relation to fees and we have indications that the issue of distance coding for rural practitioners will be reviewed.

We have continued with our work on a new GP Model – a Blueprint for General Practice which envisages a new way for GPs to manage workload through the use of new technology and support systems. Following on from the GP National Meeting in January 2011 we prepared a detailed presentation for Ms Roisin Shortall, TD and Minister for State with responsibility for Primary Care, and we have engaged with service providers to further develop a roadmap for the delivery of the objectives.

Consultants

Consultants have in the past year faced sustained attacks focusing on pay and attempts to damage reputations through the use of flawed and biased information on public private mix. In an effort to redress the balance the IMO completed a comprehensive Benchmark Study of Consultants in Ireland to gain a true picture of the reality on the ground and assist us in determining strategy and priorities for consultants.

While the results of the survey are no surprise to consultants working on the ground, they are an indictment on the HSE and how they value their employees. Shockingly one in four consultants are contemplating leaving the public health system and this is as a direct result, not of dissatisfaction with pay, but of the complete breakdown in trust between the HSE and consultants. This is most clearly evidenced by the stark fact that consultants are working to the terms of the new Consultant Contract while the HSE is not. It is a priority for the IMO to ensure the Contract Implementation Group begins to work effectively and proactively in resolving the many outstanding issues.

The Benchmark Study formed the basis of the IMO Consultant Strategy which will, over its lifetime, deal with, in addition to contract implementation, issues around measurement systems, capacity planning and retention policy for the Health Services, risk management and the whole attempt by the HSE to undermine the very professionalism and clinical independence of consultants.

NCHDs

Given the debacle of the HSE's recruitment initiatives in respect of NCHDs in 2011 and the fact that the Irish health system is not an attractive option for a career as a consultant, it is critical that the HSE engage with the IMO on the whole area of capacity planning – the time for short term quick fix solutions is over.

While there has been talk of a new grade within our public hospital system we have received no detail to date nor have we been involved in the Minister's Working Group looking at the issue.

This issue is also of critical importance for NCHDs where recruitment and retention issues had a hugely negative impact over the past year. We have seen the farcical situation whereby the HSE, having blatantly disregarded NCHD contracts, effectively forced large numbers of our young doctors abroad to pursue training and career opportunities not available in Ireland, and then undertook a badly managed recruitment process to try to fill the gaps they had created. The whole experience should serve as a warning of the dangers of unplanned and misguided reform agendas.

In 2011 the IMO highlighted these and other serious problems for Ireland and its public health service- a direct result of the manner in which the HSE is treating NCHD employees. Our *ENGAGE FOR CHANGE CAMPAIGN* and the IMO NCHD Benchmark Study demonstrated clearly the systematic abuse of the NCHD Contract, the absolute requirement for improved training both in terms of access and funding and the absolute necessity to develop a defined and planned career path leading to consultant posts. Our findings were presented to the Oireachtas Joint Committee on Health which helped highlight the issues to the wider public.

Our focus is clear and we are working to deliver upon the objectives which we outlined at our National NCHD Meeting in October. During 2011 the IMO has reacted quickly and decisively in all situations where NCHDs have been deprived of their contractual rights and we will continue to defend our members in this regard. We are prepared to resolve matters with employers but it must be done so, in an honest manner which respects the rights and entitlements under the Contract. In recent years, NCHDs united behind the IMO in taking legal action against the HSE which forced the HSE to reverse unilateral breaches of contract and ultimately led to the new NCHD Contract. It is only with the strength of our NCHD members that we can continue with our fight to have all aspects of the Contract implemented and honoured.

Public Health and Community Medicine

Manpower and resources have also been a major problem for doctors in Public Health and Community Medicine. In 2011 we made further submissions to have the moratorium lifted so as to alleviate the problems in providing a full range of services and continuing with the HPV Programme. Albeit, that we have some concerns about the process, we welcome the appointments of several specialists in Public Health Medicine and we would encourage the

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Report of Chief Executive

George McNeice and Dr Ronan Boland with the IMO student debate winning team; Cormac Mullins, TCD, Mary Randles, UL and Kevin O'Grady, UCC.

HSE to show similar flexibility in appointing other public health and community health doctors.

During 2011, as part of our efforts to ensure our structures best meet the needs of members, the Public Health Doctor Committee was reorganised into two sub-committees dealing with specific issues for Public Health and Community Health Medicine. The sub-committees then report to the main committee which considers the issues and deals with agenda items of mutual interest.

For our Specialists in Public Health, for whom we have now claimed consultant status, the main issues during the past year have been in the areas of Transformation of the Population Health Directorate and the Public Health Emergency Out of Hours Medical Service. The key problem in resolving outstanding issues in this regard has been the lack of positive engagement by the HSE in the process. However the IMO and the Public Health Committee will continue to push this agenda forward, particularly now in light of the Minister's plans for a post HSE era.

2011 has seen the IMO efforts to resolve the long standing issue of AMOs continue with a two pronged approach – pursuing the industrial relations option which has to date yielded little progress, despite strenuous efforts to bring the employers to agreement, and taking a case to the Equality Tribunal on the basis that the remaining AMOs are de facto victims of discrimination on the ground of age by having been appointed prior to the enactment of the 2003 Agreement. A significant body of work has already gone into preparing for the case and we expect to be in a position to proceed in early 2012.

In respect of the Community Health Review the work has been completed and we await the publication of the report. It is inevitable that this will lead to a number of industrial relations issues and we have been, over the past year, preparing our positions in relation to the future of community health medicine.

Over the past year Public Health and Community Health have seen severe cuts in terms of resources and this has put increasing strain on our members attempting to deliver a full service. It is clear that the HSE fails to recognise the importance of the work and commitment of doctors providing these vital services, but the IMO, as clearly demonstrated by our efforts over the past year, continue to prioritise these issues and to ensure that their position as integral parts of the health environment is recognised.

Professional Representation and Strategic Alliances

Our priorities for 2011 – 2014 in this area as identified in the Strategic Plan are as follows:

- Champion an affordable, high quality health system for all
- Lobby and influence the implementation of Quality Standards
- Promote the Role of the Doctor
- Engage on the practical application of CPD

Following on from the publication in 2010 of the IMO Principles on Universal Health we have continued to promote key issues around inequalities in health and accessing healthcare. Our engagement has been through the form of debate in the public affairs arena, submissions to relevant bodies, including pre budget submissions, and in direct engagement with the Oireachtas.

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Report of Chief Executive

Chief Executive George McNeice and Prof. Sean Tierney with representatives from Sinn Fein, Labour, Green Party and Fine Gael at the Health Hustings 2011

It is important for the Organisation to focus the debate on Universal Health around these core principles and we will continue to use every available opportunity to pursue our objectives in this regard. Universal Health raises many issues but the IMO will remain a staunch supporter of a properly resourced public health system, which delivers high quality medicine to all our citizens on the basis of medical need while retaining the principle of clinical independence which best serves patients' interests.

In 2011 we continued with our series of position papers on the Role of the Doctor. We dealt with the issues surrounding Doctor Patient Confidentiality which is central to the doctor patient relationship. The paper sets out the issues involved particularly with the growing use of technology in healthcare and sets out important guidance on patient confidentiality.

The focus of our work during 2011 has been to develop policies and positions both at national and European level which are practical, have demonstrable health benefits for patients and are cost effective in the long term.

Advocacy and influencing policy is an important function of the IMO and one we take seriously. It is however a frustrating road, particularly in times of economic difficulties, so we were pleased to be recognised for our work in the area of Road Safety when we received a European Award of Excellence in Road Safety.

In the context of the General Election at the beginning of 2011, the IMO, with the Dental Association and the Pharmaceutical Union engaged in an Election Hustings to present and debate our priorities for health to the health spokespersons from the political parties. Such events and ongoing advocacy activities enhance our position as the key medical representative body that is proactive and innovative in providing solutions.

Our economic difficulties in recent years have brought into sharp focus how influential Europe is in our national affairs and the area of health is no exception. The IMO has long been committed to representing the interests of doctors at European level though our participation in European Medical Bodies and indeed on a more global basis through our involvement with the World Medical Association.

There are critical issues at European level which will increasingly affect the way in which we work in and resource our health services and it is critical that the voices of Irish doctors and not just Irish politicians are heard on these matters.

In 2011 we continued to engage with and make submissions to the Medical Council on the practical application of Continuing Professional Development and the Professional Competence Scheme. Fundamentally all doctors should be in a position to fulfil their commitments in this regard but the IMO must ensure that the HSE also meet, as the employer, their own responsibilities in terms of resourcing CPD. There are particular issues regarding retired doctors and we continue to seek an equitable resolution in this regard, additionally, the IMO as an organisation is committed to providing members with opportunities to avail of CPD through the AGM and other IMO meetings.

Engaging with Members

The strength of the IMO lies in its membership and our aim is to ensure we continue to be a strong trade union offering an excellent value for money service to members. It is imperative,

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Report of Chief Executive

At the Doolin Lecture: Mr. George McNeice with Sr Paula Doolin and Bill Nolan, daughter and grandson of the late William Doolin.

particularly in these times, for doctors to have a strong voice, and through the IMO to ensure that that voice is listened to. It is clear that Government, the HSE and hospital managers are making attempts to undermine contracts, and doctors need a strong trade union to represent them - for the IMO to be successful in achieving its goals it is vital that more members get involved in the work of the Organisation.

During 2011 we developed a Membership Development Strategy with the key objective to encourage more doctors to join with the IMO in pursuing our objectives in the areas of industrial relations and policy development. We have sought to explore greater opportunities for two way communication between members and the IMO Head Office and Specialty Committees and to this end we have, in the past year, initiated two major projects;

- A new IMO Website which offers members up-to-date news and information and a range of support material to assist members in their career and working lives
- Revitalising the IMO at local and regional level

I welcome any feedback from members on the further development of our website and online services and I would encourage all members to visit our new site at **www.imo.ie**. In 2011 we completed work on the IMO Time Tracker which is an app for NCHDs to record working hours and we intend to launch this to IMO members in early 2012.

In 2011 we continued with our project to engage medical students in the work of the IMO and the development of Health Policy and in December we held a very successful inter medical school Student Debate on the motion

"This House Believes Ireland Gets the Health Service it Deserves"

The debate was lively and interesting with excellent contributions from all sides, and clearly demonstrates the importance of harnessing the enthusiasm of medical students in trade union activity and medico-political affairs.

Conclusion

I hope it is clear from this review that 2011 was another very busy year but one in which we've made significant progress across a number of areas.

I trust it's also clear that there will be no quick respite from the pressures facing doctors of every specialisation in this country, and no let-up in the need for us to defend, promote and advocate in the interests of all our members.

It is apparent that the pressure for transformation and change will increase not decline through this year and beyond. We will have to work night and day to ensure that the changes agreed are realistic and fair and thoroughly planned for.

Our members and the wider community should expect no less, and I reiterate our commitment across the organisation to do so.

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Council Management Members

Council is the governing body of the Organisation. It is chaired by the President and has 25 members elected by the Specialty Groups. Under the Rules of the IMO, Council is composed of seven members nominated from General Practitioners, Consultants and Non Consultant Hospital Doctors group, three from the Public Health Doctors group and one place is set aside to represent those who are not covered by above mentioned Groups. Council meets four times per annum.

IMO Council 11/12

Dr Ronan Boland (President)
Dr Paul McKeown (Vice President)
Dr Johanna Joyce Cooney (PHD Chair)
Dr Brett Lynam
Dr Joe Barry
Dr Mary Gray (GP Chair)
Dr Eleanor Fitzgerald
Dr Martin Daly
Dr Jim Keely
Dr Truls Christiansen
Dr Ray Walley
Dr Mark Murphy (NCHD Chair)
Dr David Flanagan
Dr Toby Gilbert
Dr Remi Mohammed
Dr Kishan Browne
Dr Ronan O'Leary
Dr Matthew Sadlier (Hon Secretary)
Dr Trevor Duffy (Consultant Chair/ Hon Treasurer)
Dr Siobhan Barry
Dr Neil Brennan
Dr Peadar Gilligan
Dr Peter A. Healy
Dr Seamus Healy
Professor Sean Tierney (Past President 2010/11)

IMO Management 11/12

Mr George McNeice (Chief Executive)
Dr Ronan Boland (President)
Dr Paul McKeown (Vice President)
Dr Trevor Duffy (Hon Treasurer/Consultant Chair)
Dr Matthew Sadlier (Hon Secretary)
Professor Sean Tierney (Past President 2010/11)
Dr Mary Gray (GP Chair)
Dr Johanna Joyce Cooney (PHD Chair)
Dr Mark Murphy (NCHD Chair)

Profession-wide Issues

Public Service Agreement (Croke Park)

The agreement continued to operate and regular meetings on its application were held during the year. The anticipated HSE Service Plan for 2012 was returned by the Minister in December for further changes and as a consequence it was not agreed before the end of the year. It is expected that this will detail further cost savings which will be subject to negotiation and consultation under the agreement.

The operation of the Health Service Implementation Body (HSIB) and the National Joint Council (NJC) had to tackle difficult decisions throughout 2011 and maintaining a stable industrial relations environment continued to prove difficult.

Review of Main Points

- Efficiencies and productivity to be maximised by appropriate use of resources
- Significant cost-saving reform measures across all parts of the public service including by extensive reforms in work practices and conditions of employment
- Review of extent of savings generated to be held in early each year
- Reduction in staff numbers across the public service
- No additional pay cuts
- Current Government moratorium on recruitment and promotion to continue to apply
- No compulsory redundancies but flexible re-deployment arrangements necessary
- Unified public service labour market to be created
- Promotion and incremental progression based on performance
- Industrial action in respect of matters covered by the pay agreement are banned
- Discussions to take place with the IMO in relation to the Government commitment to make appropriate changes to the Competition Act and the Transformation Agenda for GPs to be completed within 2 weeks

Agency Staff

New agreements with agencies implemented on Monday 14th March resulted in significant pay cuts for agency staff and, potentially, were in breach of the Public Service Agreement.

Due to the inability of the PSA Health Implementation Body to resolve the issues the health service unions referred the matter to the Central Implementation Body. The issue was subsequently referred to the Labour Relations Commission (LRC) and discussions have been ongoing for a number of months.

The IMO is also involved in a working group with the HSE, the Department of Health and other trade unions, which is examining the possibility of 'converting' a number of agency staff into HSE employees. In effect, the two sides broadly agreed that the recruitment of permanent staff is better value for money/continuity of care than bringing in Agency staff on an ad hoc basis. At a recent meeting at the LRC, the HSE indicated that they were in agreement with the union proposition that converting these staff to HSE employees represented a potential cost saving but that the four Regional Directors of Operations ought to be given discretion in this regard rather than having a national agreement imposed on them.

Further documents are awaited in this regard.

The Temporary Agency Workers Directive 2008/104/EC was published on 5th December 2008 and was implemented into Irish law on 5th December. This directive provides equal treatment to agency workers regarding working conditions and employment conditions from their very first day of work.
The IMO is monitoring the application of the Directive.

Moratorium on Recruitment

The IMO continues to press for the moratorium to be lifted in specific instances; the policy of removing two NCHD's for every Consultant appointment and Specialists in Public Health Medicine (SPHM) being two examples. In certain instances a request to lift the moratorium has been accepted for the Consultant/NCHD ratio - particularly where members have expressed the view that patient safety may be an issue. The IMO continues to challenge other instances that arise.

For SPHMs, the IMO continues to point out that failure to lift the Moratorium could result in the Out of Hours Service not being operated at various times when the 1 in 5 rota was not met. Following lobbying from the IMO, a business case has been put forward by the employer to the Department of Finance to exempt SPHM from the Moratorium. In April and July, competitions were held which resulted in the appointment of several SsPHM.
Notwithstanding some concerns arising from the appointment process, the IMO welcomes these appointments. The IMO will continue to press the employer side to fill all outstanding SPHM posts to allow the full Public Health Medicine service to be delivered at optimal efficiency.

Medical Practitioners Act – Professional Competence

The Medical Practitioners Act obliges registered doctors to comply with professional competence requirements from 1 May. A meeting was held between the IMO and the Medical Council on this issue. The meeting dealt with the issues arising out of professional competence, registration issues, Registration of practitioners providing medical services from outside the state, NCHD Registration issues, and language competence for those providing treatment. There was a good exchange of views and the IMO confirmed there would be a formal submission made to the Medical Council about the issue of professional competence. The IMO made this submission in November 2010. A further meeting on the issue of professional competence and NCHD training was held in April. Representatives of the IMO attended the Annual Conference of the Medical Council held in Croke Park on Friday 8th April which gave a detailed overview of professional competence and the requirements of the Act.

Profession-wide Issues

Speaking to an IMO motion, Anthony Owens, Industrial Relations Officer, at ICTU Biennial Delegate Conference

IMO motion on Expenditure in Health adopted by ICTU

The IMO spoke to a motion on necessary expenditure in health at the ICTU Biennial Congress in July. The IMO motion read:

"Expenditure on health is an investment in the future well-being of the nation. It is vital that the mistakes of the late 1980s should never be repeated. Congress urges the Government to consider the health of the nation and not just the health of our banking sector and refrain from further cuts to health service funding"

The IMO stated that it stands ready to facilitate State policy to treat more patients in primary care, but that adequate funding must follow the move. Equally, the Government must not use this as an excuse to abandon supporting secondary care. The point was reiterated that Ireland has seen increased cuts to funding, affecting public health and other social services, and patients increasingly denied early intervention find themselves suffering from more costly-to-treat chronic diseases. The motion on health funding was adopted.

Dr Trevor Duffy, Chairperson

Consultants

Consultants Committee 2011/2012

Committee Members: April 2011 – April 2012

Regional Representatives

Dublin/Mid Leinster
Prof Sean Tierney
Dr Niall Sheehy

Dublin/North East
Dr Trevor Duffy
Dr Pat Manning
Dr Peadar Gilligan

South
Dr Neil Brennan
Dr John Morris
Prof John Higgins

West
Mr Hugh Bredin
Dr Seamus Healy
Dr Naishadh Patil
Mr Finbarr Condon
Dr Christine O'Malley

Speciality Representatives

General Medicine
Dr Bernard Walsh

Obstetrics/Gynaecology
Dr Michael O'Leary

Pathology
Dr Clive Kilgallen

Anaesthetics
Dr Peter A. Healy

Psychiatry
Dr Siobhan Barry

IRISH MEDICAL ORGANISATION
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Consultants

1. Consultant Strategy

Background

The IMO Consultant Strategy was launched at the Consultant National Meeting in Aviva Stadium in Dublin, March 2010 and was presented at the Annual General Meeting in April 2011. The implementation of the strategy was set out at the Consultant Committee meeting in May 2011.

The Key Areas set out in the Strategy are:

- Capacity Planning/ Retention
- Policy development
- Professionalism
- HSE Management
- Morale

Working Groups of the Consultant Committee have been established to advance the Strategy and have been working to advance the main areas of action.

2. Public Service Agreement

The HSE indicated that it wished to consider changes under the Public Services Agreement (Croke Park Deal) to how certain consultants work within the health system.

A meeting was held with the HSE on 21 February 2011 including representatives of the IMO and the IHCA. The HSE wanted to outline the changes they would like to achieve. The HSE set out that they would like to gain more flexibility from consultants with the wider use of working from 8-8 and 5/7 working. They want to introduce a system of performance management. They also set out their changed arrangements for the appointment of locum consultants. In addition they wanted to discuss the treatment of historic rest days.

At a subsequent meeting on 5 May 2011 the issue of flexible working was raised again by the HSE, who indicated that the flexibility would be required in certain specialties. It was made clear that a compelling rationale was required and it would be necessary to show that such flexibility should not impact on any other service. The issue of historic rest days was also included although it was felt at the meeting this issue would be less important with reconfiguration and the advent of larger rosters.

A meeting was held with HSE National Director HR and his team with consultant representatives on 29 August 2011, where he proposed changes for consultants under the Public Service Agreement. The main proposals were that consultants should work additional hours without pay and the relevant consultants should abandon their entitlement to historic rest days. This view was rejected by the IMO as completely unacceptable as these provisions are outside the terms of the agreement and are not for discussion. It was made clear to the HSE that the IMO are prepared to discuss any necessary changes within the terms of the agreement. It was agreed at the meeting that there would be a further meeting but no date was set.

There has been an exchange of correspondence with the HSE setting out the IMO position that consultants are available to engage in discussions on change within the provisions of the Public Services Agreement 2010 -2014. It has also been set out that any change to the arrangements on historic rest days are outside the provisions of the agreement and are not up for discussion.

3. Outstanding issues under the Common Contract 2008

The Consultants Common Contract 2008 came into effect in August 2008 and was to be implemented on a phased basis since that time. The payments were to be made in 3 phases over the agreement. Phase 1 was paid, Phase 2 was paid 6 months later and Phase 3 remains outstanding.

The outstanding issues of implementation were to be arranged through the Contract Implementation Group composed of representatives of the IMO, the IHCA and the HSE under the Chairmanship of Mark Connaughton SC.

The IMO made representations to the Contract Implementation Group on 7 December 2009. The issues that were raised were;

1. Appointment of Chair to the Contract Implementation Group
2. Full honouring of the salary and other payments due under Section 23 of Consultant Contract 2008.
3. Payment of a further 2.3% to reach the full 7.3%, as opposed to 5%, due from 14 September 2007 to Consultants continuing on their existing contracts and retired Consultants
4. Back payment of the balance from 14/09/07 to 01/01/09 of the 7.3% award due to consultants on existing contracts, as well as retired consultants.
5. Back payment of premium payments for weekend working from uptake of the contract to 01/01/09
6. Back payment of the CME allowance from 01/06/08 to 01/01/09
7. Consultants in Emergency Medicine – Unabated salary and back pay for the period June to December 2008
8. Implementation of Academic Consultant Contracts
9. Resolution of the contention by the HSE that a consultant who has private rooms on the public hospital site attends these rooms outside of his 37 hours but his practice in these rooms comes within the 80%/20% public private mix
10. The difficulty regarding acceptance on the part of the HSE that a consultant who has a split site appointment has a single post and therefore his overall public private mix must be aggregated into a single set of percentages for his hospital sites
11. The position regarding private patients and Type A consultants and the undertaking given by the Department of Health/HSE during the contract negotiations. (private patients who present at the hospital and are dealt with by a Type A consultant)

On 26 April 2010 Mark Connaughton SC issued his report on the issues raised at the meeting. There are a number of issues to be addressed on foot of his recommendations

Consultants

He noted that issues were being addressed in an environment where the full remuneration due under the contract was not being paid to date. Consequently his comments were issued for guidance rather than binding.

He is no longer available to chair the talks and suggests that some of the dispute procedures within the contract could be employed to address issues.

a. Consultants holding a split site appointment – public/private practice ratio. Suggests a pragmatic solution where aggregation should be permitted for 12 months to allow the opportunity to get the mix at each location into line with the requirements of the contract.

b. Patients admitted under Type A Consultant Issues relating to pay in these cases should be resolved. There is a conflict between the Department position and the representative bodies which should be resolved through joint talks to address the issues.

c. Private outpatient clinics and the application of the relevant public/private ratio.

Private practice should be delivered outside of the standard 37 hour with the appropriate mix maintained.

The IMO wrote to the HSE to request the appointment of a new chair of the CIG so the outstanding issues set out above could be addressed through direct engagement with the HSE.

The issue has been raised with the Minister despite the objection of the HSE and the IMO has pointed out that the deliberations of the last Connaughton report are for guidance to the parties only and not definitive.

A meeting of the Contract Implementation Committee took place on Wednesday 3 November 2010. The outstanding issues from the contract discussions set out above were addressed at that meeting. It was noted that:-

1. The Minister has appointed Mr Mark Moran as chair of the contract group. The IMO has written to Mr Moran to arrange a meeting to discuss the outstanding issues.
2. The HSE advised that outstanding payments due under the 2008 Contract cannot be honoured at this time due to budgetary constraints. The IMO insisted that consultants have delivered on their part of the agreement and expected to be paid. It was agreed that the parties would meet in the near future to try to find a solution in this regard.
3. The HSE undertook to write to the four Regional Directors of Operations advising that various back payments and medical education allowances that have fallen due should be paid.
4. Both sides committed to meet again, together with the IHCA and the Department of Health and Children to consider the anomalous position of Consultants who have signed Type A contracts and experienced unanticipated losses in income.
5. The IMO will participate in a group working with Brian Gilroy and including ESRI to identify and resolve the issue of transparency about how figures in relation to public/private mix are compiled. The IMO has written to Mr Gilroy pointing out there are serious problems with the measurement system and calling on him to address them.
6. The HSE clarified that all clinical director posts are solely appointed under the terms and arrangements set out in the 2008 Contract.

The IMO have also written to the HSE and the DOHC in relation to holders of type A contracts and in particular in relation to the establishment of a research and education fund which would be funded from the income made by type A contract holders when they treat private patients. The Department responded that they were not in favour of a group to consider payments to Type A contractors and this will need to be discussed with them.

The IMO have attended the 'Dublin Mid Leinster Regional Workshop - Consultant Contract Private Practice Measurement' which was attended by Professor Miriam Wiley of ESRI and Mr Andrew Condon of the HSE. A discussion was had in relation to HIPE data and issues experienced by consultants such as lack of transparency of the data disclosed to consultants were raised.

It is understood that this is the first of a number of regional workshops in relation to this issue.

The HSE has written to the IMO seeking comment on their New Regulations NFR 21 which sets out how they propose to raise fees from consultants who are in breach of their public private mix commitments. The document has not been discussed previously with the IMO and the contents are not acceptable.

The IMO wrote to National Director HR, HSE and pointed out that the measurement system was flawed and was not an acceptable basis on which to claw back payments from consultants and any attempt to do so would be contested by the IMO. Work on the development of an improved measurement system is now underway. This work is being conducted through the Public Private Measurement Committee.

The sub group dealing with the work of anaesthetists met on 23 November 2011 to discuss the issues of capturing all the work done within the public hospital. An amount of this work is not captured on Casemix and the issue must be referred to the public/ private measurement committee.

4. NCHD Recommendation from the Labour Court

The IMO (NCHDs) is currently scheduling a series of follow up meetings with these training bodies in order to provide an update on the implementation of the EWTD in light of the IMO/HSE Settlement/Collective Agreement including on implementing the EWTD. The IMO has recently held meetings with the College of Anaesthetists and RCSI and hopes to meet with the RCPI and ICGP in the coming weeks.

In light of the major implications of a 48 hour working week for NCHD training, the IMO met

Consultants

with a number of training bodies to discuss these implications and possible measures to address same including the Irish College of Psychiatry, the College of Anaesthetists and the Royal College of Physicians Ireland and the Royal College of Surgeons.

The IMO met with the HSE as a result of the shortages and is monitoring the situation on an on-going basis.

5. Medical Council

The IMO maintains contact with Medical Council on matters of mutual interest and meets a number of times a year. Competence Assurance is an important issue at present with significant implications for members.

The Medical Council launched the details of the competence assurance programme and how it will operate. The issues discussed at that meeting included:-

1. Competence Assurance;
2. Registration Issues; and
3. Registration requirements for those providing medical services from outside the State.

The Consultant Committee noted that, in relation to competence assurance, no credit would be given to practitioners by the Medical Council for any training etc. carried out before 1 May 2011. It was further noted that there was speculation that the details of the competence programme have changed since the most recent circular was issued in June 2010.

It was also noted that in relation to registration requirements for those providing medical services from outside the State, the Medical Council have not relayed a definitive position. It was agreed that the IMO should write to the Minister for Health on this issue. The IMO are finalising a letter to be sent to the Minister on this issue and this will be circulated to members of the committee for comments before sending.

The IMO met with the Medical Council in April 2011 where the Council updated the IMO on the appointment of the training bodies to provide the competence assurance programmes. The IMO raised the issues related to competence assurance for retired doctors.

The Medical Council has initiated a process to consider issues relating to the rules for the maintenance of professional competence and the development of performance procedures where the IMO has made a submission on this to the Medical Council. A meeting with the Medical Council is scheduled for early in 2012

6. VHI

VHI are dealing with strong competitive pressures and falling numbers of subscribers. They have made changes to their fees and have provided this information to the IMO for their members. There are also a number of service issues and how different procedures are deal with that are relevant to members.

The VHI have been requested to provide an update on progress on the issues discussed. The health insurance companies have decided to implement E-claiming through the Irish Insurance Federation. They wish to consult the IMO and will provide further information on how this will be progressed.

VHI have written to 2008 'B' Contract holders declined to pay for private practice in certain cases. The IMO have written to the claims department challenging this approach and demanded that payments should be made without delay. It is understood that this issue has now been resolved.

7. Occupational Health Physicians

IMO agreed a process and timetable with the HSE for the provision of a review of the role of Occupational Health Physicians by Hays group. It involved Hay consultants researching the work of the Occupational Health Physicians and included a number of questionnaires and face to face interviews with them.

The report was issued to Occupational Health Physicians and will form the basis of on-going discussions with the HSE. The HSE has undertaken to consider their position and revert. Ongoing discussions are taking place with the HSE on the type of service provided, the structures to provide it, and the role of Occupational Health Physicians.

A review group has been established to address the issues of Occupational Health and an independent chair has been appointed to the group to deal with the issues.

8. Consultant Benchmark Study

A Consultant Benchmark study was conducted to gather more information about consultants, to identify what are the important issues for consultants and as a follow on to establish what issues the IMO can work on to make improvements for consultants.

Full results of the benchmark survey were launched at the IMO National Consultant Meeting in the Aviva Stadium on Sunday 27th March 2011 and subsequently at the Consultant National meeting at the AGM in Killarney. Additionally the presentation was made at a number of hospitals.

9. Mental Health Services

The IMO Research and Policy Unit has produced a first draft of a position paper on Mental Health Services in Ireland, which explores the economic rationale for investing in mental health services as well as the lack of progress implementing the national mental health strategy A Vision for Change. The strategy looks at the treatment of mental health problems at GP level and what support is needed in primary care. A questionnaire was issued to GPs and Psychiatrists to gain their input and this forms part of the position paper. The paper is complete and was launched by IMO in December 2010.

The IMO has made a submission to the Department of Health on the Mental Health Act 2001. The IMO made a written and oral submission to the Department of Health on fees paid to medical practitioners relating to work on behalf of the Mental Health Commission.

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Non-Consultant Hospital Doctors

NCHD Committee 2011/2012

Dr Mark Murphy, Chairperson

Committee Members: April 2011 – April 2012

Regional Representatives

Dublin/Mid Leinster
Dr Arshad Hussain
Dr Remi Mohammed
Dr Muhammad Razi Shaikh
Dr Eimhin Ansbro

Dublin/North East
Dr Jean Donnelly
Dr Toby Gilbert
Dr Maitiu O'Faolain
Dr Fergal Kavanagh (Co-opted)

South
Dr Joe Baker
Dr Michael Barrett
Dr Ronan O'Leary

West
Dr Micheline McCarthy (Co-opted)
Dr Dela Osthoff
Dr David Flanagan
Dr Kishan Browne (resigned Oct 2011)

Speciality Representatives

General Practice
Dr Mark Murphy

Obstetrics/Gynaecology
Dr Iftikhar Ahmad Sohail
(resigned Oct 2011)

Paediatrics
Dr Nalini Somaiah

Psychiatry
Dr Michael Murphy
Dr Matthew Sadlier

Surgery
Dr Myles Smith

Engage for Change

The IMO launched the NCHD 'Engage for Change' Campaign in mid 2011, the aim of which was to foster a culture of positive engagement among NCHDs, and ultimately to ensure that the Irish Health Service can retain our best medical talent through the provision of excellent training, defined career paths and the highest standard of patient care and safety. The key objectives of the campaign were;

- A better, safe and efficient Irish health service with the highest standards of patient care
- An engaged, proactive & positive NCHD cohort
- Full implementation of NCHD Contract 2010
- Improved working conditions & hours
- Improved training in terms of access & funding
- Defined and planned career paths for all grades & specialities
- To stop the brain drain

The campaign commenced with a series of twenty four 'IMO Fight or HSE Flight' hospital meetings in a 3 week period from 15th August to 2nd September 2011. The meetings were well attended with NCHDs engaging positively with the campaign. The campaign was supported by 'Fight or Flight' posters in NCHD residences across the country, regular website updates and media coverage.

The rollout of the campaign culminated with a National NCHD Meeting which was held in Croke Park, Dublin on 22nd October 2011 and which featured a wide range of speakers who specialised in various aspects of the NCHD experience. The national meeting was also used to launch a major Benchmark Survey into the experiences and intentions of NCHDs (on

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Dr Mark Murphy addresses the National NCHD meeting

which more below). Following the national meeting, a video presentation of the events of the day has been sent to all NCHDs and the Behaviour and Attitudes survey and the IMO NCHD Strategy are to be combined into a booklet to be issued to all NCHDS.

NCHD Benchmark Survey

In September 2011, the IMO conducted a landmark Benchmark survey into the conditions and opinions of NCHDs working in Ireland. The Survey contained 45 questions. The results were worrying in terms of the ability of Ireland to retain and/or attract high class medical talent. A summary of the results are set out below:

- On average, NCHDs were working 63 hours per week; this is well in excess of the 48 hour limit envisaged in the European Working Time Directive, which was transposed into Irish law in 1997. The respondents estimated that 30% of their working week is spent on non-medical tasks.
- Strikingly, less than one in five NCHDs describe their morale as high, three times as many describe it as either low or very low, and three quarters believe that morale among their colleagues is either low or very low.
- Only one in twenty NCHDs believe that there are sufficient Consultant or General Practitioner posts in Ireland to allow them to practice in their chosen field upon completion of their training. However, a similar number expressed a preference to stay in Ireland, if the opportunity arose.
- Over 70% felt that they had no input or opportunity to contribute to changes in their work environment / hospital.
- When asked what factors drove NCHDs to leave Ireland, the most popular answers were: Career opportunities (89%), work / life balance (87%), access to training (85%) and length of working hours (77%).
- When asked what factors would drive them, as an individual, to leave Ireland, the most popular answers were; lack of training opportunities (30%), ill defined career path (29%), excessive working hours (19%) and non payment of all hours worked (11%).

These results indicate a widespread disaffection among NCHDs who are currently working in Ireland. Given the mobility of NCHDs and the ongoing recruitment of Irish and Irish trained NCHDs by other health systems, a cogent HSE NCHD retention strategy is more important than ever. This continues to be a priority for the IMO and it behoves the HSE to address this issue strategically to prevent shortage crises arsing twice a year.

Contract Implementation

The current National NCHD contract came into effect on 8th February 2010. This contract is based on the principles of Labour Court Recommendations 19559 and 19702, agreed Principles of Rostering and the IMO HSE High Court Settlement/Collective Agreement lodged with the High Court on Friday 22nd January 2010. From day one, the IMO has been in close and detailed discussions with the HSE, under the auspices of the Labour Relations Commission (LRC), on a number of issues arising from the implementation of the contract. Among these are:

- Annual Leave/Public Holiday Entitlements
- 39 Hour Core Working Week/Protected Training Time
- Proposed 2 Year NCHD Post & associated issues
- GP Travel Allowance
- Principles of Rostering & EWTD Implementation
- Training Funding & Professional Competence
- Educational Leave

Non-Consultant Hospital Doctors

NCHD National Meeting:
Ms. Shirley Coulter, IMO Assistant Director of Industrial Relations, Chief Executive George McNeice, and Dr Mark Murphy with guest speakers Leo Kearns, John O'Mahony, Prof. Cillian Twomey, Dr Paul Darragh, Dr Philip Crowley

- NCHD Recruitment & Retention
- Review of Loss of Earnings as per Labour Court LCR19559

The IMO met with the HSE to discuss these issues in May and June of 2011, but it became clear that there were significant differences between the sides. The parties reconvened in October and November 2011 but were unable to bridge the gaps. Subsequent meetings have had to be delayed owing to the inability of the HSE to produce documents as promised and also because of events relating to unrostered overtime in HSE South.

NCHD Shortages

The IMO have continued to engage robustly with the HSE to attempt to alleviate NCHD shortages in various locations and in various specialties. Following protracted negotiations with the HSE, aimed at securing agreement on a two year rotational NCHD post, the IMO referred the matter to the LRC for conciliation in April, at which time, the HSE confirmed that no job offers had been made as, belatedly, the HSE conceded that the inducements contained in the proposal would be inequitable on long serving employees. It was agreed that if this matter was to progress it would have to be through further negotiation.

Conscious of the likely NCHD shortages, the IMO requested meetings in June to discuss HSE contingency plans for the predicted NCHD shortage in July. Regional meetings were held in each of the four HSE areas in June and July, with the HSE outlining the numbers of vacancies per area but with only vague detail provided as to the contingency plans and with a significant reliance on the India/Pakistan recruitment project to fill the vacancies. A meeting with the HSE nationally to discuss the issue was held on 17th August, where an update was provided on the registering of India/Pakistan doctors for work. The IMO highlighted the misleading nature of the correspondence issued to doctors during this recruitment drive. The HSE confirmed that all NCHDs are employed on the NCHD Contract 2010 and salary scales. The IMO has written to Minister Reilly a number of times in relation to the India/Pakistan recruitment campaign highlighting the unacceptable treatment of the doctors recruited as part of this campaign, calling for a full investigation and also arguing that these NCHDs should be paid at the grade for which they were recruited upon their arrival in Ireland. The IMO has also highlighted the unacceptable treatment of these doctors through the media.

The IMO met with the Oireachtas Joint Committee on Health and Children on 20th October 2011, having submitted a detailed written submission to the Committee on 13th October 2011. The issues under consideration were the NCHD shortage, education, training and the reliance on NCHDs to staff hospitals. After the hearing, the IMO delegation was pleased with the reception afforded to them and also with the interest shown in the conditions of NCHDs by the Committee. Subsequently, details of this presentation and meeting were forwarded to all NCHDs.

Several representatives of the IMO attended a seminar at the RCPI on 1st December, the aim of which was to encourage NCHDs to stay and practice their profession in Ireland. Among the other attendees was Mr Cathal Magee, Chief Executive Officer of the HSE and other senior managers who had the difficulties experienced by NCHDs impressed upon them. A document summarising the day and the agreed points is to be circulated by the RCPI.

Non Payment of Unrostered Overtime

Regrettably, the IMO continues to be made aware of instances where NCHDs are not appropriately remunerated for all of the hours that they have worked, particularly in relation to unrostered overtime. The IMO continues to engage with Hospitals, with HSE Human Resources and with third parties on this matter, and achieved several notable successes in the

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NCHDs attending the Dublin 'Engage for Change' Information Meeting

first half of 2011, some of which are summarised below:

- An agreement was reached with AMNCH, Tallaght on 6th May in which the Hospital committed to resolve any outstanding queries and pay all outstanding NCHD overtime by 31st August. The Hospital is to put in place more transparent processes, including NCHD involvement, and time recording procedures to ensure that a similar situation does not arise in the future.
- Acting on the outcome of a February Labour Court hearing, which removed 'inability to pay' as a reason for the withholding of unrostered overtime, the IMO secured the establishment of a process to pay outstanding unrostered overtime hours to NCHDs who had worked in Mayo General Hospital in the period July 2008 to June 2009.
- In May, the IMO reached an agreement with Beaumont Hospital that established a process whereby NCHDs who have queries on unrostered overtime payments in Beaumont can bring those to management attention via a dedicated email address and a meeting will be arranged with the NCHD within 3 working days. Management will assess claims and will discuss any outstanding or unpaid payments with the IMO. The IMO reserves the right to refer this matter to a third party if this is necessary.

Notwithstanding the above and the precedent that has been established, in August directives were issued from a number of HSE South hospitals explicitly stating that unrostered overtime was not to be paid. While the IMO remains cognisant of the budget difficulties faced by hospitals, service demands require NCHDs to work compulsory overtime and, furthermore, NCHDs have a contractual right to be paid for all hours worked. The Hospitals involved, were

- Cork University Hospital
- Wexford General Hospital
- Waterford Regional Hospital
- South Tipperary General Hospital

Collectively these Hospitals employ almost ten percent of NCHDs and this problem demanded a robust response. Initially, the IMO secured the agreement of HSE Human Resources that these hours must be paid but this did not change the positions of the Hospitals involved. Consequently, after meetings with NCHDs and Management, the IMO opted to ballot NCHDs in CUH for industrial action.

Armed with a successful ballot, the IMO met several times with Management in CUH and secured their agreement to enter into a two month process, the end result of which would see all outstanding unrostered overtime paid in full. CUH have also committed to establish a joint NCHD/Consultant/Management forum to devise rosters and try to ensure that this situation does not arise again.

With regard to Waterford Regional Hospital and South Tipperary General Hospital, the IMO has advised that individual NCHDs will be assisted in taking cases under the Payment of Wages Act (1991). In response, South Tipperary have sought to meet with the IMO and to establish a process similar to that adopted in Cork.

IMO 'Time Tracker' App

In response to the ongoing difficulties that have been experienced by NCHDs having all of their hours appropriately remunerated, the IMO developed a 'Time Tracker' App for the Apple iPhone to allow NCHDs to track and archive their working hours. The App also contains a facility to write a note into each day and can be used to automatically record overtime hours. There is also a facility to export to Excel for archiving. The App is available to download and is free to IMO Members.

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Personal Cases Unit

Since its inception in July 2010, the Personal Cases Unit has been staffed by three dedicated professionals charged with the provision of advice and representation on an individual level **to all IMO members**. To date the Unit **has dealt with in excess of 4,500** queries from members of each craft group; NCHDs, General Practitioners, Consultants and Public Health Doctors.

The staff of the Unit provides advice and counsel to members on matters related to their employment, and they provide representation at all levels of the industrial relations process including disciplinary proceedings, Rights Commissioner hearings, Labour Court hearings and in the Employment Appeals Tribunal amongst others.

The Unit acts in conjunction with the national office to identify trends in industrial relations matters affecting individual health professionals and groups, in order to best provide advice and assistance in the development of overall strategy for the promotion and protection of doctors' rights.

In the course of the past 18 months, the Personal Cases Unit has further assisted in promoting the IMO as a representative body and will play a key role in developing a coherent and effective membership strategy in the coming months. With the protection and enforcement of doctors' rights the core aim of the Unit, and a growing success rate in the provision of industrial relations advice and representation, the Personal Cases Unit is well placed to ensure that all members of the IMO are provided with access to advice, updates and representation as and when it is required.

Below you will find a summary of some case studies that reflect the services provided by the Personal Cases Unit:

CASE STUDY 1

An NCHD was having difficulties in reclaiming his unrostered overtime from the Hospital in which he was employed. Despite numerous attempts on his part, the Hospital refused to pay the outstanding balance of monies owed to him. He contacted the IMO with a view to resolving his issue and the IMO, through a series of meetings and phone calls, was able to secure the payment of all outstanding monies.

CASE STUDY 2

A Consultant had been employed in two separate HSE areas for in excess of 4 years. Following this time he sought a contract of indefinite duration based on section 9 of the Protection of Employees (Fixed term Work) Act, 2003. A series of meetings, letters and phone calls was entered in to with the Hospital and the HSE who refused to acknowledge that such an entitlement existed. The IMO was able to represent the doctor at all meetings and when the matter was referred to the Rights Commissioner service for resolution the IMO represented him by attending and preparing an in depth submission outlining chronologically the history of the proceedings, appending all relevant documents and arguing his case before the third party hearing. A decision from the Rights Commissioner is expected shortly.

CASE STUDY 3

A Consultant had been working in the same hospital for a number of years when she left to take maternity leave. Upon return she found her position at work had been drastically changed in terms of her working conditions and her salary, which had decreased during her leave period. The IMO set up a series of meetings with the Hospital and the HSE and were eventually able to secure her return to the salary she had been on and the restoration of her terms and conditions with some minor modifications in her favour.

CASE STUDY 4

An NCHD who had been taken off call due to issues with her performance contacted the PC Unit. The hospital set up a meeting to deal with these issues and she had contacted us for assistance. The PC Unit met with the Doctor and discussed the matter, explained the process and gave some guidance as to how she might address the issues. Hospital management was contacted prior to the meeting and we provided representation at the meeting. The Doctor was returned to on-call and an agreement was reached into dealing with her performance going forward.

CASE STUDY 5

A GP contacted the IMO with a view to receiving advice surrounding referral to the Rights Commissioner Service under the Unfair Dismissals Acts 1977 – 2007 in their capacity as an employer. The IMO met with the GP and advised them as to the nature of proceedings before the Service and with regard to the law as it applied in the instant case. The IMO attended the hearing with the doctor and a settlement was reached.

CASE STUDY 6

Despite receiving a new position as a Specialist Registrar in his new Hospital and having previously been paid at the fourth point of the SHO scale, there was no recognition of incremental credit. Through the intervention of the IMO, the relevant section of the NCHD Contract was enforced and the doctor's salary scale was amended to the correct second point of the Specialist Registrar Scale.

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Personal Case Unit

CASE STUDY 7

The IMO was contacted by a Consultant who was having issues with regard to locum cover being provided. They were advised that it was unlikely that cover would be made available. Communication was issued to the Hospital manager in respect of this and they responded confirming that the cover would be provided.

CASE STUDY 8

A Consultant had been employed in a hospital for a number of years. Due to effluxion of time, a contract of indefinite duration was found to have come in to existence which was refuted by the hospital. The Doctor subsequently took up another post in another HSE area and requested the IMO to follow up on his case with the primary hospital. Following correspondence over a number of months, the Hospital refused to concede his entitlement and the matter was forwarded to a third party for review. The IMO successfully argued on his behalf before the Rights Commissioner service. This was then appealed by the HSE and Hospital to the Labour Court where the IMO once again successfully defended the Doctor's entitlements under the Act and secured an additional award of compensation.

CASE STUDY 9

The IMO were contacted by a GP who was having an issue with a patient being assigned to his list. The patient resided over 40 miles from his practice and was being assigned to him as there were a number of issues with the patient and the PCRS were trying to put him on rotation between Doctors in the area. The doctor had written to the PCRS and had no success. We contacted the PCRS and after a number of conversations received confirmation that the Doctor did not have to accept the patient on to his list and that the patient would be reassigned.

CASE STUDY 10

An SHO had been advised by his Consultant that due to issues of punctuality and behaviour a report was being referred to hospital management for investigation. The IMO met with the doctor and advised him both of his rights and as to the nature and role of the IMO as representative at a series of meetings with the Hospital. The IMO attended all meetings to ensure that the doctor was provided with all relevant information and had the opportunity to answer all queries put to him. The matter was treated delicately by the hospital who observed all correct procedures and the doctor, while reprimanded for his behaviour, undertook to address the outstanding issues which would be reviewed in a few months' time. Following a successful period and a vast improvement in work and behaviour, the SHO had a written warning removed from his file and continued to make excellent progress. Without the support of the IMO the outcome could have had more serious consequences for the doctor.

On an individual level the Personal Cases Unit has assisted in the provision of advice and service to record numbers of General Practitioners. We have engaged with the national section of the IMO in the formulation and drafting of correspondence with the HSE and PCRS resulting in the resolution of many issues and confirmation that the commitment must be maintained to ensure the receipt by GPs of their rights and entitlements as provided for under the GMS Contract.

Dr Mary Gray, Chairperson

General Practitioners

General Practitioners Committee 2011/2012

Committee Members: April 2011 – April 2012

Regional Representatives

Dublin/Mid Leinster
Dr Michael Mehigan
Dr Truls Christiansen
Dr Padraig McGarry

Dublin/North East
Dr Ray Walley
Dr Declan Connolly
Dr Jim Keely
Dr Illona Duffy

South
Dr Ronan Boland
Dr David Molony
Dr Niall Macnamara
Dr Donal Coffey
Dr Ciaran Donovan

West
Dr Martin Daly
Dr Henry Finnegan
Dr Mary Gray
Dr Eleanor Fitzgerald
Dr Colm Loftus
Dr Michael Kelleher

1. IMO GP Strategy

The direction of GP issues for the IMO has been set out in the Strategy for General Practice which was endorsed at National Meeting of GPs in Dublin, March 2010 and at the Annual General Meeting in April 2010. It sets out the IMO strategy for general practice for the future and deals with each of the following areas.

Key Areas of Strategy

- GP MODEL
- PRIMARY CARE TEAMS
- GMS CONTRACT (Current and Priorities for any Review)
- PROFILING GPs and GENERAL PRACTICE
- COMPETITION ACT

Primary Care Teams

Primary Care Teams arose as a key feature of transformation. GPs participating must be enabled to do so optimally through further negotiation. There must be equity of access of primary care facilities to all GPs.

GP Model

Following completion of the GP work load study on the operations of general practice and recommendation from national GP meetings, Symbio were engaged to develop a GP model. *"A Blueprint for the Design and Implementation of an Optimal Business Model for General Practice in Ireland'* which was launched at the AGM in Killarney along with recommendations for next steps. An AGM motion was passed in support of this and the IMO is now proceeding with the recommendations as outlined. A presentation was made to Minister Roisin Shortall on

General Practitioners

15 June 2011 The output was presented to many of the other major decision makers in both the Department of Health and the HSE. Purposeful representations continue

GMS Contract Issues

It is crucially important that the current GMS contract is preserved and protected in its entirety. Attempts to undermine the contract by reinterpreting it and changing arrangements at both a local and national level have been forcefully resisted locally and nationally.

The support of the personal cases unit has been invaluable in setting out what is and what is not covered by the contract. The IMO promoted and distributed a poster clarifying the services covered by the contract, and this has been of great use to many practitioners. There have been some attempts by the HSE to pressure some GPs to provide services not covered by the contract and this has been challenged by the IMO.

Profiling GPs and General Practice

The profile of general practice has been good, as evidenced by the high satisfaction ratings for GPs illustrated in the Medical Council survey in 2011. Discussions were held between the IMO and the RTE Programme Operation Transformation to illustrate some of the work undertaken by GPs which will be shown in early 2012.

Competition Act

Following the passing of the Public Service Pay Agreement (Croke Park Deal) the IMO continues to pursue the implementation of the following section:

Discussion with the Irish Medical Organisation

Further discussions will take place with the Irish Medical Organisation in relation to the Government commitment to make appropriate changes to the Competition Act and a transformation agenda for General Practitioners (GPs). These discussions will be completed within two weeks.

It is a cause of concern that progress is so slow and the IMO has written to the Minister for Enterprise, Trade and Innovation and the Secretary General of the Department of the Taoiseach to implement the agreed legislative changes. It has been decided that should the need for legal action arise for any breach of contract, a Legal Fighting Fund is to be established and details would be made available to issue to all GP members.

These issues were discussed and communicated with members at a National GP Meeting in Athlone in January 2011 and at subsequent regional meetings throughout the county. There was follow up communication with members at a series of well attended branch meetings at the end of 2011.

2. Government reduction of GP professional fees

The impact of the Government reduction of GP professional fees announced in the 2010 Budget under the Financial Emergency Measures in the Public Interest Act (FEMPI) were significant for large numbers of GP practices. These particularly affected large numbers of rural practices and those with large numbers of nursing homes on their lists. In some cases the impact was devastating for the viability of the practice and puts them under significant financial pressure.

The Act gives significant power to the Minister who has the right to set the fees as the Minister deems appropriate. As provided for under the FEMPI Acts the Minister for Health reviewed the impact of the combined reductions in fees in December 2011. The IMO undertook significant consultation of members to establish the impact of the cuts and held a number of regional meetings throughout the county. Additionally the IMO conducted surveys amongst GP members to assist in preparation of the submissions and an excellent response representing 25% of GMS GPs was received.

On the basis of feedback from the committee and the information received from GP members, the IMO made detailed written submissions for the consideration of the Minister setting out the impact of the cuts and the disproportionate impact on rural practices and on those with large nursing home numbers. This was followed up when an IMO GP delegation presented the case at Oral Hearings in the Department of Health on 8 December 2011.

The Minister has since informed the IMO that he is satisfied that the existing fee reductions remain in force. However the Minister has accepted there is an issue to be considered further on the effect of the reductions on rural practice and has undertaken to work with the IMO to look at this issue.

Additionally the Minister conducted a review of the effects of the fees under Cervical Check and heart watch in November 2011 and reviewed the impact of the fee reductions applied. The IMO made detailed written submissions, and an IMO delegation presented at Oral Hearings in the Department of Health on 11 November 2011. The Minister subsequently informed the IMO that he is satisfied that the existing fee reductions remain in force.

Immunisations

In August 2011 there were proposed changes to the fees paid for immunisations and the IMO was invited by the Department of Health to submit its view on the part of members. The IMO conducted a survey of GP members where it became clear that a significant reduction in the fee would undermine this service by making it unviable where many GPs were of the view they could no longer provide the service. This information was included in both the written and oral submissions made by the IMO.

While the Minister confirmed that the fee would be reduced to €28.50 this was significantly less than the fee paid to other service providers of flu vaccine for a similar service. This had taken into account the higher workload and complexity in providing this service to patients who potentially had a range of illnesses and debilities.

General Practitioners

At the GP Conference in January: Drs Christy Cunningham, Aonghus Flannery, Alfie Mannion and Brendan Day

3. IMO/HSE/Department of Health & Children Working Group on GP Manpower

The IMO participates in the Joint Working Group which was established between the IMO/HSE and the Department of Health to consider issues of GP Manpower. The Group deals with the whole area of GP manpower, GMS access/entry, the creation of a number of zero panel lists and the marking schedule for GMS interviews. A number of meetings have taken place between the parties throughout 2011.

At one of these meetings with the IMO and HSE/Department of Health Management gave the IMO an update on the recent meeting that had taken place between the Minister for Health and the Competition Authority. The Competition Authority has raised concerns about the current and proposed GMS Marking Schedule as in the view of the Authority the current and proposed GMS Entry Arrangements would disadvantage foreign applicants. The HSE are exploring the issues involved with the Human Resource and Legal functions within the HSE.

4. Immunisations

There was some concern at changes in legislation where the flu vaccine could be provided to certain categories of patients by pharmacists. The IMO was concerned that appropriate governance structures were in place and highlighted that GPs had no contractual obligation to support these services. A provision in the legislation that pharmacists should provide details to GPs is a cause of concern and the IMO is in correspondence on this issue.

5. An Post

The IMO and representatives of An Post have been in discussions regarding the implementation of revised fees and the issue of retrospective payments. An Post has now reverted with a position on retrospection which was considered by the IMO GP Committee and was balloted by IMO members providing services to An Post. The ballot was accepted in December 2010 by GPs providing this service and payment was made in the course of 2011

6. General Practitioners who Specialise in Substance Abuse

A number of on-going issues concerning General Practitioners who Specialise in Substance Abuse following the HSE's announcement that it intended to make significant cost savings in the Addiction Services over the coming months. The IMO met with representatives of Doctors Specialising in Substance Abuse to discuss a number of ongoing issues and an action plan to progress matters was agreed. The main issues are:

- Clinical Indemnity
- Professional Added Years
- 7 Day Dispensing
- Changes to working hours
- New Posts

The IMO has sought to have this matter dealt with a national level by the HSE and has advised the HSE that any new arrangements must be discussed with the IMO. A meeting with HSE Management on the issues will place over the next two weeks –

Additionally, in regard to the HSE Review of GPs Specialising in Substance Abuse the IMO has engaged with the review group and made the submission on behalf of the GPs which seeks a number of changes to the service.

There has been no response from the HSE since 20 October 2010. In the meantime the IMO has referred to case of issuing different contacts to GPSSA doctors to the LRC. The IMO is awaiting a meeting date from the LRC.

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General Practitioners

The GP Regional Meeting in Croke Park – EricYoung, IMO Assistant Director Industrial Relations, Dr Ronan Boland and Mr. Niall Saul, Symbio HR Solutions

7. GP Unit Doctors

The IMO arranged a national meeting for all GP Unit Doctors to discuss the current situation in full. The meeting took place on Wednesday 27th January 2010 in IMO House. A number of areas were discussed during the meeting:

- the current GP Unit Doctor situation
- the lack of Role definition
- structuring role within the Primary Care Team environment
- need to pursue Contracts of indefinite duration for those eligible
- issue of non payment of national wage rounds

The matter of non payment of national wage rounds was referred to the Labour Relations Commission as provided for in the 2005 Agreement. This was subsequently followed by a hearing at the Labour Court who declined to hear the case due to restrictions of the Competition Act. They were also of the view that the issue of outstanding payments is not permitted under the arrangements in the Public Services Agreement.

8. Prison Doctors

The Irish Prison Service (IPS) continues to refuse to apply all outstanding national wage rounds to Prison Medical Officers. The IMO met with the IPS throughout the year to discuss the non-payment and other issues of concern for prison doctors. As no agreement was reached on the pay issue the IMO referred the matter to the Labour Relations Commission and a hearing is scheduled for 22nd September. A national meeting of Prison Doctors was held in IMO on 16th September and the IMO will now develop positions and submissions in respect of all the issues affecting this group.

A hearing at the Labour Court was scheduled for hearing on 12 January 2011. At this hearing IPS withdrew their consent for the case to be heard and in that event the Court decided that it did not have jurisdiction to hear the case as the doctors were employed by the state. The onus is now on IPS to identify an appropriate third party to hear the claim.

9. PCRS / GMS Contract Issues

Medical Cards

The IMO and PCRS continue to engage in a process to consider the IMO recommendations in relation to the application and processing of medical cards. A number of meetings have been held to date and the PCRS presented the IMO with a draft document outlining their proposed action in respect to the 17 IMO recommendations contained in the IMO submission to the Joint Oireachtas Committee.

The main focus for the IMO in responding was to ensure:

a) the proposed new processes as they apply to GPs are practical and workable for GPs and their staff

b) the proposed new procedures do not impact on current contractual arrangements

c) patient lists remain the responsibility of the HSE and any agreed proposals on list verification/additions/deletions will not infer responsibility on GPs nor can GPs be penalised for unforeseen errors.

There have been a number of meetings in relation to this issue and the document has been agreed. The pilot programme involving a cross section of practices was completed where the practices have been asked to provide their feedback to PCRS and the IMO.It was decided to change some of the arrangements in place and a revised document is to agreed early in 2012 when it is proposed to extend the facility to all practices.

General Practitioners

Out of Hours Payments:

A number of GPs have had a portion of out of hours payments withheld by the HSE without any written explanation and this is not acceptable to the IMO. While legal correspondence has exchanged between the parties, the IMO sought to agree a process with PCRS whereby individual queries in respect of out of hours payments could be addressed.

As there is insufficient progress on this issue the IMO has written to PCRS and asked them to agree an arbitrator so this issue can be resolved without further delay. The letter calls on PCRS to appoint an arbitrator by 19th October by which time the issue will be referred to the chair of the Labour Court.

PCRS responded to the IMO letter and declined to appoint an arbitrator on this issue. This issue has been the subject of on-going correspondence and it is expected this issue will be considered and resolved in quarter one of 2012

Practice Allowances/Grants:

The cases of individual GPs have been raised with the PCRS. Some progress was made and a number of issues have been resolved for individual GPs. These issues have been addressed by PCRS and PCRS confirmed that all outstanding payments will be made in May 2011.

Study Leave Payments:

The IMO have raised the issue of non-payment of study leave applications to members with the PCRS. At a meeting with the PCRS the IMO disputed the PCRS position and have subsequently written to the PCRS insisting that all valid study leave claims be honoured in line with Department of Health Circular 2/95, failing which the matter would be referred to arbitration. PCRS agreed to make these payments which were issued to the relevant GPs

10. Phlebotomy Services including the Mid West

HSE Mid West issued a memo to GPs in the region regarding laboratory services indicating that GPs should provide routine/non urgent phlebotomy services to patients. The IMO has responded to the HSE at regional level stating:-

a) that GPs have no contractual obligation to provide Phlebotomy services to GMS patients

b) that GPs who may have been providing such services on a pro bono basis may not be in a position to continue to do so given the increasing pressures on practice

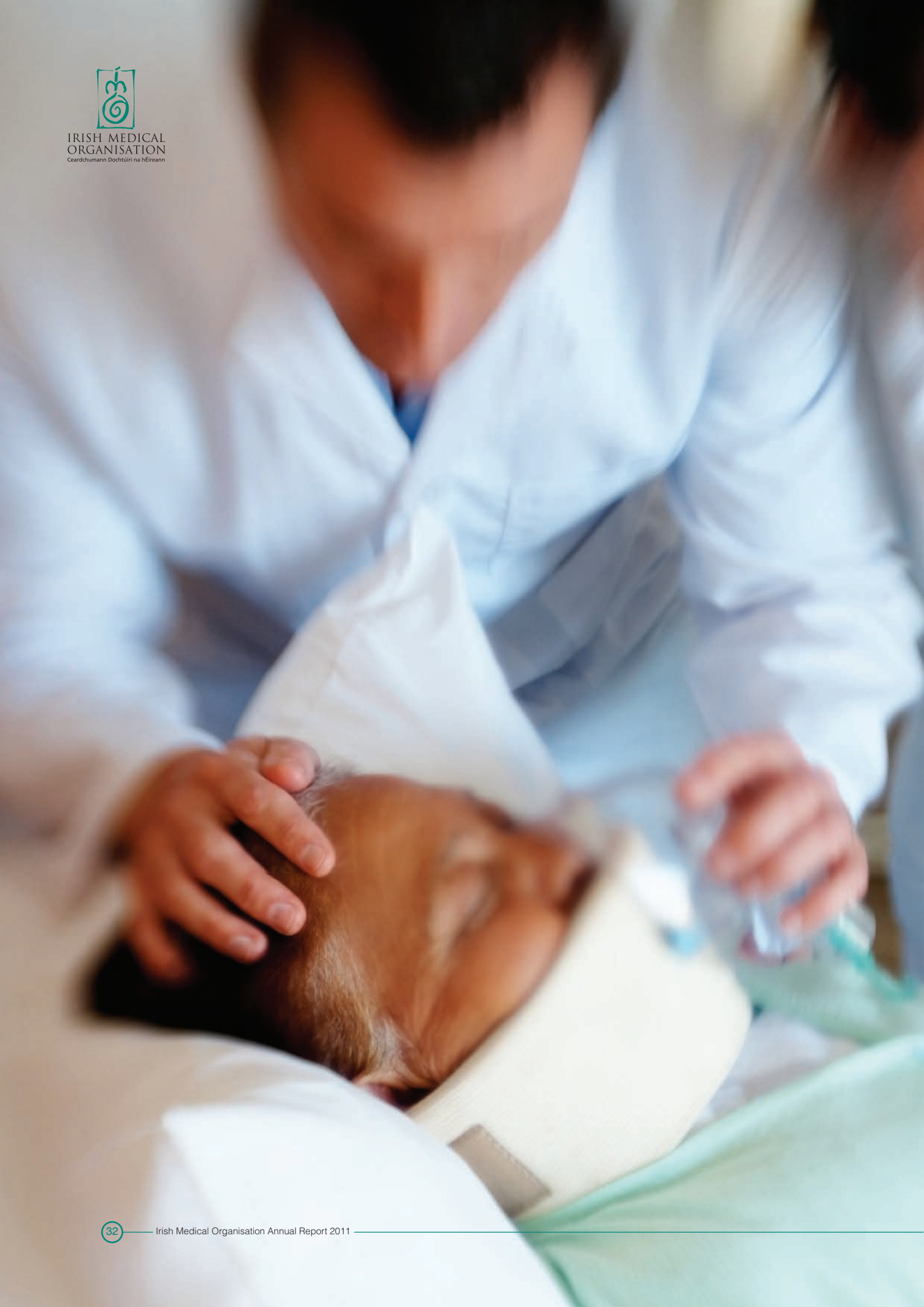
c) given that there is no contractual arrangements in place not all GPs are in a position to provide such services

d) that there is no GP Phlebotomy service in place on a contractual basis and therefore GPs are free to refer patients to HSE phlebotomy services as is their entitlement under the Health Act

e) HSE should be aware of GP contractual position before issuing further communication

f) HSE mid west has issued a further email changing this service and the IMO has written setting out our position which remains that GPs do not have responsibility for this service

It is the IMO view that routine phlebotomy is not covered by the GMS and if this service is provided it is a matter for the GP on what basis this is provided. The IMO has provided support to a number of GPs who are experiencing difficulties with the HSE and other bodies in relation to this issue.



Public Health Doctors

Public Health Doctors Committee 2011/2012

Dr Johanna Joyce Cooney, Chairperson

Committee Members: April 2011 – April 2012

Regional Representatives

Dublin/Mid Leinster
Dr Howard Johnson
Dr Mary Conlon
Dr Phil Jennings
Dr Johanna Joyce Cooney
Dr Catherine O'Malley

Dublin/North East
Dr Paul McKeown
Dr Maeve Diver

South
Dr Brett Lynam
Dr Orlaith O'Reilly
Dr Bridin Cannon
Dr Mary O'Mahony
Dr Ina Donoghue
Dr Kathleen O'Sullivan

West
Dr Anthony Breslin
Dr Heidi Pelly
Dr Darina Fahey
Dr Patrick O'Sullivan
Dr Mary Fitzgerald
Dr Deirdre Murray
Dr Ann Hogan

This past year has seen a significant reorganisation of the operations of the Public Health Committee of the Irish Medical Organisation (IMO). Responding to requests from Members of the Committee, the IMO established a subgroup to examine the interaction between the two constituent parts of the Committee – Public Health and Community Medicine – and to consider whether future Committee operations could be aided by an internal Committee reorganisation.

Following several meetings, and mindful of the December 2010 ballot of IMO Community Medicine and Public Health Members, the subgroup decided that two subcommittees would be established within the main Committee. These subcommittees would meet separately but would report back to the main Committee, which would also discuss matters of mutual interest.

This proposal was accepted by the full Committee and has been in operation since the December 2011 Committee meetings. The incoming Committee will have the option to extend this trial for a further year.

Transformation of the Population Health Directorate

Following the decision of the Board of the Health Service Executive (HSE) to operationally manage the service through four Regional Directorates, the IMO and the HSE engaged in a long and detailed process to transition Public Health Medicine from the Population Health Directorate into the Regional structure.

While these engagements were largely constructive in nature, a number of issues arose between the parties that could not be resolved and which required the two parties to refer the issue to the Labour Relations Commission (LRC) for conciliation.

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Dr Paul McKeown, Vice President and Public Health doctor, speaking at the pre-AGM press conference

A conciliation session was convened and the two sides attended the LRC on 24th May 2011 and the issues that remained for discussion were:

- Process for Appointing Regional Directors of Public Health
- Status of Current Acting Directors of Public Health
- Medical Clinical Leads
- National Leadership in Public Health

Following a robust exchange of views, the Conciliation Officer noted that there seemed to be room for movement on point three but there was no hope of immediate agreement on the others. As such, it was decided to adjourn, to reconvene when the HSE, including financial control documents from the Department of Finance, had forwarded the documents that were requested by the IMO.

Unfortunately, the IMO did not speedily receive any of the requested documentation despite taking the unusual step of writing to the Conciliation Service on 26th July. This delay served only to create confusion where there need not have been any.

Quite coincidentally, the IMO met with the lead HSE official in this regard and discovered that he had changed his post and was no longer heading up this project. The IMO then ascertained that the project had been passed over to HSE – Corporate Employee Relations Service and this was confirmed in September 2011.

The IMO met with the HSE, the Departments of Health and Public Expenditure and Reform in late November 2011 and expressed its disappointment and displeasure at the delay and also at the seeming withdrawal of the HSE from the formal process. The IMO also advised the official from the Department of Health that it planned to fully engage at all levels with the Department's Public Health Policy Framework. Separately, the Public Health subcommittee is devising a policy document aimed at outlining future delivery and organisational options for Public Health Medicine in the post-HSE period. This is to be circulated to all IMO Public Health Members for consultation and comment.

Public Health Emergency Out of Hours Medical Service

The HSE and other Management representatives continue to display a marked reluctance to engage with the IMO on the Public Health Emergency Out of Hours Medical Service. This is despite decisions taken by the IMO in late 2010 and early 2011 to advise Members not to populate certain rosters and also an advisement to management that the issue of Consultant status must now be considered settled in favour of Public Health Doctors.

Throughout 2011, the IMO continued to make the management side aware of its acute disappointment with their failure to demonstrate similar commitment and goodwill as had been shown when Public Health Doctors entered into the service. The IMO also pressed the management side, repeatedly, to tackle the shortfalls in Public Health staffing that made one-in-five rosters, as envisaged in the initial 2009 Agreement, impossible.

The IMO met with the management side on 29th November and raised numerous issues, particularly the issue of consultant status, support services, and staffing shortfalls that made agreed rosters unfeasible. The management representatives present were open to granting consultant status but sought more time to consult with colleagues. The IMO also advised that without movement from Management, by the end of January 2012, to put support structures in place, a referral to the LRC was unavoidable.

On the subject of appointments of Specialists in Public Health Medicine, the IMO welcomes recent developments in that regard, albeit with reservations about the actual process followed. Health service management have

Public Health Doctors

advised that, within the context of the HSE Service Plan for 2012, further appointments may be considered but that there can be no commitments in this regard.

Anomalous Position of the Remaining Area Medical Officers

As previously advised, the IMO has decided to pursue a twin track approach in this matter; keeping the industrial relations avenue open while simultaneously working up a case to take to the Equality Tribunal arguing that the remaining Area Medical Officers are de facto victims of discrimination on the ground of age by having been appointed prior to the enactment of the 2003 Agreement.

On the industrial relations front, the IMO had a most unsatisfactory meeting with health service employers in July 2011 and repeatedly and strongly stressed the inequity of the position in which the remaining Area Medical Officers found themselves. The IMO also urged Management to engage on this issue and make the relatively minor investment in the Community Medicine service that would bring this issue to a satisfactory conclusion. The Management side, while conscious of the acute difficulties that had been caused by this issue, were unable to bring anything new to the table. Unfortunately, given the attitude of Management, progress proved to be beyond reach at this meeting.

It should also be noted that the IMO wrote to the Minister for Health, Dr James Reilly TD, asking that he intervene on behalf of the remaining AMOs and press the HSE to make a small investment in return for which considerable goodwill would accrue. The Department's response, which did not arrive until January 2012, proved to be unsatisfactory.

With regard to the Equality Tribunal, the Community Medicine subgroup, the IMO and the IMO's legal advisors have debated several options to advance the cause of the remaining Area Medical Officers. It is anticipated that the complaint will be lodged in early 2012 and the IMO will continue to work with the subcommittee in this regard.

Review of Community Health Medicine

For some years, the IMO has been pressing the HSE to establish a forum that would consider the service delivery and governance roles that Community Health Medicine would play within the HSE and was informed by the HSE that an internal review of Community Medicine, as opposed to a forum, was to be established in mid-2010.

The IMO nominated two Community Medicine Doctors to the Review, albeit they were appointed as HSE staff. The IMO have contacted leading HSE officials to discuss the Review and have been assured that upon completion of the Review, the IMO will be brought into the process to negotiate on the industrial relations issues that will inevitably arise from an undertaking of this magnitude.

HPV Vaccination Programme

The IMO, together with our colleagues in the INMO, met with the HSE in September 2011 to discuss the September 2011 rollout of the HPV Vaccination Programme and particularly the Minister for Health's stated intention that this Programme encompasses sixth year students.

At this meeting, the unions were advised that the additional resources that were put behind the campaign in September 2010 was once again to be made available and that the campaign would be underpinned by the Agreement that was reached between the HSE and the unions in 2010. Crucially, this reaffirmed that clinical decisions would be left to doctors while the overall responsibility for the Programme will rest with the HSE.

Both unions pointed out to the HSE that since 2010 Community Medicine and Public Health nursing have lost significant numbers of staff and that, in this context, the resources that were being made available were insufficient to conduct the Programme while maintaining the routine workload of Community Medicine Departments. This point was accepted by the HSE, which nonetheless emphasised that the HPV Programme was to be prioritised at the expense of other tasks, if necessary. The IMO monitored this Programme and has noted, for the benefit of the HSE and the Department of Health, the ability of Community Medicine to deliver rapid health interventions on a cost effective basis in community settings.

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Website Report

New Web Presence for the IMO

June 2011 saw the launch of the new IMO website with enhanced functionality and design, benefitting members and providing ease of access to information.

The new-look IMO website makes it easy to search all sections of the site, review news items, issues and research publications, as well as update membership fees and personal details.

Information for each doctor speciality is set out in a dedicated section. For a quick overview, news feeds and issue updates can be viewed on the homepage. Salary scales, FAQs, contract details and upcoming events are easily accessed.

The IMO Financial Services website has an improved design, a new pension calculator, online enquiry forms, online appointment request system, and the ability to share relevant video content for events and products.

Other useful additions are the committee forums, and across the website video players and photo galleries highlight topical material and events in the IMO calendar. Sections of the website are protected for member access only. Your IMO member log-in details are used for this purpose.

Regular updates and user friendly search tools means that www.imo.ie is now a beneficial member resource, reflecting the needs and expectations of the IMO membership.

IMO App

Scan to go directly to the iTunes Store and download the IMO 'Timetracker' app.

The IMO app is password protected, and exclusive to IMO members.

IMO App

The IMO App was launched at the National NCHD Meeting in October with the intention of assisting NCHDs and other doctors to better record hours worked. The IMO iphone app will enable Non Consultant Hospital Doctors to set, track, archive and export their working hours.

IMO NCHD Chairman, Dr. Mark Murphy said; "This app will prove very beneficial for NCHDs. It has a simple easy to use interface for quick intuitive operation and functionality designed specifically for easy use. This will quickly become one of NCHDs indispensable Apps."

Benefits and details of the IMO app can be viewed at www.imo.ie

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Communications Unit

At the Health Hustings:
Mr. Darragh O'Loughlin, IPU,
Prof. Sean Tierney, Claire Byrne (Chair)
and Dr Conor McAlister, IDA.

The Communications Unit continues to promote and highlight the activities of the Organisation. These vary from issues relating to industrial relations, lobbying, policy development and international affairs. In addition the unit develops and maintains strong working relations with other organisations and where appropriate, work in conjunction with these on issues of mutual interest to enhance the delivery of our health service for the medical profession and their patients.

The unit is also responsible for organising interviews with the medical, national and local print and broadcast media on a wide range of health related stories which appear daily in the media. Some key events which the unit also work on include; the IMO Doolin Lecture, IMO Press Conferences, Lobbying at European Parliament, promoting the Irish Medical Journal and the IMO Annual General Meeting. Included in this report is a synopsis of some of the activities undertaken by the communications unit during the year.

IMO Health Hustings 2011

February 2011, IMO Called on Political Health spokespeople to engage in meaningful dialogue with all those who provide healthcare if we are to successfully overcome the challenges of the next decade.

The IMO, along with the IDA and the IPU organised the event at which spokespersons from the five main political parties outlined their health policy and responded to questions from IMO representatives who highlighted in particular issues relating to the Role of statutory Bodies in the Quality Assurance of Irish Healthcare; Primary Care and funding Long Term Care for the Elderly.

The event was very successful and attracted significant media attention.

Prof Sean Tierney, IMO President addressed Political spokespersons from Fianna Fail; Fine Gael; Greens; Labour and Sinn Fein at the event.

Prof. Tierney said; "There is often relatively little time in an election to tease out the detail in issues like these in health which are of enormous importance to people in their day to day lives. While there is clearly listening today, it has been our experience that once Governments are formed the hearing deteriorates dramatically."

He said; "We too in the IMO have a manifesto for what we would like to see in healthcare, it is documented in the carefully researched position papers that our members, all of them experts in their field, have produced over the past years. However, over the past seven years we have had difficulty in getting Government to listen to those positions. We have found that when we speak on any matter we are portrayed as being a vested interest and our proposals ignored or deliberately undermined."

"Of course, doctors make a living from healthcare and in that sense we are a vested interest. But we are also professionals who get a lot of satisfaction from being able to do our job properly and we do have a unique perspective on health issues that could help better inform the decisions of Government."

Outlining the IMO's manifesto Prof. Tierney highlighted policies on Road Safety; Co-Located Hospitals; Acute Bed Capacity; Care of the Elderly and Primary Care to name but a few.

He said; "Our policies on road safety have recently being recognised by the European Road Safety Charter as providing an important contribution to saving lives on Irish Roads. For years, we have advocated for a sensible, scientifically supported permissible level of alcohol among drivers. When proposals were brought forward by the Minister, we saw those frustrated and delayed by vested interest lobby groups and inaction on that matter has cost many lives."

"On Co-Location hospitals we have seen healthcare decisions based on money, what was thought to be profitable, rather than the needs of patients. Again, powerful lobbyists drove forward a model that has failed to deliver much needed acute hospital bed

Communications Unit

Dr Ronan Boland addresses UCC medical conferring in June

capacity. We do need more acute hospital beds. Independent reports commissioned by government have indicated that we need at least a thousand more than we have. We support the HSE initiatives to streamline care; to manage chronic disease effectively; to shift the emphasis from hospital to primary care and to use the beds we have more effectively. But we remain seriously short of the beds that are required to provide patients with timely access to effective acute hospital care when it is required."

Prof. Tierney said; "The so called "fair deal" scheme is, in our view, anything but fair and has placed an intolerable burden on the elderly, particularly those who are ill and in hospital, and on their families. We in the IMO believe that adequate care of the elderly should be provided based on need. It is a hallmark of a civilised society, of a society that values people as a resource rather than as a liability or a cost."

While the IMO supports universal access to properly resourced primary care he warned; "This will require investment and it will require renegotiation of the GMS contract. Once again the focus on marketplace solutions has failed us, our patients, the state and the taxpayer. We urgently need reform of the Competition Act so that it does not prevent the state from meaningful negotiating with those who will lead in the provision of primary care."

Prof. Tierney said; "Doctors have learned, and everyday relearn the lesson that we do not know everything. We don't always know what is best for our patients. We have learned that we need to listen to patients first and foremost and help them chose the most appropriate healthcare options for them."

He concluded; "We, our patients and the Irish people need a Government that is prepared to listen rather than just tell us what they will do. They need to listen to everyone but they also need to listen to those involved in the provision of healthcare, those who want to provide the best possible healthcare for our patients. They need to engage in meaningful dialogue with all those who provide healthcare if we are to successfully overcome the challenges of the next decade."

Future Generation of Irish Doctors Crucial in Shaping Our Health Service

IMO President, Dr. Ronan Boland addressed over 400 graduates, mainly in Medicine & Health, at UCC's annual summer conferring ceremony in June 2011.

A graduate of UCC himself, Dr. Boland addressed the parallels with the predicament in which Ireland now finds itself when he qualified in 1987. "A new Government, high unemployment, cutbacks, increases in high tax rates and reducing public services were the order of the day."

He expressed his concern that the State in not doing enough to ensure that new graduates are given sufficient opportunity to forge a career in their chosen discipline in Ireland over the next five to ten years. Ireland has one of the fastest growing populations in Europe. It is an ageing population. People are living longer, requiring more and more treatment for more and more co-morbidities in their later lives. This pattern will not change. Your skills will be needed here more than ever before. He called on the future generation of doctors to engage more with the shaping of our health service. Expressing concern that, Public expectation is being created about radical health service reform which has been inadequately thought through and which has not been costed to any meaningful extent.

IMO Receives European Award for its Commitment to Road Safety

The Irish Medical Organisation received an award for its on-going commitment to Road Safety in Ireland from the European Road Safety Charter. Vice President of the European Commission and Commissioner for Transport, Siim Kallas, presented the award to Dr. Declan Bedford, Specialist in Public Health & former IMO President and Prof Sean Tierney, IMO President. Since 1995 the IMO and in particular Drs Bedford and Howell have been highlighting the issue of road safety. The IMO have adopted several motions and produced a position paper on Road Safety. Jointly with the BMA NI, we have also presented a submission to MEPs in the European Parliament. The IMO competed with over 700 entries in its category to receive one of the six awards given.

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Communications Unit

Professor Sean Tierney and Dr Declan Bedford receiving an award for IMO's commitment to Road Safety in Brussels

Budget 2012 - IMO called on the Government to Address Inequalities in Health and Access to Health Care.

Prior to Budget 2012, the Irish Medical Organisation held a press conference and called on the Government not to make hasty short-term funding cuts but instead to focus on addressing inequalities in health and access to health care and to invest in initiatives that are budget 'neutral' which lead to long-term savings.

IMO President, Dr. Ronan Boland addressing members of the media said; "As the financial crisis continues, our members are increasingly concerned about health inequalities and the long-term impact the recession is having on lower income groups. A wide range of factors- such as poverty, inequality, social exclusion, employment, income, education, housing conditions, transport access to health care, lifestyle, stress – all impact significantly on an individual's health and wellbeing.

He outlined that; "Secured funding for Public Health is of vital importance, particularly in view of the Government's plans to introduce universal health insurance – a funding mechanism which traditionally caters poorly for Public Health requirements."

IMO Pre-Budget press conference

"Waiting lists are a major contribution to our two-tier system. 47% of the population still purchase private health insurance in order to side-step waiting lists. While, the Minister for Health has established a Special Delivery Unit (SDU) in order to address hospital waiting lists, the IMO firmly believes that for the SDU to succeed, hospital capacity must reflect demand and adequate financial and manpower resources must be provided to cope with the throughput of patients."

He warned that patients who have to pay the full costs of Primary Care may be deterred from seeking medical care, increasing the risk of delayed detection of medical problems, with the likelihood of higher health care costs in the longer term.

"Research shows that a strong primary care system is associated with good health outcomes and lower costs and can help meet the challenges of an ageing population and higher incidences of chronic disease."

"Treating patients with Chronic Disease in Primary Care is Budget neutral, however the transfer of services from secondary to primary care must be accompanied by an equivalent transfer of resources," said Dr. Boland.

The IMO called for a cross-departmental approach for the promotion of healthy lifestyles and the prevention of chronic disease.

Doolin Lecture 2011 - An Ombudsman Perspective on Health Care in Ireland

Emily O'Reilly, Ombudsman, delivered the IMO Doolin Memorial Lecture in December 2011. Ms. O'Reilly is a former journalist and broadcaster. First appointed as Ombudsman in 2003, she is in her second term of office. She has a clear vision of her role and the importance of the Office. During her lecture she demonstrated how she applies her Ombudsman skills when acting as an advocate for disadvantaged patients in the face of a complex and currently constrained health service. Her address was both compelling and memorable. It gave an insight into how patients struggle to access the services that they require.

In her opening comments O'Reilly said that the Irish Health Service should be subjected to critical but constructive analysis. While

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Ombudsman Emily O'Reilly receives the IMO Doolin medal from Dr. Ronan Boland, IMO President in the RCSI

conceding that there are major budget constraints, she feels that we remain a modern developed society. Further cutbacks are inevitable but they must be transparent. Unpalatable news must not be shrouded in concealment. We are in the midst of an enormous crisis and are effectively in a war zone. However we must not lose our social solidarity. We have time to consider our future. There are many interest groups who will influence how the Health Service will evolve.

O'Reilly warned that the country needs to look carefully at any developments which remove healthcare from the 'communal' public arena; there is a danger in Ireland that with our health services we may head too far down the road of choice, competition, consumerism and commodification.A state's public health service should amount to far more than arrangements to ensure services are provided. Though of course it is essential that services are provided; after the first five hours waiting on a trolley in an Emergency Department one rapidly loses interest in the philosophy underlying the public health service.

O'Reilly spoke of nursing home care and the treatment of our elderly. Health policy regarding the provision of long-stay care for older people was given legal expression within the Health Act 1970. The Health Act 1970, as she understands it, created a legal entitlement to be provided with "in-patient services" which, in the case of older people, included nursing home care. Her overall conclusion was that the State, through its agencies the health boards (HSE) and the Department, had failed over many years to provide people with their legal entitlement to nursing home care. This failure, she stated, had inevitably caused confusion, suffering and hardship.

O'Reilly addressed the kind of society we should aspire to. The context in which services are provided, the institutions providing them, the financing of the services, the governance arrangements for those services, the extent to which one is entitled to services – these are all factors which both reflect and support the maintenance of the kind of society we want to be. Health Services made available on the basis of the exercise of consumer choice within a purely commercial private market do nothing to promote social solidarity or good citizenship. On the other hand, services provided through State agencies which are dysfunctional are not the answer either.

O'Reilly concluded that we are currently in the midst of an enormous crisis the scale and extent of which is not even yet clear to us. We have time now to consider what kind of society we want to be once we come through the crisis. Any collapse in social solidarity, such as it is, would lead to enormous divisiveness within our society.

We need to cultivate and promote greater social solidarity. Those who are bearing the brunt of the present suffering need to be able to have real hope that, in the future, we will have a more prosperous and a more equitable society, she concluded.

The Communications Unit also seeks to highlight noteworthy articles contained in the *Irish Medical Journal.* Press releases are issued to the media alongside a copy of each month's publication. This has resulted in further exposure for several topical studies in many of the national newspapers.

In October, the *Irish Examiner* covered an Irish hospital study into the consent taking process for surgery ("Study advises Consent process changes"), while in November Fiachra O Cionnaith in the same newspaper considered the effect on patients who request no resuscitation ('Do not resuscitate' patients may be under treated). The *Health and Living* section of the Irish Independent included two *IMJ* studies in one recent publication, focusing on "Dairy Alert for Pregnant Women", a body of research into understandings of balanced diet in pregnant women from the Coombe and Danone Baby Nutrition, while the second study from Cork, considered injury rates in male and female GAA players ("Women's injury rate is lower").

IMO in the News: IMO in the News: IMO in the News: IMO in the News: IMO in the News:

IMO President, Prof. Sean Tierney speaking on Mary Harney's tenure as Minister for Health & Children

Her legacy will be one whereby she aggressively pursued an approach based on increasing the private sector provision of care both to private and public patients. During her term in office she expanded the private sector significantly while restraining expansion in the public sector in the hospital sector. Regrettably the result of this has been very costly to the state.

IMO CALL ON NCHDs TO ENGAGE FOR CHANGE

Over the past eighteen months the IMO has been highlighting the issues concerning NCHDs at every level within the HSE; Department of Health and with the Health Minister. However, it is quite evident from the significant public debate on the NCHD shortage that NCHDs are extremely frustrated working for the HSE given how that organisation disregards their contractual and legal rights, their training and their future careers in Ireland.

Dr. Mark Murphy, NCHD Chairman

ATTEMPTS TO WTIHHOLD NCHDs DUE ENTITLEMENTS WILL BE VIGOROUSLY OPPOSED – IMO

This is a clear breach of their Contract and Croke Park. Should management fail to revert their position the Irish Medical Organsiation will consider all options available to them up to and including a ballot for industrial actions. Any attempt to continue to withhold doctors' due entitlements will be vigorously opposed by the IMO.

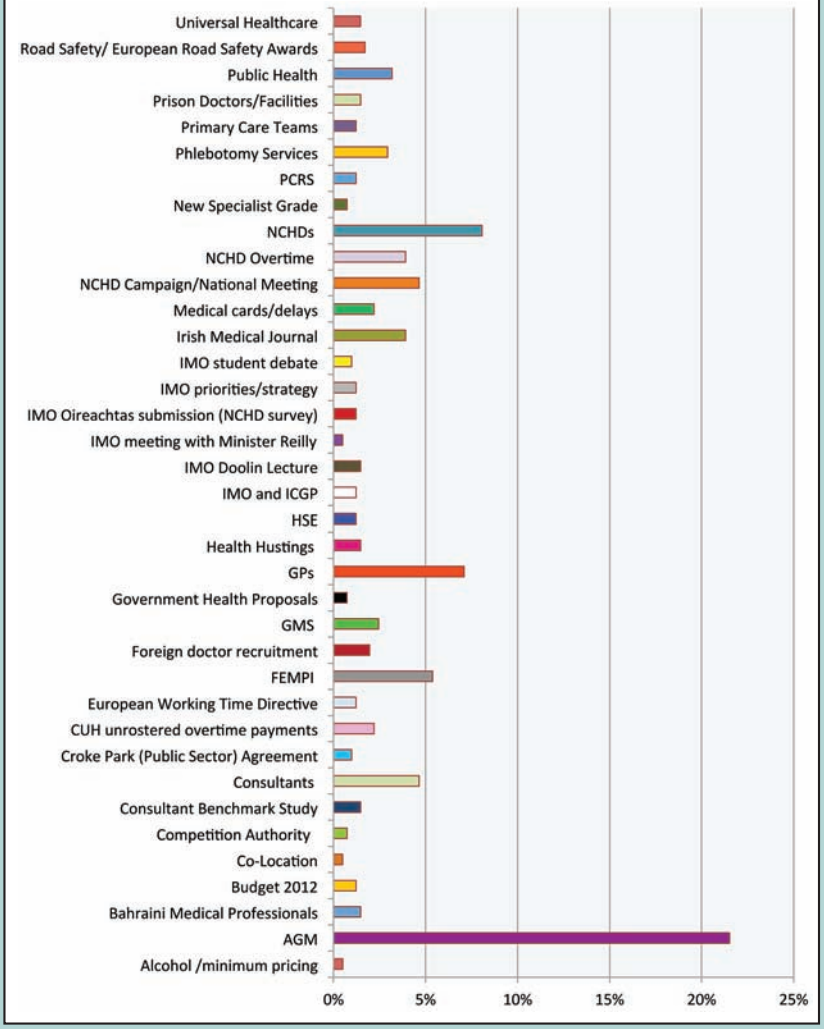
Dr. Mark Murphy, NCHD Chairman

NCHDs VIEWS VITAL IN SHAPING OUR HEALTH SERVICE – IMO

Through the Engage for Change campaign and the benchmark survey our aim is to foster a culture of positive engagement among NCHDs working in Ireland with a view to ensuring that the Irish Health Service can attract the best doctors, provide excellent training, defined career paths and the highest standard of patient care and safety.

Shirley Coulter, IMO Assistant Director of Industrial Relations

IMO Print and Broadcast Coverage by topic in National, Local & Medical Press



IMO RESPONDS TO GOVERNMENT'S SPENDING PLANS ANNOUNCEMENT

While doctors fully appreciated the scale of the financial challenges facing the State, it was clear that 2012 would see massive pressure on health services which were already "near breaking point".

Dr.Ronan Boland , IMO President

IMO WELCOMES WARNING FROM EUROPEAN COMMISSION TO REDUCE WORKING HOURS OF DOCTORS IN IRELAND

The HSE's failure to ensure the health safety of doctors through the reductions of onerous working hours required under the EWTD is yet another example of the HSE's blatant disregard of NCHDs The HSE continue to deny NCHDs their legal rights and in the process potentially compromise patient care and safety.

Dr. Mark Murphy, NCHD Chairman

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A DEBATE OF UNIVERSAL IMPORT

A discussion, chaired by Irish Times assistant editor, Fintan O'Toole was on the topic of universal healthcare. The Panellists were Prof. Sean Tierney, IMO past president, Dr. Steve Thomas, health-policy analyst at TCD about whether a market as small as Ireland could sustain competing insurers. Insurers in the Dutch insurance scheme, serving a population of more than 16 million, had merged to leave just three or four companies competing. Tierney said a central monolith system, would not work either, and Ireland would need to come up with its own solution.

HSE'S Treatment of NCHDs

"I have been involved in the IMO since 1984, and it is something that I can never understand with health managers. They treat NCHDs the way they do, even though, these NCHDs are the very consultants and GPs they are going to deal with in 10 years time. I never get it."

George McNeice, IMO Chief Executive

TIERNEY DECRIES 'VESTED INTEREST' TAG

Of course, doctors make their living from healthcare and in that sense we are a vested interest. But we are also professionals who get a lot of satisfaction from being able to do our job and we do have a unique perspective on health issues that could help better inform the decisions of Government.

Prof. Sean Tierney, told political parties canvassing for seats in the General Election - February 2011

IMO EXPRESS CONCERN THAT HSE DELAYING APPROVAL OF MEDICAL CARDS TO SAVE MONEY

There is a twelve week delay in processing medical card applicants. It's saving the State money and the PCRS is under pressure, the HSE is under pressure financially. It may create a perverse incentive amongst people who have a responsibility to balance budgets not to solve this problem.

Dr. Ronan Boland, IMO President

RTE PRIMETIME – UNIVERSAL HEALTHCARE - Extracts

Irish GPs say they welcome plans to complete the primary care programme and move to universal healthcare:

Prof. Patrick Plunkett, speaking to RTÉ News regarding Consultant contracts & historic rest days

Dr Ronan Boland, IMO: The day that I have a patient sitting in front of me who needs to access services in the hospital sector that I don't have to ask the awkward question 'do you have health insurance or not..?

While the IMO say they support universal healthcare, they have concerns about who is controlling the money

IMO's Prof. Sean Tierney: I think the danger with having the whole thing around money is that it then drives activity, so you get procedures being done on patients because money will come with the new procedures, there's a fundamental conflict between profit based insurance companies and delivering care that is patient centred.

RTE TV NEWS – MEDICAL CERT FEES

Certifying patients makes up a very significant portion of my work. In relation to the actual fees and whether they should be cut or not GP fees are governed by public service agreements and also by the Financial Emergency Powers Legislation and in actual fact the fees have been revisited twice already over the last couple of years.

Dr. Boland responding to TD Kevin Humphries comments on medical cert fees.

ALMOST HALF OF GPs HAVE CUT STAFF NUMBERS

A survey carried out by the Irish Medical Organisation has revealed that 46 per cent of GPs have reduced staff numbers in their practices.

Sunday Business Post

CONSULTANTS – HISTORIC REST DAYS

The IMO has criticised the HSE for targeting the leave and working hours of hospital consultants.

Prof. Patrick Plunkett
No, you can't have it whenever you like, you can only have it immediately prior to retirement, so effectively we were mortgaging away for twenty or thirty years what we were entitled to at that time and now they are talking about taking it away.

McNeice criticises HSE's so called 'get tough' approach over consultants..
The HSE's instructions that all consultants have to be Catergory A, was taken without any thought to the service. This was a rush of blood to the head that is only going to start another row and make the relationship between Consultants and the HSE even worse

CAREER GRADE

What the HSE would probably do, which always worries me, is that they create this grade without any consultation with anyone and create an even bigger problem.

Mr. George McNeice, IMO Chief Executive

NEW MEASURES NEEDED TO RETAIN DOCTORS - RTE NEWS

Dr. Anthony O'Connor - IMO
If I could say one thing to the Minister and to the HSE, go and talk to the doctors that are leaving there's delegations being sent around the world to India and Pakistan to try and recruit doctors but nobody is actually talking to our own doctors who are leaving.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Research and Policy Unit

As the representative body for the medical profession, the IMO in its mission statement is committed to the development of a caring, efficient and effective Health Service and thus a key activity of the IMO is advocacy. The Research and Policy Unit conducts research and develops IMO policy on a wide range of Health Service and Societal issues and aims to influence Government proposals in a constructive and practical way. In 2011 the Research and Policy Unit produced the following work:

- General Motions 2011 Update
- IMO Role of the Doctor Series: Doctor-Patient Confidentiality
- Advocating for Change: IMO Position Papers 2005-2010
- IMO Budget Submission 2012
- Miscellaneous Submissions as requested by external bodies

General Motions 2011 Update

The General Motions from the IMO AGM are managed by the Research and Policy Unit. Following the 2011 AGM, the Unit wrote to the Minister for Health and Children, other Government Departments, the HSE, the Medical Council and relevant bodies, informing them of the motions passed and requesting a response. Many motions from 2011 and previous years were also included in the different policy papers and submissions written during the year. For example:

Medical Practitioners Act 2007

The IMO raised the following issues in relation to the Medical Practitioners Act on numerous occasions with the Medical Council in letters, submissions and meetings:

- That legislative deficiencies exist placing limitations on doctors currently on the Training Register while doctors on the General Register are able to practice in a Specialty without sufficient competence assurance (motion 11/08).
- That current interpretation of Section 94 Subsection (1) of the Medical Practitioners Act will result in retired doctors being removed from the medical register thus preventing them from intervening in any emergency or accident. (motion 11/09)

The IMO also wrote to the Minister for Health and continues to press the Minister and the Medical Council for a review of the Medical Practitioners Act to address these issues.

Road Safety

2011 Road Safety motions called on the Minister for Transport to implement the legislation to ensure that there is mandatory alcohol testing of all surviving drivers in road crashes where a person is injured (motion 11/28) and to commence the provisions of the Road Traffic Act 2010 to reduce drink driving limits from 80mg/100ml to 50mg/100ml for qualified drivers and 20mg/100ml for learner, novice and professional drivers (motion 11/27).

Since the 1st of June 2011, Gardaí must conduct a preliminary breath test where they believe a driver has consumed alcohol or at the scene of a crash where someone has been injured and requires medical attention and on the 26th of October 2011 the new drink driving limits came into effect.

Following the introduction of the new drink driving limit the IMO received a message from the Road Safety Authority thanking the IMO for its help and support in the campaign leading up to this important change in Ireland's drink driving legislation stating that our support *"played a significant part in getting this implemented"*.

The IMO is committed to Road Safety and signed the European Charter on Road Safety in May 2010. In February 2011 the IMO received an 'Award of Excellence in Road Safety 2010' from the organizers of the Road Safety Charter in the Federations Division.

Health Inequalities

In both the Submission to the Department of Health on the Public Health Policy Framework and the Budget Submission 2012, the IMO called on the Taoiseach for a review of current inequalities and inequities in health to include variances in access to health care and inequalities in health status, either by economic grouping or geographic location (motion 11/37), and the establishment of a Minister for Public Health in view of the large contribution social determinants make to the health status of the population of Ireland (motion 11/29).

Universal Health Care

In 2011, the Research and Policy Unit continued to promote the IMO principles of universal health care as outlined in the IMO Position Paper on Universal Health Coverage. General motions 11/72 to 11/77 relating to Universal Health Care were outlined in a letter to the new Minister for Health in April 2011 and in the IMO Submission on the Department of Health's Strategy Statement 2011-2014.

IMO Role of the Doctor Series: Doctor-Patient Confidentiality

In April 2011, the IMO Policy Position Paper on Doctor-Patient Confidentiality was published as part of the IMO Role of the Doctor Series. The paper first looks at how confidentiality is central to trust in the doctor-patient relationship. Doctors must be careful when communicating with families, carers of patients or with other health care professionals.

On occasion patient confidentiality can come into conflict with other professional, legal and ethical obligations. The paper looks at:

- Confidentiality v. protection of the patient
- Confidentiality v. protection of the public interest
- Confidentiality v. legal obligations
- Confidentiality v. the advance of medical knowledge

While the benefits of Information and Communications Technology in healthcare (eHealth) are increasingly apparent, at the same time the use of eHealth poses important issues of privacy and confidentiality and who should be allowed access to what information and under what conditions. The Data Protection Acts 1998 and 2003 set out the law in relation to the storage of medical records. The IMO also calls for the urgent publication of the Health Information Bill to clarify issues of confidentiality, access and security in relation

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to a national system of electronic health care records and the secondary use of data.

The position paper finishes with **IMO General Guidance on Patient Confidentiality**

- Take care with patient data: do not allow correspondence, notes or records to be accessed by others unnecessarily
- When using ICT, familiarise yourself with your requirements under Data Protection Legislation
- Ask yourself whether disclosure is really necessary
- Refer to the Medical Council's Guide to Professional Conduct and Ethics for Registered Medical Practitioners
- Always try to obtain consent to share patient data
- If legally or ethically obliged to breach confidence, it should be done only to the extent necessary and only to the relevant party or authority
- When disclosing information to national registers, for audit or research anonymise or de-identify the patient where possible otherwise seek permission from the patient
- If in doubt seek legal advice.

Advocating for Change: IMO Position Papers 2005-2010

For the IMO AGM 2011, the Research and Policy Unit compiled all the position papers of the IMO into a single document designed to act as a quick reference guide to IMO policy. The document provides a short summary of each position paper and the principle recommendations. Where recommendations have been updated in IMO submissions, these have also been included. The document also includes joint papers from the IMO and the British Medical Association (BMA), Northern Ireland.

Budget Submission 2012

In this year's budget submission the IMO members urged the Government not to make hasty short-term funding cuts but instead to focus on addressing inequalities in health and access to health care and to invest in initiatives that are budget neutral and will lead to long-term savings. A number of recommendations were made under the following headings:

Health Inequalities

Good health is socially, economically and environmentally determined. The IMO Budget Submission raised the issue of health inequalities and the long-term impact the recession is having on lower income groups. Evidence shows that lower socio-economic groups have relatively high mortality rates, higher levels of ill health and fewer resources to adopt healthier lifestyles. In view of the large contribution social determinants make to the health status of the population the IMO recommended:

- The Taoiseach publishes an annual review of inequalities and inequities in health.
- That all public policy must be "health proofed";
- The establishment of a Minister for Public Health to oversee the development and implementation of policy to address the social determinants of health;
- Funding is ring-fenced for the implementation of a new public health strategy.
- Renewed focus and investment is needed in Child Health Services.

Access to Primary Care

Falling incomes and spiraling household debt mean that the number of adults now unable to access Primary Care has undoubtedly increased. Research shows that a strong primary care system is associated with good health outcomes, lower costs and can help meet the challenges of an ageing population and higher incidences of chronic disease. The IMO recommended:

- Increase the income threshold for receipt of a medical card to the minimum wage to more accurately reflect levels of disposable income.
- The management of chronic disease in the primary care setting must be adequately costed and resources must be forthcoming.
- Primary Care Teams must be established and evaluated before services are withdrawn from acute care.

Access to Public Hospital Care

Since 2007, employment in the health services has fallen by 6,654 Whole Time Equivalents. Activity levels have been sustained and even increased in some areas despite the staff reduction indicating that more is being done with less. However, for those reliant on the public health system, access to hospital care is becoming increasingly more difficult. Overcrowding in Emergency Departments continues, waiting lists for elective care have increased and HIQA has described long waiting times for outpatient appointments as "unacceptable and unsafe". The IMO recommended that:

- As waiting lists mainly apply to patients awaiting elective care, hospital capacity should be increased through funding for units for elective care.
- No further hospital beds should be closed until alternative services are in place.
- Protect funding for hospital services.
- Prioritise the recruitment of essential frontline staff.

Access to Long-term Residential Care

Despite an additional €6 million in funding for the Nursing Home Support Scheme, many applicants are awaiting funding under the "Fair Deal" scheme. Public nursing homes are closing due to lack of capital investment and there are concerns that funding levels under the Nursing Home Support Scheme are inadequate to meet the complexity of care and to comply with National Quality Standards. The IMO recommended:

- Capital investment in Public Nursing Homes is required to both increase capacity and enable Homes to comply and exceed current minimum standards.
- Urgent Review of the Nursing Home Support Scheme is needed with a view to replacing it with a fairer and more equitable system of financing health care.

Lifestyle and the Prevention of Chronic Disease

In the Budget Submission 2012, the IMO recommended a cross-departmental approach to the promotion of healthy lifestyles and the prevention of Chronic Disease. The IMO called

on the Departments of Health, Justice, Finance, Education and Skills, Transport, Tourism and Sport and the Department of the Environment to implement IMO motions in relation to lifestyle. The IMO also called on all Government Departments to carry out Health Impact Assessments on all new policies at design, implementation and review stages.

Electronic Medical Records

Finally, the IMO again highlighted the obvious and immediate savings that could be made from investment in electronic medical records and recommended that the Minister for Health:

- Publish the long-awaited Health Information Bill to clarify issues of confidentiality, access and security in relation electronic health records and secondary use of data;
- Direct HIQA to accelerate the adoption of national standards for the storage and exchange of digital medical records;
- Ensure that current and future investment in electronic medical record systems such as the electronic referral system is protected.

Miscellaneous Submissions as requested by external bodies

HIQA Consultation on Standardised GP Referral Information

In January 2011, HIQA published a Draft National Template for Consultation on Standardised GP Referral Information. In response the IMO insisted that patient safety must be the predominant driving motivator for system change.

The IMO also recommended that a pilot study should be carried out to make sure the final document:

- is user-friendly for the GP
- does not add to the workload of the GP
- can be easily embedded within GP practice management systems
- can be effectively and securely transmitted between healthcare settings.

The IMO made a number of suggestions in relation to data items.

And in general feedback, the IMO wrote that:

- All referral forms should pass across the consultant's desk within 24-48 hours.
- The quid pro quo for standardised GP referral forms should be satisfactory standardised discharge letters
- And no form can deal with the human element.

HIQA Consultation on Draft Quality Assurance Criteria for Clinical Guidelines.

The IMO welcomed the Draft Quality Assurance Criteria for Clinical Guidelines which with further development and application has the potential to be a very useful tool. In a detailed submission to HIQA the IMO pointed out the need for flexibility in the development of guidelines:

- Classical Quality Assurance (QA) seeks to control to a quality standard removing variation both below and above the standard chosen. QA guidelines should not require clinicians that provide excellent care to dumb down.
- While Clinical Guidelines are designed to be applied to groups (population care), clinical practitioners are required to respond to the expectation of patients for personalised care. Clinicians judge the effectiveness and appropriateness of care by monitoring individual patient response and need to be able to react to this clinical feedback on the effects of any guidance they may be following. Guidelines are to be adhered to only if they result in an optimal clinical outcome.
- Medical Practitioners have a paramount responsibility to act in the best interest of a patient and to advise patients on the different options of care available to them including the most effective care. It is not appropriate for a clinical guideline that is constrained by resources to propose conflict with this requirement.
- Medical practice is a dynamic process and guidelines are quickly dated. Practitioners will be up to date in their field of practice through CPD/CME. Provision should be made for clinicians to modify guidelines accordingly.

Medical Council Consultation on Draft Amendments to the Registration Rules

In June 2011, the Medical Council held a consultation on Draft Amendments to the Registration Rules allowing physicians with equivalent overseas qualifications to apply for inclusion in the General Division and the Trainee Specialist Division of the Register. In a short submission, the IMO repeated messages from previous submissions in that the rules fail to address the following issues:

- The Registration rules fail to make provision for dual registration - whereby a doctor has completed training in one specialty and begins training in another.
- There is no requirement for doctors outside the state who are providing advice, treatment or diagnosis to patients in Ireland, to be registered with the Medical Council.
- An anomaly also exists whereby a physician on the General Register may practice in any speciality without having received formal training in that speciality.

The IMO also highlighted the motion calling on the Minister for Health and the Medical Council to review Section 94 Subsection (1) of the Medical Practitioners Act with a view to a process being agreed whereby retired doctors can be permitted to remain on the medical register. The current interpretation of this Section will result in retired doctors being removed from the medical register thus preventing them from intervening in any emergency or accident.

Medical Council Consultation on Draft Rules relating to the Supervised Division

In July 2011 the "Supervised Division" to the Register of Medical Practitioners was introduced to provide a rapid solution to the shortage of Non-Consultant Hospital Doctors (Junior Doctors) in Irish Hospitals allowing doctors qualified outside the EU to undergo a two-part assessment specific to their medical speciality and to this division. Doctors registered in "Supervised" posts are not required to pass the PRES.

The IMO pointed out that while the PRES examination is considered a deterrent to doctors qualified outside the European Union, multiple factors contribute to the current crisis

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including terms and conditions of employment, the perception of Ireland compared to competing health systems and the lack of any training/development in "service only" posts. In the Submission to the Medical Council, the IMO makes a number of recommendations to make these posts more attractive to Junior Doctors including supervision by a named consultant, registration and appraisal by the relevant post graduate training body and support for those wishing to gain entry onto the general or specialist training division.

Medical Council Consultation on Draft further rules for the Maintenance of Professional Competence – Proposals to Support the Establishment of Performance Procedures

The Medical Council draft rules set out new procedures, as an alternative course of action to a Fitness to Practice hearing, to be followed where the Medical Council has concerns about the professional competence of a doctor. While referred to in the Medical Practitioners Act as a "Professional Competence Scheme", these procedures are not Professional Competence Schemes as run under agreement by the Post-Graduate Training bodies. The procedures include an assessment of the practitioner's professional competence followed by an action plan for remediation where performance is found to be unsatisfactory.

In the submission to the Medical Council the IMO pointed out that:

- The exact criteria which would lead to referral by the Preliminary Proceedings Committee to a professional competence assessment must be clarified.
- Patient confidentiality and patient consent must be respected in the procedure.
- The PRES examination may not be an appropriate test depending on a doctor's scope of practice.

Concerns were also raised about the cost and duration of these procedures.

- Rule 6 places a responsibility on the practitioner to potentially meet all the costs which may be substantial. It is unclear if such costs would be covered by the Professional Indemnity Bodies.
- The costs of the medical council review process should be carried by the medical council while in some cases retraining or remediation costs should be borne by the employer. There is a responsibility on the HSE specifically to support the Practitioner in meeting the requirements of the Act in relation to Maintaining Professional Competence.
- Self employed doctors e.g. general practitioners should not be additionally and disproportionately penalised through costs when complying with procedures and activities under these rules. Equally the HSE should be responsible for costs for GPs with a GMS contract.
- Doctors in private practice (either GPs or specialists) and recently qualified doctors are likely to be further disproportionally affected by these procedures.
- The Rules should be constructed and enacted so as to be equally and fairly applicable to EU and international graduates registered in Ireland.

Submission to the Department of Health and Children - Review of the Health Act 2007 (Care and Welfare of Older People in Designated Centres) Regulations

In the submission to the Department of Health and Children - Review of the Health Act 2007 (Care and Welfare of Older People in Designated Centres) Regulations the IMO welcomed the introduction of regulations and standards for the care and welfare of older people in residential settings but stressed that their implementation is not without cost and must be funded appropriately.

Because of the tendering arrangements (no therapies, aids or continence wear, for example) and pricing levels under the Nursing Home Support Scheme, the IMO expressed grave concerns about the feasibility of providing adequate care at current funding levels.

The IMO also highlighted that there has been a sustained and regrettable lack of capital investment in public nursing homes, and the moratorium on recruitment is having a significant impact on appropriate staffing levels. Many public nursing homes have run into difficulties or closed as in the case of Dingle, Loughloe, and Sir Patrick Duns.

IMO recommendations included:

- Urgent review of HSE and DoHC policy and practice for care in nursing homes. Current regulations, if not backed up by the recommendations below, are not sufficient on their own to respond to the very grave systematic deficits uncovered by the Leas Cross Reviews.
- Adequate funding (both capital and operational) must be provided for public nursing homes to ensure they comply with and exceed minimum standards.
- Contracting for private nursing home places must be gerontologically-informed and take into account the full range of needs, including the provision of therapists and aids/appliances.
- The moratorium on recruitment should be lifted in order to allow public nursing homes to meet adequate staffing requirements.
- Specialist support for GPs working in nursing homes, including dedicated sessions in geriatric medicine and old age psychiatry, must be rapidly developed for those clinicians who wish to avail of them.
- All residential facilities must be resourced to operate to minimum standards of infection control to minimise the likelihood and (if they occur) impact of diseases such as Clostridium difficile, influenza and outbreaks of foodborne illness.

IMO Submission to the Department of Health (DOH) Strategy Statement 2011-2014

The IMO began by highlighting support for a single tier system and the principles of health care as outlined in the IMO Position Paper on Universal Health Care. Recommendations also included 2011 motions in relation to universal health systems.

The IMO made a number of broad recommendations, reiterating IMO policy, in relation to investment and funding as follows:

Primary Care Services

The IMO welcomed, in principle, Government plans for GP care that is free at the point of access, however the IMO insist that:

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- Adequate investment in facilities and resources to support primary care teams is needed for their success.
- The negotiation of a new GP contract requires an urgent amendment to Section 4 of the Competition Act.
- The implementation of National Quality Standards must also be adequately resourced and details of a future licensing system must be forthcoming.
- Capitation is an overly simplistic method of deciding on payment. Patient attendances must be included in remuneration calculations as well as the patient demographic that a GP provides care for.
- It is important that vulnerable rural and deprived urban communities have adequate GP cover. It is incumbent on the new Government to insure that these positions remain attractive to new entrants.
- The transfer of services from the secondary to the primary care setting must be accompanied by the equivalent transfer of resources. Money must follow the patient and incentives must be provided for GPs to take on all chronic care. This must be costed correctly.
- GPs have already had their payments reduced under FEMPI. Further reduction in remuneration risks impacting further on their ability to provide adequate services.
- Patient incentives are required to encourage those with minor emergencies to attend their GP rather than the Emergency Department.
- Cost-sharing is known to deter both necessary as well as unnecessary use of medication and it is generally accepted that they should not be applied to lower socio-economic groups or individuals with higher medical needs. The 50c co-payment on prescription charges under the GMS and the Long-term illness scheme must be immediately reversed. Substantial savings can be made to the State's drug costs through the implementation of the IMO's proposal on Generic Medicines Policy.

Universal Hospital Care

The IMO supports the separation of the purchaser –provider functions and the concept of "money follows the patient" in hospital care however:

- Ireland still has an issue of acute care capacity and has one of the lowest per capita numbers of hospital beds in the developed world. Urgent investment is needed in acute bed capacity particularly units for elective and chronic care.
- Given the problems encountered in the reconfiguration of hospital services to date, the IMO insist that alternative services are in place before any further closures or downgrading of hospitals takes place.
- Savings are being delivered under the terms of the Croke Park Agreement. The Government must not renege on the Agreement by further reducing Consultant remuneration.

Care for Older People

The IMO welcomes the Governments proposals to provide additional funding for the care of elderly people and again highlighted issues in relation to the funding of long-term care. See the IMO Submission on the Review of the Health Act 2007 (Care and Welfare of Older People in Designated Centres) Regulations above.

Mental Health Services

In relation to mental health services the IMO raised the following issues:

- In the current economic climate with falling property prices, the sale of psychiatric lands can no longer be relied upon to fund *A Vision for Change*. State funding for Mental Health Services must therefore be increased and ring-fenced in line with the recommendations of *A Vision for Change*.
- The HSE's Moratorium on recruitment must be lifted to allow the establishment of full Multi-disciplinary Community Mental Health Teams.
- The IMO is appalled at the denial of human rights & citizenship of those with learning disabilities and mental health illness that result in many dozen citizens being placed abroad for many years due to the failure to meet their needs in this country and seeks urgent statement from the Minister for Health on the national plan to address this national scandal.
- 0.5% of the HSE annual budget for mental health should be allocated to mental health promotion to run an evidence-based public mental health campaign similar to the ones on stroke, breast cancer, heart disease etc.
- Patients should have direct access to publicly funded counselling and psychotherapy services in primary care for disorders that do not require specialist mental health services.

Public Health

The IMO welcomed the Public Health Policy Framework Initiative of the Chief Medical Officer but for that to succeed:

- Public Health must be placed at the centre of health policy decision making.
- Health protection must be strengthened to ensure that there is the capacity to address infectious disease and environmental threats as required at a national and international level.
- Steps must quickly be taken to ensure that Public Health Medicine is made an attractive option to non-consultant hospital doctors in order to maintain the capacity of the specialty.

Submission to the DOH on the "Your Health is Your Wealth" Public Health Policy Framework

The IMO welcomes the initiative to develop a Public Health Policy which should set out a transparent framework for improving population health over the period 2012-2020 through the promotion of strategies that:

- recognise and address the social, economic, environmental and lifecourse factors that determine health;
- promote healthy lifestyle choices and the prevention of chronic disease;
- manage and control the spread of infectious diseases, including sexually transmitted diseases, and other public health threats;
- ensure the early detection and treatment of child health and development problems;
- place disease prevention at the very centre of health and social policy.

Research and Policy Unit

The IMO's key messages in the Submission to the Department of Health are that funding for Public Health is a cost-effective investment in the health of our population and the future of our country. Thus Public Health must be placed at the centre of all policy decision making.

IMO recommendations included:

- An immediate review of inequalities in health status and inequities in access to health care;
- An inter-sectoral committee should be set up to prioritise the development and implementation of evidence-based initiatives across departments and across sectors;
- The development of an integrated public health workforce plan;
- the establishment of a Minister of Public Health and ring-fenced funding for Public Health initiatives;
- Health Impact Assessments should be carried out on all new government policies;
- Renewed focus and investment is needed in Child Health Services;
- That Ireland research and develop national competence in Lifecourse Epidemiology;
- The development of a comprehensive strategy for the promotion of sexual health in Ireland and the expansion of sexually transmitted disease clinics on a regional basis.

IMO Submission to DOH Review of the Mental Health Act 2001

In the IMO Submission to the Department of Health Review of the Mental Health Act 2001, the IMO raised issues in relation to the Time Period for Review of Admission and Renewal of Admission, the Admission of Children under the Mental Health Act 2001 and the Admission of patients (involuntarily or voluntarily) to centres that are inappropriate to their needs. Recommendations included:

- Review of the Admission Order before a Mental Health Tribunal should be held as soon as possible [e.g. 72 hours] following the issue of an Admission Order. This Tribunal might sit with the intention of looking at the events leading to the involuntary detention and determining that the Order is procedurally correct. Once the Admission Order is affirmed, the Tribunal to examine the Renewal Order might delay for a longer period e.g. 28 days.
- Legislation is urgently required to clarify the rights of "mature minors" to make decisions in respect of their own health care including the right to consent to and refuse treatment for mental illness.
- The Mental Health Act should be adjusted accordingly with a separate section for people under the age of 18 including provision for a third category of patient for children and adolescents who are admitted by parental consent.
- Children and adolescents who are involuntarily admitted and detained should have their orders reviewed by a Mental Health Tribunal with an age appropriate focus rather than by the District Court.
- All patients admitted voluntarily or involuntarily to Mental Health Services should be treated in centres that are appropriate to their needs. Urgent funding (capital and operational) as well as the recruitment of whole time equivalent staff are required for the Implementation of A Vision for Change.

IMO Submission to the Broadcasting Authority of Ireland (BAI) Review of the Children's Commercial Communication Code

In the Submission to the BAI, the IMO outlined the public health challenge of obesity and childhood obesity. The Expert Working Group on Health and Nutrition of Children Living in Ireland recommended that:

- Advertising of foods and drinks high in energy, saturated fat, sugar and salt to children should be restricted by the Broadcasting Authority of Ireland (BAI).
- The UK's Food Standards Agency's Nutrient Profiling (NP) model should be adopted completely and without amendment for the purposes of deciding on suitability of food products for television advertising to children.
- Consideration should be given to the advertising of food and drinks for children to parents/carers. This is of importance as parents/carers are the gatekeepers of their children's health and this type of advertising influences parental choice of foods for young children (under fives) in particular.
- Consideration should be given to the broadcast times of food and drink advertising as many children watch television outside of the period strictly designated as children's viewing time.
- As it will not be practical to directly control advertising of foods high in trans fats (associated with increased risk of heart disease) to children, surveys should be undertaken to ensure that intakes of trans fats remain low.

In the Submission the IMO welcomes the review of the Children's Commercial Communications Code and the recommendations of the Expert Working Group and recommends the BAI adopt the UK Nutrient Profiling Model of the Food Standards Agency (FSA) as a model for defining "healthy" and "unhealthy" food and drink. The IMO also called for a ban on all advertising of fast food before the 9pm watershed on TV and Radio as the only measure which will protect children sufficiently from exposure to advertising of unhealthy foods.

Submission to the Oireachtas Joint Committee on Health and Children on Alcohol Marketing

IMO policy in relation to alcohol marketing was sent to the Oireachtas Joint Committee on Health and Children who were discussing Alcohol Marketing in particular to young people. The Submission highlighted some of the affects of alcohol misuse and summarised IMO policy in relation to the Alcohol and Illicit Drug Strategy , Health Warnings and the Labelling of Alcohol products, Alcohol Promotion (including this year's motions relating to alcohol promotion in the public sector) and the Promotion of alcohol to Young People.

All policy papers and submissions are available at **www.imo.ie**

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

International Affairs

The International Affairs Unit manages the international policy of the Irish Medical Organisation

Dr Neil Brennan (Chairman and CPME)

International Affairs Committee Members:

Dr Neil Brennan (CPME and Chairman)

Dr Liam Lynch (UEMO and EANA)

Dr Cillian Twomey (UEMS and former Chairman)

Dr Martin Daly (UEMO)

Dr Bridin Cannon (CPME)

Dr Toby Gilbert (PWG)

The Irish Medical Organisation is a member of the following organisations:

- The Standing Committee of European Doctors (CPME)
- European Working Group of Practitioners and Specialists in Free Practice (EANA)
- The European Union of General Practitioners (UEMO)
- The European Union of Medical Specialists (UEMS)
- European Junior Doctors (EJD)
- The World Medical Association (WMA)

Overview

The International Affairs Unit manages the international policy of the Irish Medical Organisation which is the remit of a standing committee, the International Affairs Committee.

EUROPEAN ISSUES

Cross-Border Health Care

The European Parliament voted on the 19th January to accept the Patients' Rights in Cross-Border Health Care Directive which will become effective in 2013.

The Patients' Rights in Cross-Border Health Care Directive is legislation that clarifies the responsibilities for quality and safety in care when a patient seeks treatment in another Member State.

The most obvious beneficiaries will be patients seeking advanced treatments, those living along borders where the nearest hospital is across the line, or those who work in one country but want to get treatment near family members in another country.

Patients who seek treatment abroad will be reimbursed for the care but only at home-country rates. If the patient requires a hospital stay or if treatment is very expensive, they will require prior authorisation from their home health authority.

While currently only 1% of patients seek treatment in another Member State, patients with rare diseases will particularly benefit from the new Directive, with centres of expertise on rare disease cooperating together.

However, national health authorities can refuse authorisation if the treatment or healthcare provider in question presents a risk for the patient or if the treatment could be obtained quickly in the patient's current country.

Each country will establish a national contact point where patients can access information about health providers, reimbursement procedures and advice on prior authorisation requirements.

Other key points:

- Continuity of care is paramount, with the Directive outlining measures on the transfer of written or electronic medical records from the country of origin to the treatment country and back again. The Directive also outlines enhanced cooperation on eHealth between Member States which will ensure this information is transferable. The home country will also have to provide the same quality of follow up care regardless of where in the EU the treatment took place.
- Prescriptions issued in another EU country will be recognised in a patient's country of residence and vice versa, provided that the medicine is authorised for sale and available in the country.
- In regards to non-hospital care, patients do not have to seek prior authorisation, and can claim reimbursement from both public and private providers from abroad.

European Road Safety Charter

On the 1st of February, the Irish Medical Organisation was invited to Brussels to accept an award from the European Road Safety Charter for its ongoing commitment to Road Safety in Ireland in 2010.

Dr Declan Bedford accepted the award on behalf of the IMO from Vice President of the European Commission and Commissioner for Transport, Mr Siim Kallas.

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The award recognises the IMO's commitment to Road Safety through our advocacy work in highlighting road safety motions proposed and carried at our Annual General Meeting by our members, and the resulting follow up with the relevant government or interest body to affect change in the area of road safety.

The IMO was nominated in the Federations and Associations section, which consists of over 700 signatories to this category.

European Working Time Directive

The European Commission commenced a review of the European Working Time Directive (EWTD) in 2010 after the previous attempt to amend the Directive (2004-2009) failed. The second phase of consultation was released on the 21st of December 2010, proposing two frameworks to guide the review: a focused or a more comprehensive review.

The focused review proposed new solutions which focused on the questions of on-call time and compensatory rest.

The comprehensive review proposed to consider the changing working patterns and trends, and to look thoroughly at the health and safety issues raised by excessive working hours.

The IMO, along with other European National Medical Associations, agreed that there were problems with looking at both the focused and comprehensive review, and advocated our current position to remove the opt-out clause; that on-call time is working time, as stipulated by the European Court of Justice, and that compensatory rest has to be immediately granted following longer working periods as stated by the European Court of Justice. All organisations wish to see the EWTD implemented fully and consistent across the Member States, which was reflected in a joint statement signed by the European Medical Associations.

Under the Treaty of the Functioning of the EU, the Commission is obliged to consult with the social partners at EU level before making any legislative proposals regarding the EWTD. In November, the social partners agreed to enter into negotiations to resolve the outstanding issues highlighted in the previous phases of the consultation.

The social partners have nine months to agree on solutions as provided for under the Treaty, and will therefore have until September 2012 to inform the Commission of any agreements reached.

Professional Qualifications Directive

Since adoption in 2005, the Professional Qualifications Directive (PQD) has been installed to facilitate the movement of professionals when seeking establishment in another Member State. In March, the Commission launched a review process aimed at modernising the PQD in order to meet challenges facing the European workforce.

The IMO responded to the draft position paper of CPME which was disseminated amongst the other European Medical Organisations, with several of the IMO's comments adopted in the final text of the response.

From the responses provided to the European Commission in March from this first consultation, the Commission developed a Green Paper that was released in June.

The Green Paper synthesized the proposals in order to meet the challenges outlined in the previous stage of consultation. Stakeholders were invited to answer questions in the Green Paper in order to identify a way forward for the Commission. The Commission addressed a number of areas under consideration for amendment, ranging from the introduction of a professional card, minimum training times and language testing for professionals moving to new Member States.

The key areas of focus in the consultation are:

- New approaches to mobility
- Ways to build on achievements
- Modernisation of the automatic recognition.

The IMO drafted a comprehensive response during the summer, which was then sent to all European Medical Organisations, with components of the IMO's response being adopted in to the EMO's individual responses. The IMO also sent a response directly to the European Commission (the IMO response is available at **www.imo.ie**).

A draft of the formal legislative proposal was released in late December. The IMO will identify key areas of the PQD proposal to lobby relevant European and Irish MEPs, and continue to work within our European representative organisations on this issue.

Professor Cillian Twomey also participated in a meeting on issues within the Professional Qualifications Directive with the European Commission on Tuesday 3 May as part of a wider delegation of representatives from the sectoral professions to convey the situation in Ireland and to discuss broader medical professional issues within the Professional Qualifications Directive.

European Medical Organisations – Domus Medica progress

In late June UEMS officially signed the contract for the Domus Medica Europea for the premises located at 24 Rue de l'Industrie in Brussels.

Work will be carried out throughout 2012 to renovate the building and offer space to interested stakeholders to increase working capacity between the European Medical Organisations.

Standing Committee of European Doctors - CPME

CPME undertook significant portfolios of work in 2011, with particular attention paid to the Professional Qualifications Directive. Refined working structures have also benefited the organisation, with a number of papers proposed and finalised in 2011.

Late in 2010, CPME voted to install weighted voting. However, due to an issue regarding the presence of a notary from Belgium to oversee

International Affairs

the changes, weighted voting could not be fully installed in 2011. Therefore, CPME will operate on the one country one vote system until the statutes can be fully changed in accordance with Belgian law.

Due to a clash with the IMO's Annual General Meeting, the IMO was unable to be present at the Spring meeting. At the meeting, the term of office for board members, internal auditor and Executive Committee members was extended from two to three years. These terms were also harmonised so that all office holder's terms run parallel to that of the President.

Papers adopted included:

- CPME Statement on the European Innovation Partnership on Active and Health Ageing
- CPME policy on the impact of task shifting on doctors in training
- Climate Change – CPME policy
- Ammendment to Health Inequalities 2010 paper
- CPME Position on Access to Medicines – Biosimilars
- Response to consultation on the Revision of the 'Clinical Trials Directive'

Over the Summer months, particular attention was given to responding to the Green Paper on the Modernisation of the Professional Qualifications Directive, with in-depth negotiations between the National Member Associations to reach a compromise in order to deliver an agreed response. The IMO was heavily involved in the working group and negotiations, participating in telephone conferences and web discussions in order to shape a response that reflected the IMO's position.

The Autumn meeting was held in Warsaw in late November. The CPME conference held prior to the commencement of the meeting was entitled 'Mobile Doctors, Mobile Patients – How Does Patient Safety Travel In Europe?' and explored perspectives in cross-border patient mobility.

During the course of the meeting, two positions called for candidates due to vacancies. In the Executive Committee, an election was held for Vice-President, with Dr Heikki Palve being elected for the remaining term of 2012. CPME also endorsed the nomination of Dr Wolf-Dieter Ludwig for the European Medicines Agency after a number of candidates were presented.

Papers adopted at the meeting included:

- CPME policy on Smoking in the Presence of Children
- CPME position on the legislative proposal for a Regulation on European Standardisation
- CPME Statement on Health Technology Assessment in Relation to Cross-Border Healthcare
- CPME Statement on Mental Health, combating Stigma and Social exclusion

CPME also became aware of a situation in Slovakia regarding industrial action by doctors, aiming to address working conditions and changes to the health care system. CPME drafted and adopted a Declaration in support of Slovakian Doctors.

At the meeting in Warsaw, CPME presented an update on a European project aimed at 'mapping' how current European countries plan their health workforce. The IMO was invited to contribute their perspective in early January 2012 and provide input on the report which will be presented to Commission, who are developing a Joint Action Plan in 2012 that is hoped will address the gap in the supply of health workers.

CPME is part of the EU Alcohol and Health Forum and as part of their participation, CPME have made commitments regarding their ability to promote awareness of alcohol related issues amongst its members. The IMO reported on the 2011 alcohol motions and the process undertaken to lobby and inform the government, also highlighting the IMO submission to the Oireachtas Joint Committee on Health and Children on Alcohol Marketing.

CPME will submit its first activity report to the Commission in 2012, where the efforts of the IMO will be used as an example of the profession's impact on a national level.

European Working Group of Practitioners and Specialists in Free Practice (EANA)

The EANA representatives continue to discuss and work on topics that have a unique impact on independently employed physicians.

Unfortunately the IMO did not attend the Spring meeting in Gibraltar. However, the meeting presented findings from a survey on prevention conducted by the German delegation, which highlighted the differences in delivering screening programmes throughout the member countries.

EANA adopted the statement of Gibraltar, which discussed the importance of independent medical practice, and dangers around the corporatisation of medical practice. EANA wished to highlight that with the reform of health care around Europe, some countries are implementing new operational regulations which threaten the survival of small practices.

In Autumn, EANA met in Germany with much of the work from the Spring meeting continuing on. A guest speaker from the German regional association presented a summary of health information on the region.

Elections for both the President and for Treasurer were held. It was decided that current President Dr Jörg Pruckner would stay on for the first half of the new Presidential term (2012-2013), with Dr Claude Schummer taking over the role for the second half (2014-2015). This proposal was unanimously agreed upon. Dr Liam Lynch from the IMO was also elected to the role of Treasurer of EANA and will work closely with the Executive team.

EANA will continue to work on the significant issues threatening independently employed physicians and highlight them at a European level throughout 2012.

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European Junior Doctors – Permanent Working Group (EJD)

The Spring meeting of the EJD took place in Zagreb from the 6-7th May, where the organisation was formally incorporated under Belgium law and going forward to be known as the European Junior Doctors, to better reflect their members and their remit.

The Spring meeting was also saw the election of a new Executive Committee, with the outcome as follows:

President: Dr Carsten Mohrhard (Germany)
Vice President: Dr Hrvoje Vrazic (Croatia)
Treasurer & Chair of Economy Committee: Dr Homayon Chaudry (Switzerland)

Chairpersons of committees were also elected, with Dr Pedro Gomes (Portugal) responsible for European affairs; Dr Indre Butiene (Lithuania) responsible for Postgraduate Medical Training; Dr Noora Ritamäki (Finland) chairing the Medical Workforce Committee. Marco Capizzi (Italy) was elected Communications Officer and Anna Savinkova (Latvia) elected as Medical Education Officer.

Discussion centred around the non-compliance of the EWTD, and the EJD reinforced its position of calling for the proper and safe implementation of the EWTD in its current form. Countries presented their situations, with representatives reporting instances of non-compliance to varying degrees. Also discussed at the meeting was upcoming work on the Professional Qualifications Directive.

Over the summer, the secretariat was handed over from the Portuguese Medical Association to the new German secretariat. Significant work was undertaken over the summer to update website capabilities to progress tasks outside of the meetings.

The Autumn meeting of PWG was held in Malta, and due to a meeting clash, the IMO could not attend.

Guest speaker Dr Ramin Parsa-Parsi presented information around the implementation of the third cycle of the Bologna process, and updated the membership on the significant advances. The EJD has started a process to collect data in member countries on the implementation and will prepare a policy statement on the issue.

Other projects discussed at the Autumn meeting included the EuroMed Mobility Project and its reinvigoration to track junior doctors training and working conditions and to provide an outlet to discuss professional issues for European Junior Doctors.

The EJD has also made contact with Dr Thomas Ulmer MEP and will begin working on the topic of task shifting and the effects on Junior Doctors, and will work to advance this topic within Europe.

European Union of General Practitioners (UEMO)

The Spring meeting of UEMO was held in Budapest, to mark the start of the Hungarian Presidency's term of office. The meeting started with contributions from a number of Hungarian health officials and Mr John Dalli, European Commissioner for Health and Consumer policy.

Policy advisor to UEMO, Ms Marie-Christine Bonnamour outlined her close contact with the Commission regarding the options for the modernisation of the Professional Qualifications Directive, and the hope of UEMO to have General Practice/Family Medicine as a recognised specialty in the EU.

The Spring meeting also saw a change in working group structure, with a more streamlined programme to include the topics of Specialist Training, Preventative issues in General Practice, and the Ad Hoc Committee to look at any other matters that need to be discussed and progressed. A presentation during the course of the meeting triggered debate on the competencies in General Practice, and it was decided that a working group looking at the competencies of GPs in the management of complexity would be established.

Each of these working groups defined their upcoming work programmes to identify input opportunities in policy work throughout the EU and to raise the profile and awareness of professional issues concerning General Practice/Family Medicine.

The Autumn meeting of UEMO was held in Turin, where Dr Aldo Lupo was elected as a new Vice President for UEMO. UEMO also reached a decision on the end of its two year trial of weighted voting, with both Spain and Italy withdrawing their request for the implementation of weighted voting on political decisions.

The CME working group was restarted to map CME organisation in different countries, discuss the quality improvement for GP CME and to investigate the option of working with UEMS to establish CME accreditation for General Practice.

Working groups also outlined a number of significant projects that will see UEMO as key participants. UEMO will participate in the SMART project, which is a survey on the use of eHealth in primary care. UEMO, through its member organisations will be key in delivering this project. Member Associations will contribute to the project by utilising the experience of GPs through the collation of data via surveys in how they utilise eHealth in a variety of formats, including internet and even communication with patients.

UEMO will also work with partners in the 'Tell Me' project, which is an initiative of the EU Commission looking to improve communication between health professionals during outbreaks of infectious diseases. UEMO's participation will require interviewing 30-40 GPs from the UK, Italy, the Netherlands, Finland, Slovenia and Hungary. The project will involve testing simulation software and also looking at web communication between health professionals.

While both of these projects involve significant work, UEMO has a strong position within the EU representative environment and is working

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closely with the Commission on a range of topics concerning General Practice.

UEMO is also continuing to work toward the recognition of General Practice as a specialty in the EU. While it was originally thought that the Modernisation of the Professional Qualifications Directive would accommodate this, a meeting with the European Commission in December has indicated that this will not be the process for this action. Further work will be undertaken by UEMO in 2012 on this matter withthe Specialist Training working group leading this activity in 2012.

European Union of Medical Specialists (UEMS)

2011 was a historic year for UEMS, as they finalised the purchase of their premises in Brussels to house the European Domus Medica.

The Spring UEMS meeting took place in Brussels on the 8-9th April. UEMS reported its strong position regarding the accreditation of European CME events and discussed the possibility of expanding their role to include provider accreditation. A considerable body of work was proposed by the taskforce for UEMS' European Accreditation Council for Continuing Medical Education, which proposed documents on the avoidance of bias in educational activities; guidelines for commercial support for CME events; EACCME recommendations for CME providers; the use of EACCME logo and name and a mission and objectives document. All of these policy documents were accepted. Additionally, a policy document regarding the accreditation of e-learning materials by the EACCME (revised criteria) was also adopted.

The Council also heard an update on the European Council for the Accreditation of Medical Specialist Qualifications that the pilot assessments at the start of 2011 were a success, and further pilot assessments were to take place later in the year.

Other outcomes of the spring meeting included:

- The establishment of a Multidisciplinary Joint Committee on Sexual Medicine
- The change of name of the UEMS Section of Medical Biopathology to include Laboratory Medicine.

The Autumn meeting of UEMS took place in Napoli from the 6-8th of October. Elections for the Executive Committee took place in Napoli and were tightly contested, with the results as follows:

President: Prof. Romuald Krajewski (Poland)
Secretary General: Dr Edwin Borman (UK)
Liaison Officer: Dr Zlatko Fras (Slovenia)
Treasurer: Dr Giorgio Berchicci (Italy)
Vice Presidents: Assoc. Prof. Hans Hjelmqvist; Dr Salvatore Ramuscello; Prof. Jan Skhra; Dr Hans-Peter Ulrich

The EACCME taskforce decided to look at two key issues going forward: European CME credits, and the possibility of developing criteria that would reward quality learning, rather than rewarding time spent on CME/CPD. Also to be explored will be how the reviewers are remunerated for their time, and how the funds are distributed.

Under the EACCME taskforce, the following documents were proposed and accepted:

- Criteria for the Accreditation of Live Educational Events by the EACCME
- Proposed Constitution of the Governance Board of the UEMS Standing Committee on Continuing Medical Education and Professional Development

UEMS also endorsed Chapter 6 in the areas of Medical Microbiology, Neurology and Oro-maxillo-facial surgery. UEMS also created a Section of Emergency Medicine, however will also keep the MJC of Emergency Medicine to ensure that other sections can still contribute in this area.

There was also a presentation from the UEMS Section of Occupational Medicine on health issues related to doctors working time which was adopted.

World Medical Association

The WMA reached a new milestone at the General Assembly held in Montevideo in October, reaching 100 constituent members of the Association. Dr Josè Luiz Gomes Do Amaral from Brazil was installed as President for 2011-2012 and Dr Cecil Wilson from the American Medical Association was named as President elect in 2012-2013.

The Scientific Session was dedicated to Tobacco Cessation, and proved very informative particularly in regards to different initiatives around the world for cessation treatments. Also profiled was legal action undertaken by Tobacco lobby groups against national governments who sought to introduce new packaging legislation.

The Montevideo meeting provided considerable policy output. A number of statements and resolutions were passed, including:

- Revision of the WMA Statement on End-of-Life Care
- Statement on Professional and Ethical Usage of Social Media
- WMA Statement on the Global Burden of Chronic Disease
- WMA Statement on Social Determinants of Health
- WMA Statement on Protection and Integrity of Medical Personnel in Armed Conflicts and Comments
- WMA Resolution on the Access to Adequate Pain Treatment and Comments
- WMA Statement on Disaster Preparedness and Medical Response

The IMO gave considerable input to a proposed Declaration on the Ethics in Palliative Sedation. The IMO welcomed the outcome that after much deliberation, it was decided that a working group would continue to look at this issue.

International Affairs

Bahrain Situation

Council signed a Resolution on Bahrain that was sent directly to the Bahraini authorities, and also passed a Resolution on the Independence of Medical Associations which were both adopted by the General Assembly. The IMO also wrote to the Bahraini authorities in May, and also to the Department of Foreign affairs in regards the situation in Bahrain

Alcohol

On the 12th of December the WHO held a consultation with civil society on ways it can contribute to reduce the harmful use of alcohol. The IMO sent in details of our 2011 motions regarding Alcohol and also offered the contribution of the IMO submission to the Oireachtas Joint Committee on Health and Children on Alcohol Marketing, to demonstrate our activities in this area.

Conclusion

It has been a very busy year with international projects, and the agenda for 2012 is shaping a significant work schedule with the modernisation of the Professional Qualifications Directive taking centre stage, along with discussions by the social partners on the European Working Time Directive. The International Affairs department will continue on the success of work undertaken in 2011 with our European and International colleagues on issues affecting the profession and to represent the views of the IMO members at the highest level.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Dr Martin Daly, Chairperson

IMO Financial Services

IMO Financial Services

Board Members during 2011

Dr Martin Daly, Chair

Mr George McNeice, Managing Director

Mr Pat Dineen, Director

Mr Jim Brophy, Director
(appointed December 2011)

Mr Willie Holmes, Director
(appointed December 2011)

Mr Mattie Rice, Executive Director
(resigned September 2011)

IMO Financial Services continued to provide a professional, personal and high quality service to members of the IMO during what was a very challenging year.

Group Schemes

The company operates a range of schemes for IMO members including Group Life, Income Protection and Waiver of Premium. The schemes are designed to enable doctors obtain protection cover on favourable terms, particularly in the area of underwriting. In late 2011, in line with best practice, we initiated a review of all our Group Schemes with a view to ensuring that they continue to meet the needs of our members and have the most favourable terms given current market conditions. It is expected that the review will be concluded in early 2012.

Individual Financial Consulting Service

During 2011 the company engaged with 650 doctors on a range of services and products including pensions, life and income protection, insurance and financial reviews.

In response to members needs in the current environment we enhanced our Financial Review Service to enable clients get a true picture of their financial status and plan accordingly for the future.

Another key issue during the past year was the effect of the significant changes introduced in 2010 in relation to Pensions and the contribution limits allowable for tax relief. In this regard we held five pension information seminars around the country and dealt with over 300 members individually in respect of pension planning. Additionally, supporting videos, articles and information was available to all IMO members on the IMOFS website.

Property Investments

Between 2005 and 2008 IMO Financial Services offered four property syndicate schemes to members either as a pension or direct investment option. Given the economic downturn and the fall in property values across Europe these investments have not performed in line with expectations and this will result in losses on the individual's original investment but no liability to any outstanding bank debts of the property syndicates as the loans were on a non recourse basis. While the role of IMOFS was in the promotion of the investment options, given the very unique relationship between IMOFS and its clients, we have expended our own resources to engage experts to deal with the banks and the disposal of properties in an effort to minimise losses to individual doctors. Shareholders have been advised of all developments in this regard.

Web Development

In 2011 the IMOFS website was enhanced to provide a greater range of information on our products and services to doctors and also to provide articles and videos in the areas of pension funding, practice incorporation, and pension issues generally. Additionally the website enables IMO members to book appointments with our financial advisors and receive quotes by return email. We are intending to further expand the range of

IMO Financial Services

content and support material on the website including issues around tax planning and preparing for revenue audits.

IMOFS Board

Two new members were appointed to the Board of IMO Financial Services and the appointments were advised to the IMO Management Committee. The new directors are Mr Willie Holmes and Mr Jim Brophy both of whom have expertise in financial services and we look forward to working with them.

Conclusion

The key objective of the company is to provide a high quality service to members and to continue to support IMO activities. Given the very significant changes in pension and taxation issues we will review our range of products and services to ensure they continue to best meet the needs of members now and into the future. IMO Financial Services is a wholly owned subsidiary of the IMO and the values of the company are reflected in the IMO Financial Statements.

MEDISEC

MEDISEC IRELAND

Board of Directors

Mr Des Lamont, Chairman
Ms Dorothy Collins
Dr Larry Fullam
Mr Hugh Governey
Dr Mary Gray
Dr Liam Lynch
Mr George McNeice

Staff

Mr Pat Mahony, Chief Executive
Ms Suzanne Browne, General Manager
Ms Antonella Toselli, Member Services Administrator
Ms Sarah Keegan, Advisory Co-Ordinator
Mr William Crean, Financial Controller

Medisec is the only Irish Independent non profit-making company, owned by its members, GPs in Ireland, with the objectives of providing General Practitioners with:

- A fair deal in Professional Indemnity. **The Medisec product is unique in that it is a fully insured non-discretionary contract, with a €10 million limit of indemnity.**
- A high quality Advisory and Mediation Service.
- A GP integrated Risk Management process, facilitated through Newsletter publications and a continuously updated website together with Risk Management presentations.

Subscriptions paid by general practitioners will be used exclusively for general practitioners.

Medisec is a single-agency intermediary with Allianz Plc and is regulated by Central Bank of Ireland.

The Board of MEDISEC is comprised of medical practitioners and professionals in other areas who combine to provide the highest standards of service for medical practitioners.

Medisec in conjunction with it's Insurer, Allianz, has a GP Advisory Panel which defines and keeps current a definition of the range of services normally provided by a General Practitioner. It also provides advice and expertise in relation to what is involved in certain treatments and procedures and the clinical implications involved. The Medisec GP Directors advise and support Medisec and its members in relation to on-going Claims, Advisory and Mediation cases.

The membership of Medisec has grown to in excess of 1,100. This contrasts with the initial membership under IGPIMAS in July 1992 of less than 250 members.

The Advisory Service provided by Medisec Ireland Limited is availed of by over 30% of members annually and feedback indicates a high level of satisfaction with the response time and quality of assistance offered. It is worth noting that only a small number of queries result in claims.

On retirement at normal retirement age (sixty-five), having been a member of the scheme for a continuous minimum period of ten years immediately prior to reaching the age of sixty-five years, members will be entitled to an extended reporting period after the expiration of the policy i.e. Tail Cover. No Additional Charge will be levied against retired members for this cover which will be funded by Medisec.

Membership Unit

The strength of the IMO lies in its membership, and our aim is to ensure that the organisation remains a strong trade union, offering value for money and extensive supports for its members. The Irish Medical Organisation is committed to representing the best interests of its members, and is reliant on the support of a united membership in order to achieve the best possible outcomes for each of the medical groupings represented by the organisation.

The IMO remains the only negotiating body on behalf of all doctors in Ireland. This year the IMO recorded a membership figure of 5,337.

The services and benefits available to members continue to expand in order to meet changing demands in the work environment and to best equip our members in carrying out their central role in the care of the patient.

As well as offering national representation and negotiation in dealings with all Irish medical bodies, government and health service providers, the IMO now offers individual support in the form of the Personal Cases Unit.

On an international and European level, members benefit from the work of the International Affairs unit, providing representation on and working with policy bodies that will influence the work of Irish doctors into the future.

In addition, every member may avail of the free services of the Financial Services unit; for pension, loan, tax and insurance planning and advice.

As a member of the Irish Medical Organisation you receive regular notifications, newsletters and emails on developments in your specialty area. The new-look IMO website also provides updated information, news and reports per medical grouping. The IMO website is now a useful member resource, where contact details and member renewals and payments can be made at any time.

The membership unit strives to maintain up-to-date membership records and we are reliant upon members advising us of any changes to contact or address details. It is equally important that we are kept informed of your career progression as this will ensure you receive the most relevant material and updates from the IMO.

The IMO 2012 Subscription Rates remain at the same rate as 2011. Management are mindful of the financial constraints under which our members are operating, and bearing in mind the cumulative 8% reduction in fees to date.

In recognition of career paths there are special rates for General Practitioner Assistants years one to three, and newly appointed Consultant for years one to three also.

Overseas membership rates can be availed of by members pursuing a career abroad. This is free of charge and means you will be kept up-to-date on developments in the Irish Health Service via a monthly email newsletter.

Members can choose from a number of payments options in terms of paying their annual subscription:

- Annual Cheque
- Direct Debit monthly/annually
- Credit card annually (online option)
- GMS via the Primary Care Reimbursement Service (GPs only)

The Membership Unit is available to assist with your detail changes, to discuss your membership benefits and options.

Mission Statement

The role of the IMO is to represent doctors in Ireland and to provide them with all relevant services. It is committed to the development of a caring, efficient and effective Health Service

Interns attend Cork Information Evening, and Dr Mark Murphy speaking at the Information Evening in Galway

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Publishing Unit

Dr John FA Murphy, Editor, Irish Medical Journal

In 2011 there were 10 editions of the IMJ. It was published both in paper and electronic forms. There were 10 commentaries, 20 editorials, 60 original papers, 13 case reports, 5 short reports, 6 research correspondence, 34 letters to the editor, 21 book reviews, 9 medicine and poetry and 2 occasional pieces. A wide spectrum of topics and issues were addressed across the IMJ pages.

Delaney et al reported on the important issue of folic acid supplementation in the prevention of neural tube defects (NTDs). They found that only 36% of women had taken folic acid periconceptionally. It appears that little has changed from previous years. The authors state that 'in the absence of fortification with reliance on a low uptake of supplements and uncertain dietary intake during these years of economic stringency it is possible that the decline in NTD numbers observed during the past decade may reverse'.

Tajuddin et al described the presentation of coeliac disease in adults. The mode of presentation has been changing to a more atypical or silent disease. There were 47 patients, two thirds being women. Forty per cent presented with diarrhoea, 21% presented with anaemia. The time between presentation and diagnosis was 9 months.

Duffy et al described the functioning of a GP led sexually transmitted infection clinic. The authors pointed that the number of Irish STI cases trebled between 1995-2006. The 3 STIs accounting for most infections were ano-genital warts 35%, chlamydia 32%, non-specific urethritis 22%. The authors found that 80% of patients never or only sometimes used a condom.

Watts et al demonstrated the effectiveness of acute medical assessment units (AMAUs). Among 1562 patients seen in the AMAU, 12.6% were admitted. In contrast among 1465 patients seen in the emergency department 43% were admitted. The success of AMAUs is based on better communication with GPs, senior clinicians and access to designated OPDs.

Dunne and McLoughlin described the use of electro-convulsive therapy (ECT) throughout Ireland. They found that only 24 of 64 approved centres provided ECT with the overall rate being 9.6 per 100,000 Irish people. The rate is comparable with international centres. The regional variation was less than previously reported.

Johnson et al reported on the management of major obstetric haemorrhage (MOH). They quoted a rate of 3.5 per 1000 births. The major cause were uterine atony 35%, placenta praevia/accreta 19%, retained products of conception 19%. The authors recommended that ultrasound location of the placenta should be performed in all women with a previous caesarean section.

Martin et al described alcohol attributable hospitalisations and costs in Ireland. The net number of bed days due to alcohol was 2,899,734 in the period 2000-2004. The corresponding net costs were €805,158,217. Chronic conditions accounted for 95% of the hospital bed days due to the harmful effects of alcohol.

Mulroy et al analysed the time from admission to brain CT scan. The mean time is falling 2004-2007 (19-24 hours), 2008 (15 hours), 2009 (3 hours). It is pointed out that stroke is time sensitive and that 2 million neurones die

Publishing Unit

for each minute delay. Recombinant tissue plasminogen activator (tPA) needs to be administered within 4.5 hours of stroke onset to be effective.

Sheridan et al report on the admissions and costs to acute hospitals resulting from road traffic accidents 2005-2009. There were 14,861 discharges related to RTAs. Two thirds were male and one third of victims had head injuries. Over the period there has been a small year on year reduction.

Noone et al reported on the national neonatal transport programme (NNTP) for the period 2004-2009. A total of 1621 transports were undertaken, a yearly average of 271. The mobilisation time was 34 minutes. 54% of transported were completed outside the scheduled hours 09:00-17:00. Consideration is being given to extending the service to 24 hours.

Reynolds et al reported on the St James experience in the management of oesophageal cancer 2004-2008. 603 cases were referred of whom 310 were treated with curative intent. Adenocarcinoma is twice as common as squamous cell carcinoma. The in-hospital postoperative mortality was 2 % and the 5 year survival was approximately 40%.

Dunican et al reported on the first 500 patients referred to a rapid access lung cancer clinic. The mean time between referral and being seen was 5.5 days. The 2 weeks target was achieved in 98% of cases. 41% were diagnosed with a malignancy. The diagnostic rate indicates that appropriate patients are being referred.

Dhillon et al described the advantages of an adhesive surgical ward round checklist. Its use increased adherence to good surgical practice, 91% in the sticker group compared with 55% in the controls. There was better documentation of the management plan, abnormal bloods and vital signs.

Cox et al reported that the effects of MRSA infection on the pulmonary function of children with cystic fibrosis. They found that persistent MRSA adversely affected lung function. When compared with children with cystic fibrosis without MRSA they had a significantly reduced FEV1. Other parameters were similarly reduced.

Thanks to all authors who contributed to the IMJ during 2011. A special thanks to everybody who acted as a referee, your effort is greatly appreciated. Thanks to the editorial board and the IMO management committee. Thanks to George McNeice for his constant support. Thanks to Susan Clyne in her role of finance and administration. I am extremely grateful to Lorna Duffy, assistant to the editor for her pivotal role in producing the journal.

JFA Murphy
Editor

AGM 2011 Killarney


PRESCRIPTION
FOR
CHANGE
2011
ANNUAL
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MEETING
IRISH MEDICAL O


16. The IMO calls on the Minister for Health to rei
the penalties for those in breach of the Public
Acts 2002-2004 so that those who
guilty of selling tobacco products to chil
ence to sell tobacco products for
IRISH MEDICAL ORGANISATION

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Ceardchumann Dochtúirí na hÉireann

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

2011 financial statements

For Year ended 31-12-2011

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Financial Statements

For the Year Ended 31st December 2011

(These pages do not form part of the audited financial statements)

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Trustees and other information

The Irish Medical Organisation is a Trade Union Registered under The Trade Union Act 1941.

TRUSTEES:	Dr. Larry Fullam Dr. Mary Hurley Prof. Cillian Twomey Dr. Henry Finnegan Dr. Michael Thornton
MANAGEMENT COMMITTEE:	Mr. George McNeice Professor Sean Tierney Dr. Ronan Boland Dr. Matthew Sadlier Dr. Trevor Duffy Dr. Paul McKeown Dr. Mark Murphy Dr. Mary Gray Dr. Johanna Joyce Cooney
BANKERS:	Allied Irish Banks Plc., 40/41 Westmoreland Street, Dublin 2.
SOLICITORS:	John O'Connor & Co., 9 Clare Street, Dublin 2.
AUDITORS:	HSOC Financial & Business Advisors, Chartered Certified Accountants, Registered Auditors, Adelaide House, 90 Upper Georges Street, Dun Laoghaire, Co. Dublin.

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Report of the Management Committee for the Year Ended 31 December 2011

The Management Committee has pleasure in submitting its report together with the audited financial statements of the organisation for the year ended 31 December 2011.

Statement of Management Committee's Responsibilities

A. We are responsible for the preparation of the organisation's financial statements, which give a true and fair view of the organisation's affairs as at 31 December 2011 and of the surplus for the year then ended.

B. In preparing the financial statements we have selected suitable accounting policies and have applied them on a consistent basis, making judgements and estimates that are prudent and reasonable.

We have used applicable accounting standards in preparing the financial statements, subject to any material departure being disclosed and explained in the financial statements.

We have prepared the financial statements on a going concern basis.

C. We are responsible for keeping proper accounting records, for safeguarding the assets of the organisation and for taking reasonable steps for the detection and prevention of fraud and other irregularities.

Post Balance Sheet Events

No significant events have occurred since the balance sheet date.

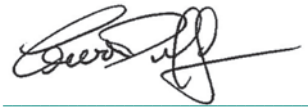
Auditors

Our Auditors, HSOC Financial & Business Advisors, will be re-appointed for the coming year.

On behalf of the Management Committee:

President

PRESIDENT DR RONAN BOLAND



Treasurer

HONORARY TREASURER DR TREVOR DUFFY

Date: 23/02/2012

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Treasurer's Report

It gives me great pleasure, as Treasurer of the Irish Medical Organisation, to present my report and the Financial Statements for the year ended 31 December 2011, which have been audited without qualification by HSOC Financial & Business Advisors, Chartered Certified Accountants, Registered Auditors, Dun Laoghaire, Co Dublin.

Strategic Plan 2011-2014

In early 2011 we launched our third 3 Year Strategic Plan which remains faithful to our mission statement and sets our goals in the three key areas of Excellence in Industrial Relations, Professional Representation & Strategic Alliances and Engagement with Members. Our overriding objective is to ensure all our activities enhance our role as the key medical representative body in Ireland, provide our members with the best possible service and develop policies in the interests of patients and the health services. Our budgets are based on the objectives outlined in the Strategic Plan.

Key initiatives in line with our Strategic Plan during the past year have been the development of the new IMO website which meets our twin objectives of providing essential online information and resources for our members and reducing our costs in the areas of print/post. We intend to continue with our investment in the area of technology to further enhance our web presence and communication systems. During the past year we have held national meetings for Consultants, NCHDs and GPs and also begun our initiative to revitalise branch structures and local meetings. The strength of the IMO is the membership and we hope that, at this crucial time, more doctors will become involved with the Organisation and we will be making every effort to make that two way communication process easier and more effective.

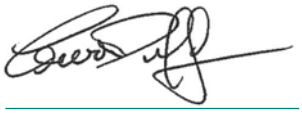
Corporate Governance & Financial Performance

Recognising the financial constraints under which our members are operating there has been a cumulative 8% reduction in membership subscription rates in recent years.

These audited Financial Statements report a net surplus of €309,918 and the net worth of the IMO now stands as at 31st December 2011 at €10,786,313. In accordance with International Accounting Standards and best accountancy practice, the Balance Sheet shows all assets at cost less accumulated depreciation. In order to reflect the true value of the Irish Medical Organisation, a consolidated Balance Sheet incorporating up to date valuations together with appropriate notes and explanations has been prepared and attached to these accounts. Given the potential legal challenges which the Organisation may have to take it has been deemed prudent to retain a significant legal accrual in these Financial Statements.

The financial governance systems within the Organisation are robust with monthly management accounts, externally prepared quarterly management accounts, annual audited accounts and annual budgets.

I would like to thank Mr George McNeice, Chief Executive for his continuing stewardship of the IMO and also my thanks to my fellow honorary officers during the past year.



DR TREVOR DUFFY, TREASURER
Honorary Treasurer

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Independent Auditors' Report to the members of the Irish Medical Organisation

We have audited the financial statements of the Irish Medical Organisation for the year ended 31 December 2011 on pages vii to xxi, which comprise Income and Expenditure Account, Balance Sheet, Cashflow Statement and the related notes. These financial statements have been prepared under the historical cost convention and the accounting policies set out on page xii.

This report is made solely to the management committee, as a body, in accordance with Section 11 of the Trade Unions Act 1871. Our audit work has been undertaken so that we might state to the management committee those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the organisation and the management committee as a body, for our audit work, for this report, or for the opinions we have formed.

Respective Responsibilities of the Management Committee and the Auditors

The Management Committee of the Irish Medical Organisation is responsible for the preparation of the financial statements in accordance with applicable law and Irish Accounting Standards as set on page iii in the Statement of Management Committee's Responsibilities.

Our responsibility is to audit the financial statements in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the financial statements give a true and fair view and are properly prepared in accordance with the Trade Union Acts and all relevant legislation. We also report to you whether in our opinion proper books of account have been kept by the organisation; and whether the information given in the Management Committee's Report is consistent with the financial statements. In addition, we state whether we have obtained all the information and explanations necessary for the purposes of our audit and whether the organisation's balance sheet is in agreement with the books of accounts.

We read the Chief Executive's Report contained in the Annual Report and consider whether it is consistent with the audited financial statements. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any other information.

Basis of Audit Opinion

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements. It also includes an assessment of the significant estimates and judgements made by the Management Committee in the preparation of the financial statements, and of whether the accounting policies are appropriate to the organisation's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Independent Auditors' Report to the members of the Irish Medical Organisation

assurance that the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error. In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion the financial statements give a true and fair view of the state of the organisation's affairs as at 31 December 2011 and of its surplus for the year then ended and have been properly prepared in accordance with all legal requirements.

We have obtained all the information and explanations we considered necessary for the purposes of our audit. In our opinion proper books of account have been kept by the organisation. The financial statements are in agreement with the books of account.

In our opinion, the information given in the Management Committee report is consistent with the financial statements.

HSOC Financial & Business Advisors
Chartered Certified Accountants,
Registered Auditors,
Adelaide House,
90 Upper Georges Street,
Dun Laoghaire,
Co. Dublin.

Date: 23/02/2012

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Income and Expenditure Account for the Year Ended 31 December 2011

	Notes	2011	2010
		€	€
Income	1	3,614,452	4,438,246
Other Income	3	223,197	231,324
Publishing Contribution	Schedule 1	(9,294)	8,344
		3,828,355	4,677,914
Expenditure	Schedule 2	(3,500,994)	(4,045,586)
Surplus for the Year before Taxation	4	327,361	632,328
Taxation	5	(17,443)	(20,098)
Surplus For The Year After Taxation		309,918	612,230
Opening Accumulated Revenue Surplus		5,651,258	5,039,028
Closing Accumulated Revenue Surplus		5,961,176	5,651,258

There were no recognised gains or losses other than those passing through the profit and loss account and, therefore, no separate Statement of Recognised Gains and Losses has been prepared.

The notes on pages xiii to xxi form part of these financial statements.

The financial statements were approved and authorised for issue by the management committee on the 23/02/2012 and signed on its behalf by:

President
DR RONAN BOLAND

Treasurer
DR TREVOR DUFFY

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Balance Sheet
as at 31 December 2011

	Notes	2011	2010
		€	€
FIXED ASSETS			
Tangible Assets	**6**	293,783	244,682
Deposit with the Court of Justice	**8**	10,640	10,551
		304,423	255,233
FINANCIAL ASSETS			
Investments	**7**	91,562	91,562
		395,985	346,795
CURRENT ASSETS			
Debtors	**9**	5,767,882	5,007,455
Cash & Bank Balances		2,427,987	2,810,883
		8,195,869	7,818,338
CURRENT LIABILITIES			
Creditors (amounts falling due within one year)	**10**	(2,613,858)	(2,478,523)
NET CURRENT ASSETS		5,582,011	5,339,815
TOTAL ASSETS LESS CURRENT LIABILITIES		5,977,996	5,686,610
Creditors (amounts falling due after more than one year)	**11**	(16,820)	(35,352)
		5,961,176	5,651,258
FINANCED BY			
Accumulated Revenue Surplus	**14**	5,961,176	5,651,258
Members' Funds	**16**	5,961,176	5,651,258

The notes on pages xiii to xxi form part of these financial statements.

The financial statements were approved and authorised for issue by the management committee on the 23/02/2012 and signed on its behalf by:

President
DR RONAN BOLAND

Treasurer
DR TREVOR DUFFY

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Consolidated Balance Sheet as at 31 December 2011

	Notes	2011	2010
		€	€
FIXED ASSETS			
Tangible Assets	**6**	8,167,626	8,310,459
Deposit with the Court of Justice	**8**	10,640	10,551
		8,178,266	8,321,010
FINANCIAL ASSETS			
Investments	**7**	355,735	402,764
		8,534,001	8,723,774
CURRENT ASSETS			
Debtors	**9**	581,167	346,904
Cash & Bank Balances		5,964,588	5,926,147
		6,545,755	6,273,051
CURRENT LIABILITIES			
Creditors (amounts falling due within one year)	**10**	(3,186,035)	(3,020,766)
NET CURRENT ASSETS		3,359,720	3,252,285
TOTAL ASSETS LESS CURRENT LIABILITIES		11,893,721	11,976,059
Creditors (amounts falling due after more than one year)	**11**	(1,107,408)	(1,836,072)
		10,786,313	10,139,987
FINANCED BY			
Accumulated Revenue Surplus	**14**	9,464,934	8,817,693
Revaluation Reserve	**15**	1,321,379	1,322,294
Members' Funds		10,786,313	10,139,987

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Cashflow Statement for the Year Ended 31 December 2011

	Notes	31 December 2011		31 December 2010	
		€	€	€	€
Reconciliation of Operating Profit to Net Cash (Outflow)/ Inflow from Operating Activities					
Operating profit			327,360		632,328
Depreciation on tangible assets			260,473		94,526
(Profit)/Loss on disposal of tangible assets			(15,679)		8,927
(Increase)/Decrease in debtors			(597,287)		(345,208)
(Decrease)/Increase in creditors within one year			(201,814)		(96,308)
Net cash (outflow)/inflow from operating activities			(226,947)		294,267
Taxation			(20,008)		–
Capital expenditure and financial investment					
Payments to acquire tangible assets		(165,873)		(35,847)	
Receipts from sales of tangible assets		24,675		41,331	
Net cash (outflow) for capital expenditure			(141,198)		5,484
Net cash inflow/(outflow) before management of liquid resources and financing			(388,153)		299,751
Financing					
Increase/(Decrease) in Capital element of finance lease contracts			5,168		20,521
	1		(382,985)		320,272

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Notes to the Cashflow Statement for the Year Ended 31 December 2011

1 Analysis of Net Funds

	1 January 2011	Cashflow	Other non cash changes	31 December 2011
	€	€	€	€
Net Cash:				
Cash at bank in and hand	2,810,883	(382,985)	0	2,427,987
Bank overdrafts	0	0	0	
	2,810,883	(382,985)	0	2,427,987

IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Accounting Policies

The significant accounting policies adopted by the organisation were as follows:

A. Basis of Accounting

The financial statements have been prepared in accordance with the historical cost convention and financial reporting standards as prescribed by the Accounting Standards Board of Ireland and the United Kingdom as modified by the revaluation of certain fixed assets.

B. Subscriptions Received

Subscriptions received in the income and expenditure account refer to subscriptions received for that year.

C. Depreciation of Tangible Fixed Assets

Depreciation is calculated to write off the original cost less the expected residual value of the assets over their expected useful lives at the following annual rates:

Motor Vehicles	20% Straight Line
Fixtures and Fittings	10% Straight Line
Office Equipment	20% Straight Line

D. Leased Assets

The cost of fixed assets acquired under finance leases are included in fixed assets and written off over the term of the estimated useful life of those assets, while the capital portion of the outstanding lease obligations is included in creditors. The interest portion is written off to the profit and loss account over the term of the primary lease period.

E. Taxation

Taxation is calculated on non-subscription income.

F. Financial Assets

Financial Assets are stated at cost or valuation. Provisions are made for financial assets which have suffered a permanent diminution in value.

G. Pensions

The organisation operates a defined contribution scheme. Payments are made to a pension trust, which is a separate legal entity from the organisation.

H. Deferred taxation

Deferred taxation is provided at appropriate rates on all timing differences using the liability method only to the extent that, in the opinion of the directors, there is a reasonable probability that a liability or asset will crystallise in the foreseeable future.

Notes to the Financial Statements for the Year Ended 31 December 2011

	2011	2010
	€	€
1. Income		
Membership Subscriptions	3,614,452	4,438,246

	2011	2010
2. Analysis of Members	No's	No's
General Practitioners	1,959	2,034
Consultants	705	754
Public Health Specialists	122	142
Community Health	51	70
Non Consultant Hospital Doctors	2,121	2,670
Other	33	36
Student	348	437
	5,339	6,143

	2011	2010
3. Other Income	€	€
Rental Income	183,550	191,803
Publishing Royalties	15,324	15,000
Bank Interest Earned	19,430	21,213
Other	4,893	3,308
	223,197	231,324

Notes to the Financial Statements for the Year Ended 31 December 2011

4. Surplus for the Year	2011 €	2010 €
Surplus for the year is stated after charging:		
Auditors' Remuneration	18,150	18,150
Depreciation	260,473	260,526
Loss/(Profit) on disposal of assets	(15,679)	8,927

5. Taxation	2011 €	2010 €
Current Year Charge	17,443	20,098

Notes to the Financial Statements for the Year Ended 31 December 2011

6. Tangible Assets – IMO

	Office Equipment	Fixtures & Fittings	Motor Vehicles	Total
	€	€	€	€
Cost:				
At 1 January 2011	164,141	94,666	262,608	521,415
Additions	21,432	4,766	139,675	165,873
Disposals	–	–	(162,888)	(162,888)
At 31 December 2011	185,573	99,432	239,395	524,400
Depreciation:				
At 1 January 2011	103,375	19,983	153,195	276,553
Charge for Year	31,678	10,084	66,194	107,956
Disposals	–	–	(153,892)	(153,892)
At 31 December 2011	135,053	30,067	65,497	230,617
Net book value at 31 December 2011	50,520	69,365	173,898	293,783
Net book value at 31 December 2010	60,766	74,683	109,413	244,682

Included in the above at the balance sheet date were assets held under finance leases and hire purchase agreements as follows:

	2011	2010
	€	€
Net book value		
Motor Vehicles	33,328	109,413
Office Equipment	1,907	3,051
	35,235	112,464

Depreciation charged to the Income and Expenditure Account in relation to the above was:

Motor Vehicles	16,371	56,767
Office Equipment	1,144	1,144

Notes to the Financial Statements for the Year Ended 31 December 2011

6. Tangible Assets – Consolidated

	Property	Office Equipment	Fixtures & Fittings	Motor Vehicles	Total
	€	€	€	€	€
Cost:/Valuation					
At 1 January 2011	8,300,000	369,994	100,131	351,280	9,121,405
Additions	–	22,683	4,766	163,975	191,424
Disposals	–	–	–	(206,516)	(206,516)
At 31 December 2011	8,300,000	392,677	104,897	308,739	9,106,313
Depreciation:					
At 1 January 2011	332,000	240,070	48,659	190,216	810,945
Charge for Year	166,702	33,053	35,137	77,804	312,696
Disposals	–	–	–	(184,954)	(184,954)
At 31 December 2011	498,702	273,123	83,796	83,066	938,687
Net book value at 31 December 2011	7,801,298	119,554	21,101	225,673	8,167,626
Net book value at 31 December 2010	7,968,000	129,923	51,472	161,064	8,310,459

Included in the above at the balance sheet date were assets held under finance leases and hire purchase agreements as follows:

Net book value	2011 €	2010 €
Motor Vehicles	85,103	160,889
Office Equipment	1,907	3,051
	87,010	163,940
Depreciation charged to the Income and Expenditure Account in relation to the above was:		
Motor Vehicles	30,136	75,623
Office Equipment	1,144	1,144

Notes to the Financial Statements for the Year Ended 31 December 2011

7. Investments

	2011	2010
	€	€
Company		
Shares in Fitzserv Consultants Limited	1,283	1,283
Other Investments at Cost	90,279	90,279
	91,562	91,562

	2011	2010
	€	€
Consolidated		
Listed Investments at Market Value	243,035	237,145
Unlisted investments at Market value	22,421	75,340
	265,456	312,485
Other Investments at Cost	90,279	90,279
	355,735	402,764

Irish Medical Association (Limited By Guarantee):

The Balance sheet of IMA Limited indicated Net Assets as at 31 December 2011 of €1,291,462 (2010: €1,296,189)'

Fitzserv Consultants Limited at Valuation:

The Balance sheet of Fitzserv Consultants Limited indicated Net Assets as at 31 December 2011 of €3,534,958 (2010: €3,193,823)

8. Deposit with The Court of Justice

The deposit with the Court of Justice under the Trade Union Act, 1941 is invested in a fund called the BIAM GRU cash fund strategy.

Notes to the Financial Statements for the Year Ended 31 December 2011

9. Debtors	2011 IMO €	2010 IMO €	2011 Consol €	2010 Consol €
Trade debtors	–	–	219,178	309,913
Other debtors	68,544	80,238	118,914	11,701
Prepayments	177,102	25,290	243,075	25,290
Loan to subsidiaries	5,522,236	4,901,927	–	–
	5,767,882	5,007,455	581,167	346,904

10. Creditors (amounts falling due within one year)	2011 IMO €	2010 IMO €	2011 Consol €	2010 Consol €
Creditors and Accruals	2,594,871	2,454,312	3,143,990	2,983,871
Bank overdraft	–	–	12,421	–
Lease and Hire Purchase Finance	18,987	24,211	29,624	36,895
	2,613,858	2,478,523	3,186,035	3,020,766

Notes to the Financial Statements for the Year Ended 31 December 2011

11 Creditors (amounts falling due after more than one year)	2011 IMO €	2010 IMO €	2011 Consol €	2010 Consol €
Bank loans	–	–	1,087,977	1,787,977
Lease and Hire Purchase Finance	16,820	35,352	19,431	48,096
	16,820	35,352	1,107,408	1,836,073

Analysis of Leases and Hire Purchase	IMO 2011 €	IMO 2010 €	Consol 2011 €	Consol 2010 €
Wholly repayable within five years	35,807	59,564	49,055	84,992
Included in current liabilities	(18,987)	(24,212)	(29,624)	(36,896)
	16,820	35,352	19,431	48,096

Lease and Hire Purchase maturity analysis				
In more than one year but not more than two years	16,820	19,025	19,431	28,269
In more than two years but not more than five years	–	16,327	–	19,827
	16,820	35,352	19,431	48,096

Bank loans are secured by mortgages over 10 & 11, Fitzwilliam Place and a solicitor's letter of undertaking in respect of 11 Fitzwilliam Place.

12. Staff Pension Scheme

The organisation currently operates a defined contribution pension scheme in respect of its employees. The assets of the scheme are held separately from those of the organisation in an independently administered fund. Contributions within the year amounted to €266,239 of which nil was unpaid at the year-end.

Notes to the Financial Statements for the Year Ended 31 December 2011

13. Staff Numbers and Costs

The average number of persons employed by the organisation during the year was as follows:	2011 No's	2010 No's
Total Employees	24	21
Analysed as follows:		
Administration	24	21

The aggregate payroll costs of these persons were as follows:

	2011 €	2010 €
Wages and Salaries	1,582,812	1,783,014
Social Welfare Costs	152,399	168,874
Other Pension Costs	428,810	234,817
	2,164,021	2,186,705

14. Movement on Revenue Reserves

	2011 €	2010 €
IMO		
Reserve at start of year	5,651,258	5,039,028
Retained profits for year	309,918	612,230
Reserve at end of year	5,961,176	5,651,258
Consolidated		
IMO	5,961,176	5,651,258
Irish Medical Association (Limited by guarantee)	(29,916)	(26,105)
Fitzserv Consultants Limited t/a IMOFS	3,533,675	3,192,540
	9,464,934	8,817,693

15. Revaluation reserve – Consolidated

	2011 €	2010 €
Reserve at start of year	1,322,294	1,329,423
Revaluation during year	(915)	(7,129)
Reserve at end of year	1,321,379	1,322,294

This relates to the revaluation of the property at No 10/11 Fitzwilliam Place, Dublin 2 and listed investments owned by The Irish Medical Association Limited. The property was valued in January 2009.

Notes to the Financial Statements for the Year Ended 31 December 2011

16. Reconciliation of Movement in Members' Funds – IMO	2011	2010
	€	€
Surplus After Tax For The Year	309,917	612,230
Net Addition to Members' Funds	309,917	612,230
Members' Funds at Start of Year	5,651,258	5,039,028
Members' Funds at End of Year	5,961,175	5,651,258

17. Related Party Transaction

Under the agreement relating to the terms of occupancy of number 10/11 Fitzwilliam Place, Dublin 2, all charges including depreciation relating to the properties, which are owned by the Irish Medical Association Ltd are borne by the Irish Medical Organisation. The charge for depreciation in 2011 was €166,466 (2010: €166,238) and the loan interest charge was €25,316 (2010: €27,702). The Irish Medical Association (a company limited by guarantee) is an associated company of the Irish Medical Organisation.

Rent receivable in 2011 included amounts of €125,000 (2010: €125,000) from Fitzserv Consultants Limited. Fitzserv Consultants Limited is 100% owned subsidiary of the Irish Medical Organisation.

18. Comparative Figures

Where necessary comparative figures have been regrouped on a basis consistent with the current year.

19. Approval of the Financial Statements

The financial statements were approved by the Management Committee on the 23/02/2012

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Management Information for the Year Ended 31 December 2011

(This information does not form part of the audited financial statements)

SCHEDULE 1

	2011	2010
Publishing Contribution	**€**	**€**
Income	122,207	133,654
Printing and Editorial Costs	(68,254)	(59,226)
Wages	(32,458)	(32,448)
Postage and Stationery	(30,789)	(33,636)
Publishing Contribution	(9,294)	8,344

(This page does not form part of the audited financial statements.)

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Management Information for the Year Ended 31 December 2011

SCHEDULE 2

	2011	2010
Expenditure	**€**	**€**
Wages, Salaries and Pension Costs	2,164,021	2,186,705
Insurance	14,007	13,522
Telephone	34,769	32,014
Light and Heat	25,495	20,693
Postage, Printing and Stationery	107,513	146,186
Advertising and Promotional Activities	5,433	7,607
Finance Lease Charges	4,781	6,866
Motor, Travel and Branch Meeting Expenses	161,273	182,211
Corporate Events	111,221	111,166
Professional Fees	40,117	43,004
International Affairs	80,863	99,047
Subscriptions and Donations	39,690	43,943
Legal fees	115,393	512,549
Repairs and Renewals	57,453	54,520
Audit and Accountancy Fees	41,765	44,911
Rates	25,900	27,000
Bank Interest and Charges	9,760	10,016
Staff Training and Development	650	1,237
Computerisation and Website Development	127,088	132,634
Depreciation	260,473	260,526
Profit on disposal of Fixed Assets	(15,679)	8,927
Loan Interest	25,316	27,702
Strategic Planning	63,692	72,600
	3,500,994	4,045,586

(This page does not form part of the audited financial statements.)

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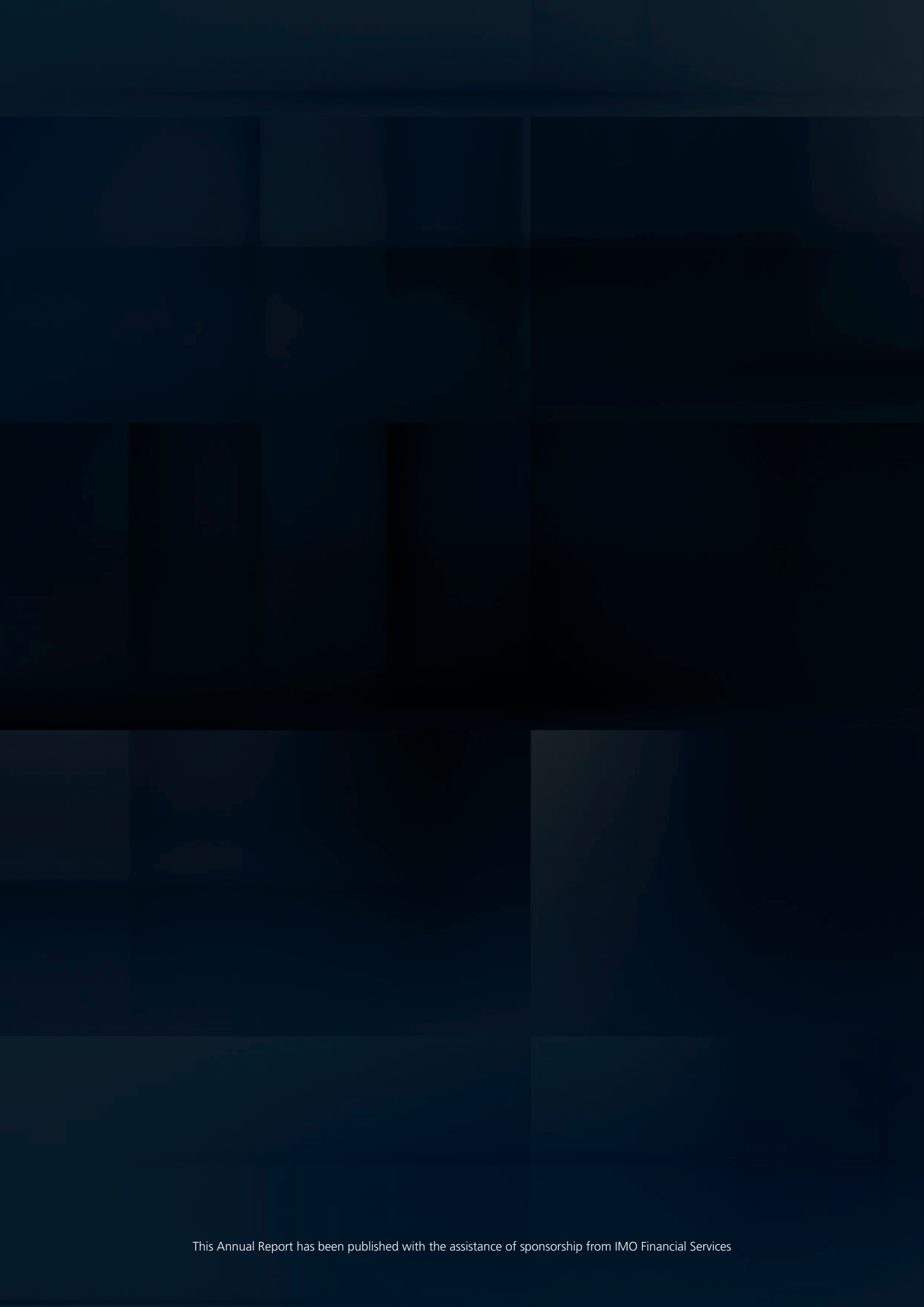

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IRISH MEDICAL ORGANISATION
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