IRISH MEDICAL ORGANISATION
Ceardchumann Dochtúirí na hÉireann

Irish Medical Organisation

Annual Report 2025

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.

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This Annual Report is published with the support of IMO Financial Services.

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Council and Executive Board Members

IMO Council
2025/2026

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President

Prof Matthew Sadlier
Vice President

Dr Ina Kelly
Treasurer

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Honorory Secretary

Dr Megan Connolly Bree

Dr Austin Byrne

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Prof Ronan Collins

Dr Tadhg Crowley

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Dr Peadar Gilligan

Dr Trish Horgan

Dr Eoin Kelly

Dr John MacFarlane

Dr Denis McCauley

Dr Padraig McGarry

Dr Darragh McKeon

Dr Rachel McNamara

Dr Mick Molloy

Dr Madeleine Ní Dhálaigh

Dr Sorcha Ní Loingsigh

Dr Brian O'Doherty

Prof Nash Patil

Executive Board
2025/2026

Dr Padraig McGarry
Chair

Dr Ina Kelly
Treasurer

Prof Tadhg Crowley

Dr Madeleine Ní Dhálaigh

Dr Rachel McNamara

Dr Laura Finnegan

Prof Matthew Sadlier

Dr Gerard Markey

Dr Mai Mannix

Dr Íde Nic Dhonncha

Mr Ronan Nolan
Non Exec Director

Mr Niall Saul
Non Exec Director

President's Report

It gives me great pleasure to present to members the 2025 Annual Report of the Irish Medical Organisation.

Dr Anne Dee
President

The role of the IMO as a Trade Union is to represent our members across all contractual and work related issues and to advocate for improvements in our health services to enable our members to provide high quality and timely care for patients. This Annual Report outlines the very significant work undertaken by the IMO in fulfilling our commitment to you, your colleagues and your patients.

The beginning of 2025 was dominated by discussion on Government formation during which the IMO made clear that health must be a central pillar of any Programme for Government. As political priorities were being thrashed out, doctors across our acute hospitals and general practice were once again struggling to manage the entirely predictable demand associated with the flu. Unfortunately, the Programme for Government failed to set out clear commitments in terms of funding and implementation timelines to address the key issues for our public health services.

Rather than addressing the persistent challenges of inadequate bed capacity and unsafe hospital occupancy rates, political attention shifted towards consultants working patterns as the reason for trolley numbers, discharge rates and waiting lists. Ignoring the root of the problems that beset our health services:

- Significant deficits in beds and infrastructure where our acute services are operating at dangerous and unsustainable levels of occupancy and demand
- Insufficient medical workforce and an absence of a fully funded medical workforce plan that is designed to meet the needs of a growing and ageing population.

Overcrowding in our Emergency Departments is directly linked to insufficient bed capacity and we made this point strongly in the context of our engagement with HIQA on a review of capacity in the Mid West. We welcomed the HIQA Report which also cited the severe deficit in bed capacity as being the root of the problem.

During 2025 there was significant discussion around extending our health service provision over seven days. The IMO is clear that it does not oppose the extension of service provision across a longer working week within our health services. However, this must be delivered through a whole system approach, supported by staffing levels to sustain care safely over extended hours and additional days. Without this, there is a significant risk that services will be displaced rather than expanded, with existing capacity diminished on other days as resources are stretched to cover additional commitments. It is simply untrue to suggest that rostering alone will solve the trolley crisis and long patient delays. For the Government to suggest that productivity and rostering measures will be the solution is disingenuous – productivity in healthcare is about more than numbers of patients seen; it is about delivering quality healthcare and improving health outcomes.

Unfortunately, the Government Budget for 2026 once again failed to plan for a future health service that is capable of meeting the needs of a growing and ageing population. Talk of record health budgets is nothing more than a smokescreen masking the real problems around capacity and workforce deficits.

In the absence of a comprehensive and fully funded medical workforce plan our NCHDs continue to be exploited by a system that demands unsafe 24-hour shifts, illegal working hours and a contract that does not meet their training needs or work life balance requirements.

Dr Íde Nic Dhonncha, Professor Matthew Sadlier, Dr Anne Dee, Prof Tadhg Crowley, Dr Rachel McNamara

The new NCHD contract talks ground to a halt mid year as the HSE failed to engage in any meaningful way – at the same time our NCHDs continued to endure high levels of burnout and stress so it is no wonder that emigration patterns continue to increase with significant numbers not returning. The IMO is committed to supporting our NCHDs and at the time of writing this report I am pleased to say that we have been successful in securing a resumption of negotiations on a new contract. In October 2025 our NCHD Committee ran a very successful NCHD meeting – *Beyond the Bleep* which covered a wide range of topics more of which can be seen In the NCHD section of this report.

Our GPs still await the long promised Strategic Review by the Department of Health and our national GP Committee is ready to negotiate a fit for purpose modern GP contract. While we acknowledge and welcome the fact that more GP training places have been made available in recent years, this has not been matched with supports for existing practices to take on more GPs and expand the GP Team, nor are there supports for new GPs who wish to establish *de novo*. The physical footprint of general practice needs to be extended if we are to cope with the demand of an increasing population. This report highlights the work of the National GP Committee in identifying the key issues and solutions for General Practice.

For our public and community health doctors we are pursuing a pay claim under local bargaining which we hope will be a first step in recognising the skill of the workforce and in righting the wrong of not paying the 2008 pay award. The committee are working on a vision for the service which they hope will be supported by appropriate remuneration that recognises the vital work undertaken by PMOs and SMOs which for too long has gone unrecognised.

For many members the most valuable aspect of IMO membership is the expert and personal service provided to doctors experiencing difficulty in securing their contractual entitlements or who are experiencing workplace issues. During 2025 our Member Advisory Team dealt with over 10,000 issues for our members. It is an indictment of our health services that so many doctors need our assistance in securing their contractual rights as contracts are mis-interpreted by employers across multiple sites.

A key part of the work of the IMO is our activities around policy and advocacy and our AGM is a key event to enable us to debate issues at our national meetings, engage in policy formation and hear from experts on a range of topical issues. Our 2025 AGM focused on;

- The Social and Commercial Drivers of Health Inequality.
- The Malign Force of Pornography in Fuelling Sexual and Gender Based Violence.
- Confronting the Care Deficit for Patients with Severe and Enduring Mental Illness.

Throughout the year, our key policy initiative was around highlighting the growing inequality in health and our health services. In the context of our Budget Submission, we called on Government to establish an intergovernmental group, which would be tasked with developing multiagency programmes to reduce the levels of inequality. It is critically important to address the fact that people from deprived areas have far worse health outcomes than those from affluent areas, a chronic problem driven by a range of social and economic factors and which is exacerbated by access to healthcare. In November 2025, the IMO hosted a major conference in Limerick - Health on the Margins- where a range of expert speakers spoke to the fact that more than ever before an Irish person's health outcomes were largely dictated by their housing quality, educational and work opportunities, and their lived environment. A full report of the AGM and the *Health on the Margins* conference is contained within this annual report.

We also focused on the negative health impacts, particularly for our children, of social media use and the dangerous algorithms implemented by social media companies to drive usage. Throughout the year the IMO has campaigned for the banning of social media for under 16s and has called on Government to legislate to avoid further harm to our children.

The conflict in Gaza has never been far from our minds and we stand in solidarity with our healthcare colleagues who struggle daily to deliver healthcare in the most appalling circumstances. In addition to issuing media statements on the issue, the IMO debated matters relating to Gaza at our AGM and we worked with our European colleagues in CPME, UEMO and WMA on statements calling for Israel to abide by international law, cease targeting the civilian population and lift the blockade on humanitarian aid.

We also wrote to An Taoiseach expressing our grave concerns for the people of Gaza who are living in constant fear and facing starvation. In our Budget Submission we urged the Government to set aside funds to support the reconstruction of the health service for the population of Gaza and to expand the funding of the International Medical Graduate Training Initiative (IMGTI) to allow doctors from Palestine to access training in Ireland. In addition, the IMO donated €5,000 to a cross union fund to support families of children from Gaza who had been brought to Ireland for medical treatment. The IMO also commissioned a banner for use by its members at marches – NO WAR ON HEALTHCARE.

Finally I want to acknowledge and thank the members of the IMO Secretariat who have shown incredible commitment to working on our behalf in the pursuance of our objectives. I also want to pay tribute to the work of my colleagues on IMO Council, IMO Executive Board and IMO National Committees who give unstintingly of their time representing and working for colleagues. Most importantly I extend my heartfelt thanks to you, the members, who continue to support the important work of the IMO.

Dr Anne Dee
President

1 Consultants

Prof Matthew Sadlier
Chair

Consultant Committee **2025/2026**

Prof Matthew Sadlier - *Chair*

Dr Caroline Baily

Prof Rónán Collins

Dr Lisa Cunningham

Dr John Duddy

Prof Trevor Duffy

Dr Peadar Gilligan

Dr Eoin Kelly

Dr Clive Kilgallen

Dr John MacFarlane

Dr Gerard Markey

Dr Mick Molloy

Dr Martin Mulroy

Dr Sorcha Ní Loinsigh

Prof Anthony O'Connor

Prof Nash Patil

Dr Aisling Snow

2025 was dominated by the announcement of plans to extend access to health services over an extended working week and implementation of productivity and rostering measures for consultants.

The work of the National Consultant Committee focused on:

- POCC – Rostering and Removal of Private Practice
- Extending Health Services over Seven Days
- Bed Capacity and Consultant workforce numbers
- Representing hospital doctors on the ED Advisory Taskforce
- Submissions to HSE on Physician Assistant Grade
- Submission to HIQA on Delivery of Urgent and Emergency Services in the Mid West
- Submissions on Mental Health Act

Consultant Contract Issues

Rostering

With increased focus on rostering the IMO has been assisting members in managing proposed changes. While the POCC allows for consultants to be rostered 8am to 10pm Mon – Fri and 8am – 6pm Saturday, to ensure safe and sustainable rostering the IMO position is that all rosters must be designed within the framework of the agreed Rostering Principles.

The IMO and other health unions engaged in lengthy negotiations with the HSE and at the insistence of the IMO specific clauses were included within the HSE Extended Working Week (Circular 009/2025) to prevent rostering changes that exceeded existing contractual arrangements. The IMO ensured that any rostering arrangements can only be in line with existing contractual arrangements. The circular does not change your current contractual arrangements and this is specifically stated within the circular:

- For consultants on POCC, any rostering of 37 hours is 5/6 Monday – Saturday (Between 8am and 10pm Monday to Friday and 8am-6pm Saturday both extendable to midnight by agreement) and must be in line with the Rostering Principles and with a three month notice period to change of workplan. Outside of call, the POCC23 contract does not provide for Sunday working, and where your employer requests you to work Sunday, this is voluntary and is payable at Sunday premium (i.e. double time).
- For consultants on 2008 contract rostering is in line with contract provisions and the specific criteria associated with the LRC Agreement of 2012 as they apply to weekend rostering. Outside of your normal 37 hours premium payments apply.

The National Consultant Meeting of the IMO discussed the issue of weekend rostering and called for a full review into the feasibility of increased rostering of consultants at the weekends given the current deficits in the consultant workforce and further called for the review to examine the consequences of such weekend rostering on weekday services.

POCC and On-Site Private Practice

A critical deadline of 31 December 2025 was set for consultants who transitioned to the POCC on or before the end of 2023. By this date, all on-site private practice in public hospitals for these holders was required to have ceased. The State committed to replacing all lost private insurance revenue however, there is no transparent system to verify that this is happening across the system. The IMO have repeatedly called for such a system to be put in place so as properly assess the impact of this measure and to ensure all income is replaced so as to allow the hospital to continue to provide services in a safe manner.

Other Contractual Issues:

Pay and Numbers Strategy: The IMO continues to engage together with the staff panel of healthcare unions to seek a removal of the pay and numbers strategy and for an appropriate workforce plan with staffing to be determined by need rather than by artificial employment ceilings, arrived at by reference to already inadequate staffing levels.

In 2025, the HSE recruited 6,000 less than their employment ceiling under the pay and numbers strategy. Laborious approval processes and increased reliance on locum work continue to impact on recruitment. The IMO through the National Joint Council and the Staff Panel continue to advocate and demand improvement on behalf of our members, in order that they can work and care for patients in an adequately staffed health service.

Historic Rest Days: The IMO secured an extension allowing consultants to avail of “Historic Rest Days” until 31 December 2025, with the HSE indicating no further extensions would be granted beyond this date.

POCC Innovation Fund: Under the Public Only Consultant Contract there is a provision for the introduction of an innovation fund of €8,000 available to Consultants to seek approval for projects/equipment/research which would be beneficial to the service. The funding can be pooled with colleagues and increased with funding from the Consultants CME allocation. Take up of the innovation fund has increased from the establishment of the fund in 2023 and the IMO held a webinar together with the SPARK office in the HSE to encourage consultants to access this fund and explain further how and when it could be used.

Public Service Pay Agreement and Local Bargaining

The IMO is the trade union representing the medical profession on the Public Services Committee (the body which negotiates public service pay agreements)..

Under the Public Service Agreement 2024 – 2026, the following pay increases were applied in 2025. These were as follows:

- 2% increase in March 2025
- 1% increase in August 2025

There were some delays in the implementation of these increases, depending on location. The IMO followed up on these and ensured all payments were backdated to the applicable dates above. The percentage increases also apply to the B and C factor payments, which cover on-call responsibilities, and build further on the 2024 public service pay agreement increases of 4.25%.

Local Bargaining

Under the terms of the current public service pay agreement there is a fund corresponding to 1% of the pay bill for additional claims by unions. The IMO has submitted a pay claim under local bargaining for an increase of 1% in the top point of the Public Only Consultant Contract. The Consultant Committee considered such claim to be of the greatest benefit to the greatest number of members and it would also give a higher base for future increases to start from. If agreed the claim will be backdated to September 2025.

Increasing Access to Health Services Over 7 Days

The IMO supports any increase in access for patients and believes that patients should receive the same treatment no matter what day of the week they present - however, to suggest that this can be achieved by simply rostering consultants at weekends is disingenuous and fails to acknowledge or recognise the very significant on call arrangements currently provided by consultants across seven days.

At the IMO AGM 2025, Prof Matthew Sadlier, Chair of the IMO Consultant Committee chaired a joint meeting of consultants, NCHDs, public and community doctors to discuss the significant challenges to this move and the need for a whole of system approach:

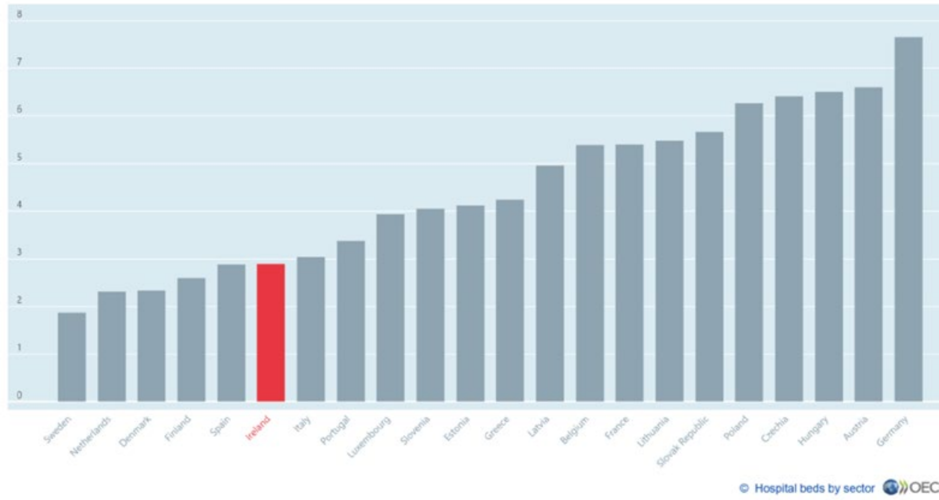
- Within the current workforce numbers, moving consultants to regular weekend rostering will create deficits of consultant on site presence Monday to Friday
- To accommodate safe working hours and rest requirements weekend rostering will require cover for in-patients Mon-Fri who are now not available due to weekend working
- Patients will receive care from multiple consultants during their in-patient stay and may be discharged by unfamiliar consultant teams
- The concept of continuity of care will be negatively impacted
- Consultants will be working without or with reduced full team support

Dr Anne Dee, Dr Lisa Cunningham, Dr John Duddy

System change will require:

- Significant increase in consultant numbers across all the specialties to effectively deliver a 7 day service which allows for safe working arrangements and maintenance of services across each day
- Whole of system change so as to ensure the consultant has access to all hospital services and structures across the seven days
- Review of the impact on continuity of care
- While 65% of consultants had signed up to or have been recruited onto the POCC by June 2025 and are willing to provide enhanced care over weekends, no calculation has been made of the consultant and other staffing requirements across the hospital and wider health system to achieve 7/7 care.

Professor Sadlier said: *"While we recognise the need to extend services to the weekend, the presence of staff on these days will not be enough to alleviate the long delays for patients. We desperately need to see wholescale recruitment of staff and the elimination of the effective recruitment freeze. We also need greater capacity in acute beds so that all patients, once deemed ill enough to be admitted, can be moved to an appropriate bed and treated in the right setting."* He warned that weekend rostering cannot come at the expense of weekday treatment. *"The IMO is not ideologically opposed to extended services, but their introduction cannot be based on robbing Peter to pay Paul where there may be a reduction in services on other days. If the HSE and Government want extended services, they must invest in workforce and capacity and ensure that all services are safe for those working in them and using them."*



Capacity and Medical Workforce Planning

The IMO Pre Budget Submission made key proposals for investment in capacity and medical workforce.

Capacity

Including private beds, Ireland has one of the lowest ratios of hospital beds per 1,000 population in the EU (2.89 per 1,000 population compared to an EU average of 5.10 per 1,000).

Both the *Acute Hospital Bed Capacity Expansion Plan 2024-2031* and the *Programme for Government 2025+* commit to an additional 3,428 acute inpatient beds and 929 replacement acute inpatient beds by 2031. In addition, the Government has committed €9.25 billion to health over the next five years under the Revised National Development Plan however, no details have been provided on the cost and delivery of the new beds, or the additional staff required.

While the proposed 3,428 beds are welcome, they will not meet the projected need. The most recent report from the ESRI estimates that there will be a need for an additional 650 to 950 day patient beds and 4,400 to 6,800 inpatient beds by 2040.

The IMO has repeatedly highlighted that the investment in our acute bed capacity is too little and too slow to meet current and projected patient demand. The year round crisis in our Emergency Departments and unsafe trolley numbers is a direct consequence of this lack of investment.

While supporting surgical hubs we must not lose focus on the number of acute beds required to allow patients receive timely care and ensure hospitals operate at safe capacity levels.

Medical Workforce Planning

There were 4,829 WTE consultants employed by the HSE at end of year 2025, an increase of 228 consultants in the calendar year 2025. While the increase in consultant numbers is welcome, Ireland is still below the OECD average across many specialties. In addition there remain many vacant and temporary filled posts particularly in psychiatry, emergency medicine, medicine and radiology.

Ireland's consultant-to-population ratio remains below that observed in many comparable OECD health systems. In the context of continued population growth and rising demand for healthcare services, this gap places increasing pressure on hospital services and contributes to longer waiting times for care. Addressing consultant workforce capacity is a key component of improving access to services and ensuring the sustainability of healthcare delivery.

Lower consultant posts relative to population need contributes to the main issues that continue to beset our health services:

- increased waiting times for outpatient appointments and elective procedures
- growing waiting lists across several specialties

- higher clinical workload per consultant
- reduced capacity to expand services in response to demand
- increased pressure on emergency and acute hospital services

The IMO has called on Government to:

- Develop a comprehensive medical workforce plan that enables a consultant delivered service and that is aligned with current and projected population demographics. Based on our current population 5,600 consultants are required to ensure a consultant delivered health service.
- Provide multi annual funding for frontloading a rapid expansion of consultant posts and fund increased training places
- Streamline approval and recruitment process for consultants

Physician Associates

The IMO continued to advocate for the position that transfer of tasks from doctors to other healthcare professionals, including Physician Associates, should only take place where there is evidence of improvement to quality of care and never be a substitute for the employment and training of highly trained medical specialists.

Following the IMO's previous engagement with the HSE on this issue where it was agreed that, pending agreement on the scope and role of PAs, all further recruitment to the role would be paused, the HSE engaged Mr Leo Kearns to undertake an independent review of the role of PAs and the IMO met with and submitted to the review group.

The IMO's key points relate to:

- **Definition of Role and Regulation:** The undefined and unregulated scope of practice raises concerns about the potential of PAs to work beyond their training competence and provide unsafe care within a multidisciplinary team.
- **Title:** The title of "Physician Associate" has led to confusion for both patients and medical professionals and PAs are often mistaken for fully qualified doctors. As a result, the role is often expanded beyond what is safe in other jurisdictions.

Dr Mick Molloy and Dr Lisa Cunningham

- **Impact on Medical Training and NCHDs:** Given the current significant deficits in medical workforce numbers, particularly in regard to hospital specialists and GPs, there are already extreme pressures in delivering high quality training to trainees. If training of PAs is to fall to consultants, this will generate additional workload potentially displacing NCHD training opportunities.

Prof Matthew Sadlier speaking to RTE

Mental Health Bill

The IMO engaged with our consultant psychiatrist members around the proposals for the Mental Health Bill 2024.

Oireachtas Committee on Health – Priorities and Concerns in relation to the Mental Health Bill (2024)

The IMO met with Fianna Fail Spokesperson for health , Dr Martin Daly TD and the Oireachtas Joint Committee on Health on our priorities and concerns in relation to the Mental Health Bill (2024) particularly the criteria for involuntary admission and the procedure for patients who lack decision making capacity and decline treatment.

The IMO highlighted that patients who require voluntary or involuntary admission to a psychiatric unit are among the most ill and vulnerable in our society and require timely and accountable care. While the intention of the Bill is to ensure the protection of patients' rights in relation to autonomy, the provisions which create a dual process for involuntary admission and consent to care, are legally, clinically and logistically impractical and could deny patients with serious mental illness the right to timely and often life-saving medical treatment.

There are already significant workforce deficits and these provisions will place further strain on our already under-resourced mental health services. Based on our current population we need about 760 Consultant Psychiatrists (WTEs). But of 570 approved posts, almost 30% are unfilled or filled on a temporary basis.

Over 400 amendments were discussed at Committee Stage including amendments to closer align the procedure for involuntary admission and treatment. The IMO continues to monitor the legislation as it passes through the Houses of the Oireachtas.

HIQA Review on Services in the Mid West

The IMO made detailed submissions to HIQA in the context of its review of urgent and emergency care in the Mid West. The Report was published in September 2025 and supported the IMO position around acute bed capacity and insufficient consultant posts to meet the needs of patients in the region.

Prof Brendan Kelly and Prof Matthew Sadlier at the Oireachtas Health Committee.

Speaking on the publication of the report Dr Anne Dee, President of the IMO and a public health consultant based in Limerick, said: *"While the IMO welcomes the publication of the HIQA report today, its findings are hugely concerning for patients and the medical workforce working in the region. The serious deficit of beds is at the root of the problem in the mid-west, and a quality, safe service for patients cannot be delivered without these beds as well as the right number of staff."*

She said that University Hospital Limerick (UHL) was operating at a dangerous capacity which was detrimental for staff and patients, adding that the primary goal in the mid-west should be to support staff with the infrastructure they need to deliver safe care, rather than an improvement in productivity.

"Patients in the mid-west have lost trust in the system, and if that trust is to be rebuilt we need to see a clear, resourced plan with targeted supports. In addition to a longer term decision, short term measures to increase capacity must be initiated with supports both in terms of beds and services within the community – we need an immediate short term plan to run alongside a longer term ambition."

2 Non-Consultant Hospital Doctors

Dr Rachel McNamara
Chair

NCHD Committee **2025/2026**

Dr Rachel McNamara - *Chair*

Dr Eoghan Carey

Dr Megan Connelly Bree

Dr Laura Finnegan

Dr Eve Gaffney

Dr Felix Gather

Dr Muhammad Khan

Dr Diane Macilwraith

Dr Sean Maher

Dr Dylan Mannix

Dr Domhnall McGlacken-Byrne

Dr Darragh McKeon

Dr Georgia Merron

Dr Brian O'Mahony

Dr Brian Murphy

Dr Ijeoma Onwuemelie

Dr Richard Prendiville

Dr Joel Rajesh

Dr Thomas Roux

Dr Sophie Van Der Putten

The IMO National NCHD Committee focused on a number of key issues in 2025:

- Progressing NCHD Contract Talks
- Monitoring implementation of entitlements under the IMO NCHD Agreement 2022 and engaging with members to secure contractual rights
- Beyond The Bleep – national NCHD Conference
- Submission of NCHD claims through the local bargaining process as allowed for in the Public Sector Agreement

NCHD Contract Talks

Negotiations on a new NCHD Contract, as provided for in the 2022 agreement, effectively collapsed during 2025 due to the HSE's failure to engage in a constructive and meaningful manner. In response the IMO met with the HSE CEO to raise our concerns, insist that the process be re-established and for the employer to engage in genuine negotiations.

Preliminary work has been undertaken between IMO and HSE officials and we have now confirmed with the HSE the recommencement of formal negotiations in March 2026.

The key issues for the IMO in these negotiations are in the following areas:

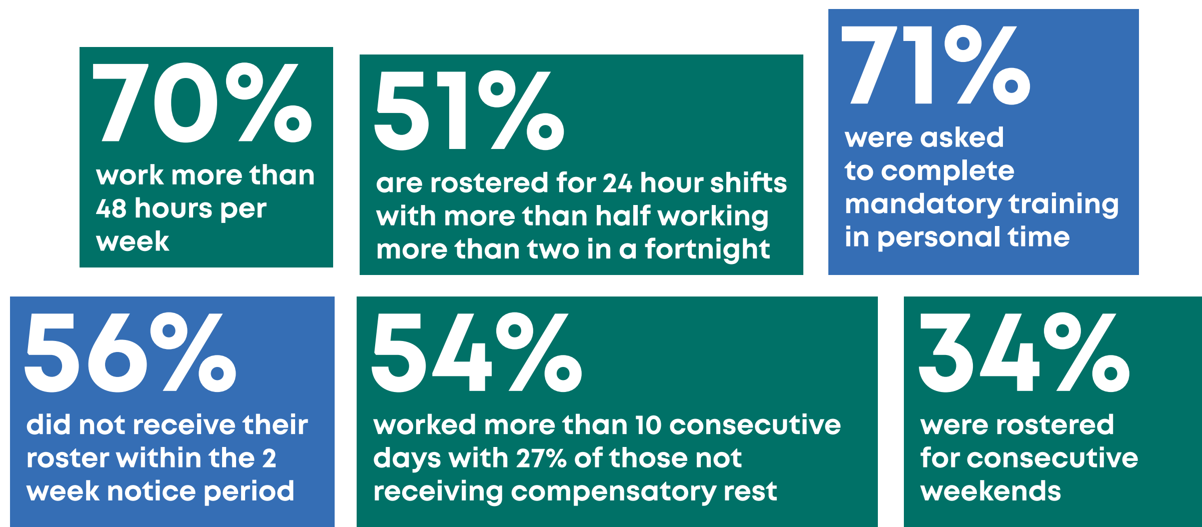
- Safe and legal working hours for NCHDs and compliance with OWTA
- Pay and structure of NCHD pay
- Working hours, patterns and rostering
- Recognition of the HSE being the employer of NCHDs and that NCHDs are not separately employed in each rotation – this is part of addressing emergency tax conjunction with payroll system
- The structure of training for NCHDs, including supports, regionalisation, predictability of rotations, greater access to flexible training and the recommendations from the NCHD Taskforce
- Expansion of the TSS scheme to reflect increasing costs and to allow greater flexibility for trainees

- Greater support for female NCHDs, including issues around maternity leave and the challenges following returning from maternity leave
- Specific challenges for international doctors, including improved induction, relocation and also a route to training for all non-training NCHDs
- Annual leave levels
- The introduction of appropriate safe staffing for NCHDs in all sites, particularly for those working on-call.

Implementation of Entitlements under IMO NCHD 2022 Agreement

Th 2022 IMO NCHD Agreement introduced a number of new entitlements for NCHDs focused on working hours, rostering arrangements and compensatory rest payments. In 2026 the IMO undertook an extensive survey of NCHDs to get a real time picture on the implementation by HSE sites. While acknowledging some progress has been made the results clearly indicate that NCHDs continue to work illegal and unsafe hours and the HSE continue to breach its legal obligations in this regard.

A summary of the results show that:



In response to each reported incident of a breach of NCHD entitlements, whether on an individual or group basis, the team at NCHDs@imo.ie engaged on behalf of members to ensure they received their contractual entitlements.

During 2025 the IMO:

- Resolved multiple site issues around non payment of overtime, compensatory rest, failure to provide rosters, inappropriate rostering, refusals of leave for exams and annual leave, failure to pay relocation expenses, failure to pay for intern induction among many other issues.
- Undertook over 25 hospital site visits and presented at 7 GP Trainee scheme Meetings.
- Attended intern induction and shadow week events where we advised interns of their entitlements and the support available from the IMO.
- Issued over 100 communications to NCHDs to ensure awareness of contractual rights, to advise on updates and to advise of actions the IMO was taking.
- Developed a strong IMO NCHD Lead Network around the country who engage with the team at IMO to raise local issues and organise local site meetings.

Training Support Issues

SPR Training Fund

There was a unilateral announcement of changes to the operation of the fund which allows SPRs, SRs and GP Trainees to claim €500 per annum. There was a proposed limitation on the items which could be claimed and there was no consultation or engagement with the IMO in relation to this. The IMO advised the HSE and NDTP that no changes could be introduced without negotiations and the matter should be addressed in the context of the NCHD Contract Talks. The IMO secured an agreement to reinstate the previous position for the training year 2025/2026 and the IMO position remains that any changes to the fund would need to be negotiated with the IMO.

TSS & Maternity Leave

Under the NCHD contract, NCHDs are entitled to a full 26 weeks of paid leave, even where their contract is expired. During this period, NCHDs are entitled to receive their entitlements including pay, annual leave and accrue incremental credit. Despite this, there was an issue with TSS not being allowed during this period and NCHDs received a lesser entitlement. There was conflicting guidance in TSS documentation. The IMO took up this matter on behalf of our members, and we secured confirmation that NCHDs on paid maternity leave are entitled to TSS.

Public Service Pay Agreement and Local Bargaining

2025 Pay Increases: The IMO, as the trade union representing doctors, is a member of the Public Services Committee (ICTU). Under the current Public Service Pay Agreement NCHDs received two pay increases in 2025. There was a 2% increase as of 1st March and a further 1% as of 1st August.

Local Bargaining: Under the terms of the current Public Service Pay Agreement the IMO are entitled to submit claims on behalf of its members up to 1% of the pay bill for those members. The claims submitted by the IMO under this phase of the process are:

- Reduction in the length of the pay scales for SHOs, SPRs and SRs
- Increase the top point for Registrars
- Move GP Trainees to the SpR rate of pay on a phased basis commencing with 4th years under this claim

Negotiations are ongoing between IMO, HSE and Department of Health on these matters which ultimately require the sanction of the Department of Public Expenditure. It is agreed that all successful claims will be backdated to 1st September 2025.

IMO site visits

‘Beyond The Bleep’ National NCHD Conference

In October the Irish Medical Organisation (IMO) held its first dedicated conference for NCHDs, titled ‘Beyond The Bleep’. The event brought together NCHDs from across the country for a day of discussion on contractual rights, artificial intelligence, and career pathways, with a clear overarching message: advocacy and solidarity remain the cornerstones of progress for the medical workforce.

Session 1: The NCHD Contract

Dr Domhnall McGlacken-Byrne provided a detailed historical overview of NCHD contract negotiations, tracing milestones from the 1997 Memorandum of Agreement through to the 2022 NCHD Agreement. He outlined the key gains secured over the decades, such as rest days, study leave, relocation expenses, the Training Support Scheme, and emergency tax measures, and stressed the importance of showing up and using your voice to shape future outcomes. A lively Q&A followed, with NCHDs raising concerns about payroll issues, centralised employment structures, and the implications of a proposed seven-day service.

Dr Domhnall McGlacken-Byrne

Dr Sean Maher, Ms Aisling Timoney, Dr Sean O’Malley, Ms Naomh McElhatton

Session 2: AI and the Future of Medicine

Aisling Timoney, Senior Legal Counsel at Medisec, opened this session by examining the medico-legal landscape around AI. She outlined tools currently in use, such as administrative automation, clinical decision support, and AI scribes, and noted that while AI scribes can save clinicians 50–60% of their time, studies show that up to 96% of AI-generated transcripts contain errors. She stressed the importance of GDPR compliance, contemporaneous record-keeping, and the reality that the doctor remains ultimately responsible regardless of what the technology does.

Dr Seán O’Malley, a dermatology registrar at St James’s Hospital, offered a clinical perspective on AI’s evolving role. He broke down the core technologies used in hospitals and pointed to real-world applications already in use at the Mater, including X-ray review and cancer detection systems. He warned against clinicians being left out of governance conversations, arguing that involvement must be substantive, not symbolic, and called on all stakeholders to take shared accountability for AI implementation.

Naomh McElhatton, founder of 'Business of AI Club' concluded the session by urging cautious, strategically planned adoption of AI tools. She noted that Ireland lags significantly behind other jurisdictions on digital infrastructure, and that structural modernisation, particularly electronic patient records, must precede any ambitious AI rollout.

Session 3: Taking the Next Step

Dr John Duddy, former IMO President and neurosurgeon, spoke about his non-linear path from computational chemistry to neurosurgery, and the role that mentorship, camaraderie, and the IMO played throughout. He highlighted his involvement in the '24 No More' campaign and encouraged attendees to seek out good mentors and professional networks, reminding them that a surgical career is open to anyone willing to commit to it.

Dr Aideen Brides, GP Partner in Monaghan, described how a conversation with a GP in Helsinki shifted her career trajectory away from infectious diseases and into general practice. She spoke warmly about the unique rewards of rural GP work, such as knowing patients and their families intimately, and fighting for them as a result, while offering a frank overview of the GP training scheme and the realities of partnership and practice ownership.

Dr Anthony O'Connor gave a candid talk on the culture of medicine. He challenged the glorification of the profession, arguing that the system is designed to perpetuate imposter syndrome, and that doctors are too often expected to sacrifice everything in service of an unrealistic ideal. His message was clear: set boundaries, embrace fallibility, and build a job around the life you want, not the other way around.

Pictured: Dr Megan Connolly Bree, Dr Anthony O'Connor, Dr Aideen Brides and Dr John Duddy

Pictured: Dr Rachel McNamara, Dr Anne Dee, Dr Patrick Kelly and Dr Maeve Leonard

Session 4: The Road Less Travelled

Dr Maeve Leonard focused on out-of-programme experience, detailing her work in expedition medicine across Indonesia, Nepal, Mexico, Peru, and South Africa. She offered practical advice on preparation and funding and emphasised that stepping outside the traditional training path builds perspective, clinical adaptability, and resilience in ways that are difficult to replicate otherwise.

Dr Patrick Kelly, the first GP in the Irish Defence Forces, spoke about deployments to Sierra Leone during the Ebola outbreak and to Lebanon. He described the value of working in resource-constrained, high-pressure environments, and closed with a simple principle, if you train hard, the fight will be easy.

Dr Anne Dee, IMO President, reflected on her time working in a leprosy hospital in Nepal. She spoke about the importance of treating the person, not just the condition, and reiterated the day's central theme: there are many ways to have a good life in medicine, but NCHDs must keep fighting to make conditions better for those who come after them.

Closing Reflections

The conference concluded with a message from NCHD Committee Chair Dr Rachel McNamara emphasising the importance of advocacy, solidarity, and sustainable working conditions for NCHDs. The final message was clear: while progress has been made, continued engagement and unity are essential to protect doctors and improve the healthcare system. The conference served as a reminder of the strength of the medical community, and the role of the IMO in shaping the future of healthcare in Ireland.

3 General Practitioners

Prof Tadhg Crowley
Chair

GP Committee **2025/2026**

Prof Tadhg Crowley - *Chair*
Dr Aideen Brides
Dr Austin Byrne
Dr Sumi Dunne
Dr Conor Geaney
Dr Rukshan Goonewardena
Dr Trish Horgan
Dr Michael Kelleher
Dr Niall MacNamara
Dr Denis McCauley
Dr Padraig McGarry
Dr Shane McKeogh
Dr Knut Moe
Dr Amy Morgan
Dr Diarmuid Murray
Dr Madeleine Ní Dhálaigh
Dr Pascal O'Dea
Dr Brian O'Doherty
Dr Maitiú Ó Faoláin
Dr Mike Thompson
Prof Ray Walley

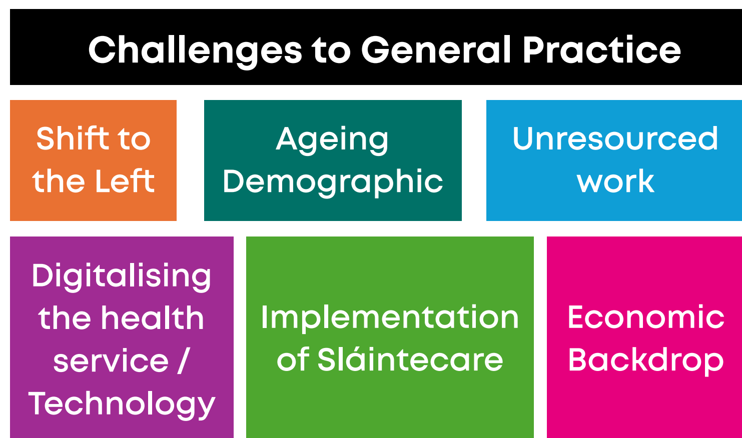
During 2025 the IMO GP Committee focused on strong engagement with members to identify the key challenges that need to be addressed to enable the development of General Practice and inform our position and develop proposals for the Strategic Review of General Practice which is being undertaken by the Department of Health and HSE.

IMO GP Meetings

During October and November of 2025 the IMO carried out GP meetings around the country including North and South Dublin, Kilkenny, Mayo, Sligo, Donegal, Galway, Westmeath, Tipperary, Cavan, Limerick, Kerry, Cork, Waterford and Wexford.

During 2025 the IMO also presented to GPs at Rural GP Meeting, GP Buddy Conference, and the Centric Conference along with presentations to GP Training Schemes.

The meetings focused on looking at the current challenges being experienced by GPs and potential solutions to bring forward to the Strategic Review.



Shift to the Left: The shift from acute services to the community and in particular to GPs, while good practice in terms of system organisation, can only function effectively where the funding, infrastructure and workforce model can accommodate this shift. The basic funding model for General Practice through capitation with add on structured care programmes like CDM and Contraceptive Scheme needs to be re-evaluated to enable this shift to the community so as to allow additional resources on the development of structured programmes, infrastructural supports to expand the physical footprint of General Practice, the expansion of the GP workforce and GP Team. Capacity both in terms of workforce and infrastructure is a significant obstacle currently and must be addressed in the Strategic Review.

Ageing Demographic: While Ireland has one of the youngest populations based in Europe, it is ageing faster than our peers with the over 65 population expected to double by mid century and the over 85 population expected to almost quadruple. The trajectory of Ireland's population has been known and documented for a long time along with the demand on GP services as GP visits and patient complexity rise sharply with age – yet there has been little or no planning for the reality of increased demand. This issue highlights the need to comprehensively plan for increased capacity within General Practice to cope with this demand, expand services like Chronic Disease Management on a universal basis and develop specific structured older persons programmes within General Practice which are sustainable and appropriately resourced.

Unresourced Work: This has become an increasingly problematic issue within General Practice. Additional work/patient follow up requests are coming from the hospital system along with additional best practice or management guidelines which are coming from HSE Clinical Programmes. It is imperative that structured pathways with adequate resources are agreed with IMO as the current practice is exposing the GP to unsustainable risk and cost.

Digitalising the Health Services: The IMO has long called for advancement in E-Health and we are currently engaging with the HSE on the E-Health Agenda as it affects General Practice including e-prescribing, electronic patient record and HSE Patient App. Notwithstanding the benefits of technology we must recognise that it may negatively impact on patient facing time so the key role of the IMO in this process is to ensure systems are designed within the data set parameters agreed, are workable from the GP perspective and neither reduce clinical time or increase administration time. With General Practice operating at capacity currently any additional time spent on new system processes will inevitably decrease the available number of consultations available.

Implementation of Sláintecare: The current Programme for Government commits to expanding GP Care which is free at the point of access to under 12s – outside of that commitment there is no clear plan on the objective of Slaintecare to expand further. In 2023 the IMO agreed with the Department of Health and the HSE to expand care to all Under 8s and to those at or below the median income. At that point we made it very clear that further expansion must take account of the capacity and workforce issues within General Practice. Our objective is to advocate for resources and expansion of care to be reconsidered and focus spending on key areas that will deliver best health outcomes including but not limited to Comprehensive Women's Health programme on a universal basis and the expansion of the Chronic Disease Management Programme on a universal basis. We also need to expand the Social Deprivation programme to combat the growing inequality in provision of healthcare to socially deprived patients and enhance the ability of GP practices to appropriately manage and deliver care to this patient cohort. A key objective of the IMO is to ensure greater risk sharing between the GP and the State as care is expanded to greater cohorts of the population.

Economic Backdrop: The Health Budget for 2026, while increasing in the global number, is in real terms in real terms not increasing sufficiently to allow for growing population, demographic shifts of ageing population and inflationary pressures. The focus of the IMO will be to ensure all new work proposed to shift to general practice is planned and sustainably funded.

Pictured: Dr Padraig McGarry and Prof Tadhg Crowley

The IMO GP Committee await the publication of the Strategic Review and are open to any discussions that will address the challenges identified by the IMO along with the many other issues which impede the development of General Practice however it must be in the context of appropriate ring fenced multi annual funding.

It is important to note that the Strategic Review will require negotiations with the IMO to agree any new contractual arrangements.

E-Health Agenda

Arising from the IMO 2019 GP Agreement we are engaged in discussions on the following. In these discussions the core objective of the IMO is to ensure that new processes are designed in such a way that:

a) Agreed data set is protected

b) Systems and processes are designed to improve efficiency not add to GP admin burden to decrease patient facing time

National Immunisation Integrated System

Under the IMO 2019 GP agreement, provision and development of an integrated immunisation system was agreed between the IMO, HSE and DoH. This has now been developed and from the end of November 2025, the Primary Childhood Immunisation Programme (PCI) is being integrated into the National Immunisation Information System (NIIS), so that, PCI records entered into your accredited GP Practice Management System (PMS) will be electronically transmitted to NIIS.

From 26th November 2025, records for vaccines administered to children born on or after 1st October 2025 and entered into your accredited GP PMS/GPVax will be automatically sent to both NIIS and PCRS, and payments will be processed and paid through PCRS.

This will simplify and streamline the payment process for Primary Childhood Vaccination for GPs. There was an interim transition period during which different arrangements dependent on whether the child was born before or after 1st October 2025 apply and the detail with regard to the new arrangements and transition arrangements were communicated to IMO members during the year.

Shared Care Record

Throughout 2025 the IMO continued to engage with the HSE on the development of the shared care record. We sought and agreed to undertake a data validation exercise with the HSE to examine the data to be uploaded to the Shared Care Record. This is with a view to understanding the likely issues that could arise and to see how the system will operate from the GP perspective. Once that validation is completed and we are satisfied that corrective measures are being incorporated to address any issues that arise we will move on to the next phase. This is a complex area in terms of scoping and development but it is imperative that the end product is workable by GPs and takes account of the day to day reality of GP consultations and business processes.

E-Prescribing

The IMO continue to have regular engagement with the HSE e-Prescribing team. While a form of ePrescribing is currently undertaken, insofar

as GPs email prescriptions through Healthmail to the relevant pharmacy, the full e-Prescribing solution is envisaged to allow a prescription to be uploaded to the cloud and will allow full sight of the list of medications over a period of, for example, six months. The project is currently going through the tender and procurement process and it is expected that it will be 2027 before a new system is in place.

HSE Patient App

The IMO are engaging with the HSE in relation to the development of the HSE Patient App. The IMO sought and received written assurances from the HSE that GPs are not obliged to interact with the app, it will not form part of an GP/Patient consultation, nor will it be used as a communication tool between GP and the patient or between GP and other HSE systems/sectors. The IMO aim is to minimise any workload attaching to this development and ensure that it works in a manner which does not place an additional burden on GPs and also allows them to have clarity and notice around which areas of the PMS data would be taken from. Different phases of the App were launched in 2025 and it is envisaged that when the app is finalised there will be information similar to what is in the shared care record available to the patient.

Chronic Disease Management

97% of GPs deliver the Chronic Disease Programme and it's introduction in 2019 has proven the value of structured care programmes in the GP setting;

- The CDM programme has reached over 400,000 patients
- 91% of patients now receiving CDM care in GP setting, reducing their reliance on hospitals
- Patients on the programme have 30% fewer ED attendances, 26% fewer hospital admissions, and 33% fewer GP out-of-hours visits

In 2025 the HSE approached the IMO to discuss their proposal to add Chronic Kidney Disease to the CDM programme. Those discussions have yet to conclude as the IMO work through the clinical, operational and funding issues with the proposed programme addition.

The IMO have sought, in the context of these discussions, to consider other diseases or areas that may be added to CDM or another structured care programme over time.

Given the success of the whole CDM Programme, the IMO position is that these should be phased in and resourced on a universal basis so as to reduce hospital presentations and deliver better health outcomes for all patients in the cohort – public and private.

Winter Surge Clinics

The IMO reached agreement with the HSE on supports to enable GPs provide additional surge clinics/consultations outside of normal surgery hours. Participating GPs were required to provide 20 additional clinical hours which could be delivered weekly in 1 or 2 hour slots before or after normal surgery hours. Additionally participating GP practices could engage in providing opportunistic consultations on any other day during the period 9th December 2025 to 15th February 2026.

Funding arrangements were:

€2,500 for each GMS GP in practice (€3,000 for single handed GPs)

€41.63 STC OOH claim for each GMS consultation

International Medical Graduate Scheme

The IMO have reached agreement with the HSE on a support grant of €12,000 per annum for practices hosting IMG doctors. With regards to the GP practices who have hosted an IMG candidate who has now completed the programme, (prior to December 2025) a €12,000 contribution will be provided to these practices. The support grant can be used for:

- Medical Indemnity for the IMG GP
- Critical Skills Employment Permit (CSEP) application fee
- UCD online courses: GP Mentorship Part 1
- GP Mentorship Part 2
- Paid study leave of calendar weeks per year**, plus 4 days induction Pro-rata** for preparation of MICGP exams only
- Membership of medical organisations (including IMO)

Social Deprivation Grant

The HSE introduced a new system for the allocation of the Social Deprivation Grant to replace the temporary arrangement that was agreed in 2019. The new system uses recognised indices of deprivation, together with PCRS data and geo location which attaches an individual deprivation weighting to each GMS patient. The Pobal HP Deprivation Index uses Census data, analysing ten measures of an area's levels of disadvantage. These include educational attainment, employment status and the numbers living in individual households.

Each GMS list is then ranked according to this system with the lists with the greatest amount of deprivation receiving the grant. The system is devised by Public Health Consultants in the HSE Health Intelligence Unit and automatically identifies those lists with the greatest levels of patients living in deprivation.

The amounts available per GMS list (limited to a maximum of two per practice) have been increased to up to €35,000 and €40,000. While this has meant a decrease in the number of practices in receipt of the grant, it is a more meaningful amount which should give greater ability to deliver specific supports for patients in deprived areas.

National GP Meeting AGM 2025

The IMO National GP meeting took place at our AGM where a wide range of topics were debated including presentations on a Women's Health Programme in General Practice by Dr Aideen Brides and a presentation on an Obesity Programme in General Practice by Dr Austin Byrne. Prof Crowley addressed the meeting on the dangers of unresourced work in General Practice and there was unanimous approval for the IMO position that all new work must be negotiated with appropriate funding attaching. At a Q&A session with HSE CEO Bernard Gloster, GP Committee members raised issues around the huge difficulties being experienced by GPs seeking appropriate CAMHS services for their patients and the HSE Clinical Programmes whereby new guidelines, pathways and advices are issued to GPs without resources.

4 Public and Community Health

Dr Íde Nic Dhonncha
Chair

Public and Community Health Committee **2025/2026**

Dr Íde Nic Dhonncha - *Chair*

Dr Helena Allen

Dr Gillian Chambers

Dr Catherine Colohan

Dr Niall Conroy

Dr Anne Dee

Dr Claire Dunne

Dr Darina Fahey

Dr Phil Fitzgerald

Dr Sieneke Hakvoort

Dr Liam Holland

Dr Barbara Hynes

Dr Ina Kelly

Dr Eileen Kiely

Dr Mai Mannix

Dr Lois O'Connor

Dr Mary T O'Mahoney

Dr Máire O'Neill

Dr Alice Quinn

In 2025 the IMO Public & Community Health Committee had a number of issues to deal with.

The committee meet as a collective group once a month to work through outstanding issues for the craft group and in 2025 these issues included:

SMO/SAMO/PMO Pay Claim

Under the current Public Sector Pay Agreement and the local bargaining clause, the IMO have submitted a claim for a 15% pay increase for the above grades.

The pay claim will apply to all paid under these grades, whether in public or community health.

Members will be aware that in 2024, the IMO were able to settle the longstanding claim for equality between Area Medical Officers and Senior Medical Officers following a Labour Court case arising from the sectoral bargaining clause in the previous public sector pay agreement.

In addition the IMO secured an increase of 83% in the CME allowance for AMO/SMO/PMO pay grades to €2,750 from the previous €1,500.

The committee hope now to build on this success and have lodged the 15% pay claim under the local bargaining clause.

The claim if successful will be backdated to September 2025 and the committee have undertaken significant work in preparing this claim.

Public Health Reform Agreement

The landmark 2021 agreement reached by the IMO on establishing the role of Consultant in Public Health Medicine has now seen the full complement of Consultant posts established an in post. In total this is 86 consultant posts.

The IMO have met on a monthly basis since 2021, firstly with the project management team for Public Health Reform and thereafter with the National Director of Public Health's office to progress and monitor compliance with the agreement and the recruitment to these posts.

For many years Specialists in Public Health Medicine, despite having the same specialist training as other consultants and being on the specialist register were not seen as the equal of their hospital based colleagues. That has now been rectified and while an important achievement, the agreement should only be seen as a first step for Public Health Medicine and continued increases in staffing and resources will be required into the future.

One of the issues that remains outstanding and was unable to be agreed in the context of the original agreement is the provision of clinical director allowances for leadership positions in Public Health. Under the agreement, the six regional director positions and national director position were to commence on a higher increment point than the consultant positions in recognition of the greater range of duties attaching to these positions. This was a temporary measure as over time, all posts would move to the top of the consultant pay scale.

It was recognised that a process would have to be put in place for allowances attaching to these positions to be examined at a later date. Building on same the IMO have lodged a claim for Clinical Director Allowances to attach to these posts. The claim has been submitted under the local bargaining clause and the IMO hope to be able to progress same further in 2026.

It is important to recognise that in progressing the overall claim for consultant status, firstly through the Crowe Howarth report and subsequently in direct negotiations the IMO had to overcome a number of obstacles. The initial offer from the state was for 11 Consultant posts with the grade of SPHM to remain in place the 11 consultant to oversee this grade.

Recruitment Freeze and Pay and Numbers Strategy

The IMO have continued to advocate for easing in the Pay and Numbers strategy and have engaged through the Staff Panel of Unions with the HSE on the issue. This has included WRC conciliation hearings and a Labour Court case.

The original recruitment freeze and its continuation under the Pay and Numbers Strategy has been disproportionately impactful on Community Health.

Pictured: Dr Anne Dee and Dr Íde Nic Dhonncha

Due to the small numbers on the teams the inability to recruit individuals has made conditions worse for the other members on the teams and had the impact of making the posts less attractive when there is a post to fill.

While there has been some easing in the number of stages required for approval of posts, the system still remain far too bureaucratic and is leading to long delays in approval and recruitment as well as increased reliance on agency. Authority to sanction the filling of posts is restricted to REO level and delegated to IHA level for funded posts.

In 2025 the HSE were some 6,000 posts short of their employment ceiling under the Pay and Numbers strategy. This is leaving staff short of the required workforce to provide a safe and sustainable service and the IMO, together with other healthcare unions, will continue to use all levers available to it to ameliorate this situation.

National Public and Community Health Meeting AGM 2025

The national meeting debated motions around

- The ongoing impact of the Pay and Numbers Strategy on community medicine and public health teams
- The need for a comprehensive review of the staffing levels within Community Health and Public Health and called for vacant posts to be prioritised given their vital work around Child Development, Vaccinations and Health Protection

Pictured: Dr Íde Nic Dhonncha addressing AGM 2005

- The need for a unique standalone children's service MCAN of care with representation from community medical services

The meeting also focused on the terms and conditions of SMOs and PMOs and condemned the ongoing failure of the HSE to address these issues which are long outstanding.

At a Q&A session with Mr Bernard Gloster HSE CEO the IMO raised the issues regarding the 20% deficit in staffing levels in community health and the negative consequences on the services. Issues were also raised in this session around the lack of support staff for Public Health Teams which is negatively impacting on their ability to achieve their objectives.

Developing a Vision for Community Health and Public Health SMO roles

The committee are continuing to work on a vision document for the SMO role, to include the current and potential future roles in both Community and Public Health. A number of in person workshops have been held in IMO House with committee members working on the development of the paper. It is hoped once completed, that this paper will be shared with the general membership for consultation and feedback.

The focus of the committee has been to highlight the current range of work undertaken by teams delivering for patients in the community and through public health as well as looking at a vision for the future where teams are properly resourced and remunerated.

Achievements and Challenges

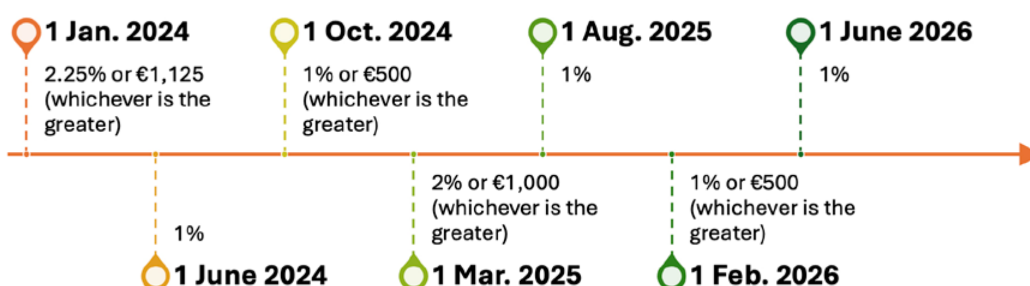
While there have been significant achievements for the Community and Public Health Medicine Committee, in particular the resolution of the Area Medical Officer equality issue, the establishment of the grade of Consultant in Public Health Medicine and the creation of 86 posts under this grade and the increase in CME allowance for AMO/SMO/PMO, there remain significant challenges.

Most pressing of these is the SMO/SAMO/PMO terms and conditions and it is hoped that the committee can address that through the pay claim submitted on behalf of this group. The IMO remain committed to utilising the full ambit of the Local Bargaining clause including if necessary the dispute resolution procedures set out in the Public Service Pay agreement to vindicate this claim.

5 Public Service Pay Agreement

The current public service pay agreement runs from 1st January 2024 to 30th June 2026.

The agreement provides for a number of pay increases over its lifetime and the increases and timeline are set out below:



The agreement also contains a Local Bargaining clause and this is detailed further below:

Local Bargaining Under Public Service Pay Agreement

Local Bargaining is a successor to the sectoral bargaining provisions of the previous agreement. This is a fund which allows unions to submit claims on behalf of members. The fund under the current agreement is 1% of the pay bill and it also provides that there is due to be a 2% fund under the next agreement, but no successor agreement has been agreed as of yet.

Claims agreed under this clause will take effect from 1st September 2025. Currently local bargaining claims across both the Health Service and wider public service are still being worked through but it has been confirmed that all claims will be backdated to 1st September 2025.

The total value of claims under this fund are limited to 1% of the pay bill.

The IMO claims submitted are as follows:

NCHDs

- Removal of point 1 from the SHO, SPR and SR scales
- Increase of the top point of the Registrar scale by 0.66%
- Moving of 4th year GP Registrars to SPR scale
- GP registrars on maternity leave to receive OOH allowance

Consultants

- 1% increase in the top point of the POCC scale

Public Health and Community Health

- Payment of 15% increase to PMOs, SMOs, SAMOs and AMOs
- Award of the Clinical Directors Allowance to the Regional and National Directors in Public Health

Other claims

- Payment of a CME allowance of €2,750 for Doctors working in the addiction service

While these claims have been submitted, the process is ongoing and no claims have yet been approved.

6 Member Advisory Services

nchds@imo.ie - NCHDs

Members continue to face issues with payment for overtime, working hours and rosters. Despite being in place since January 2023, there continue to be issues with the implementation of the 2022 agreement.

The main types of issues we provided advice on and supported members with included:

- Rostering continued to be a major issues around the country. This included issues such as the failure to provide initial rosters, rosters being changed without notice and NCHDs being asked to work while on leave. There were also specific issues around compensatory rest and being rostered to work on the day before changeover. We also assisted a number of NCHD teams where there were gaps and by working with the NCHDs were able to secure extra posts which had a significant impact for the teams themselves
- Disappointingly NCHDs who are pregnant continue to face issues, and we have had to help a number who have experienced challenges in relation to accessing TSS, to receiving their paid maternity leave. We have been able to assist the members impacted, but have seen an increase in NCHDs facing these type of issues.
- Further to this, NCHDs who are on Maternity Leave or are returning from Maternity Leave experience issues accessing Parent's Leave, due to conflicting advice provided by the hospitals. Often times, NCHDs end up unemployed for a period before they return to employment at the end of their Maternity Leave. We have been able to assist most members impacted and engage with relevant hospitals. This is becoming an increasing issue.
- Payment delays, whether they be for overtime or for other payments were also prominent in 2025, with many NCHD facing delays in receiving payments.
- Further payment issues relate to the non-payment of NCHDs Temporary Recoverable Payment, relocation expenses and being placed on the incorrect point when rotating to different hospitals as part of their approved training schemes.
- A further issue which has become more common is NCHDs who were overpaid. In many cases, they had advised the employer of the issue but it was not rectified. When the HSE then came back seeking repayment we have assisted in engaging and agreeing an appropriate repayment schedule. We have also advised the NCHDs on the impact of repaying in the current year as against when paying back in a subsequent year.
- As ever we continue to represent NCHDs who are involved in disciplinary, dignity at work and grievance processes. These can be very challenging for the NCHDs involved and we try to support the impacted members through each stage.

As in 2024, hospital meetings have played an increasing role in the work of the team. We had over 40 meetings around the country this year, many of which were in response to specific issues which had arisen. These meetings became a key way for us to understand and identify the individual site specific challenges our members are facing. The IMO Lead structure has been invaluable to this work.

gpissues@imo.ie - GPs

Our GP members continued to be supported by the MAU team in 2025.

Given the broad nature of their practices, the queries we received from our GP members are equally varied but the most commons areas were:

- Practice support entitlements, and how to structure your practice to ensure you are maximising the benefits
- Retirement and succession rules under the GMS from both the perspective of the incoming and outgoing GPs
- GMS leave entitlements including sick leave and maternity leave
- The Winter Arrangements for 2025
- Non-GMS schemes e.g., Mother and Infant, Contraceptive Scheme, and vaccinations etc.

We have also continued to provide advice and support to members dealing with:

- PCRS audits
- HR issues with staff
- Engaging with Primary Care units in relation to contractual issues
- Payment issues from the PCRS

consultants@imo.ie - Consultants

An increasing number of Consultants have the Public Only Contract but we continue to support members on all contract types.

As with previous years the types of issues our members faced included:

- On-call Payments and being paid for them. We had to assist a number of Consultants who were not in fact receiving on-call payments and we secured appropriate backpay.
- Pension issues and entitlements. Members had queries around their pension scheme, their entitlements and issues such as added years. In many instances we would assist in conjunction with our colleagues in IMOFS.
- Obligations around Saturday working under both the POCC and previous contracts.
- CME Claims which had been rejected.
- Issues around external work applications and what is allowable.
- Members have had a range of issues relating to managing attendance, disciplinary, dignity at work and grievance processes. These can be difficult to navigate and challenging to be involved in and we advise and support members throughout the process while also maintaining expectations where applicable.

publichealth@imo.ie - Public Health

communityhealth@imo.ie - Community Health

The Pay and Numbers Strategy has created very specific challenges for doctors in Public Health and Community Health. Given they work in smaller teams, when they lose team members they are left in a very difficult situation.

Some of the queries we received from members included:

- CME and Study leave
- Updates on the IMO claim for SMOs
- Pension and added year entitlements

As with other groups we have also supported members with grievance and disciplinary procedures.

7 Policy and Advocacy

During 2025 the IMO continued to develop policies and submissions on the key issues impacting the health services.

IMO Pre-Budget Submission 2026

The IMO Pre-Budget Submission 2026 focused on addressing the significant and growing health inequalities in Ireland and called on the Government to take meaningful action, through Budget 2026, to reduce health inequalities through a whole of Government approach to addressing the social determinants of health as well as through significant investment in public health services.

Key IMO Recommendations:

Address the Wider Social Determinants of Health: Establish a cross-departmental group to address health inequality in Ireland. Such a group should be tasked with addressing all the social, environmental and commercial determinants of health inequality. All new policies should be subject to a health impact assessment.

Improve Access to Care through Investment in the Public Health System: Urgent investment both capital and operational is needed to improve access to care in our public health system. Resources should be allocated on the basis of population need.

Invest in Acute Bed Capacity: Increase the number of new inpatient beds from 3,438 to 5,000 under the Acute Hospital Bed Capacity Expansion Plan 2024-2031 and publish a detailed plan laying out the costs timeline and staffing for the delivery of new beds.

Medical Workforce Planning: Develop and fund a comprehensive medical workforce plan with actions laid out to increase the number of consultants and training posts in line with workforce requirements and to address ongoing challenges in recruitment and retention. The IMO also called for an increase the number of training posts to ensure access to training programmes for our International doctors and to explore international reciprocal training programmes.

Invest in General Practice: The IMO repeated calls for targeted measures to enable GPs to establish and sustain GP practices through an independent GP contractor model. The IMO also called on the Government to increase the level of funding under the Social Deprivation Practice Grant Support to allow GPs offer a full range of services in deprived areas and introduce a weighted capitation payment for deprivation for GMS patients

Improve and Enhance Services in General Practice: The IMO called for continued investment in services in General Practice including:

- Expansion of the Chronic Disease Programme on a universal basis to all patients with specified chronic conditions over 18 years old;
- Investment in a comprehensive women's health programme in General Practice including advice on contraception, sexually transmitted infections, screening, fertility, and preconception and advice on menopause: and
- To negotiate and fund a GP-led national obesity service, integrated into primary care, with clear pathways to specialist care.

Investment in Electronic Health Records: Publish and resource an investment plan to fully digitalise the health service over the next 5 years including the roll out of Summary Care and Shared Care Electronic Health Records to enhance quality, integrated care and support service planning.

Investment in Prevention and Early Childhood Intervention: Ensure that children have the best start in life through investment in early childhood intervention and prevention services and additional resources for public health and community health services.

Care of the Elderly: Increase the number of nursing home beds, rehabilitative care beds, and financing of home care packages in line with population need.

Mental Health Services: Increase funding for mental health services and place mental health on par with physical health with allocation of resources based on population needs. Undertake an urgent review of the current model of community-based mental health services to ascertain its impact on staffing levels and patient care and facilitate better integration of specialist mental health services within the larger health system.

Support for Palestine: The Government should set aside funds to support the reconstruction of the health service for the population Gaza. The Government should expand the funding of the International Medical Graduate Training Initiative (IMGTI) to allow doctors from Palestine to access training in Ireland.

New National Obesity Strategy

The IMO contributed a submission to the Department of Health in relation to a new National Obesity Strategy. In the submission, the IMO called on the Department of Health to do the following:

- **Limit ads for unhealthy food across TV and social media:** young people, in particular, are at risk of being influenced by advertisements and promotion of products on mainstream media including false or mis-leading information disseminated through social media platforms.
- **Introduce clearer food labelling to help people make healthier food choices:** at present, there is no requirement to label unhealth content per portion size nor any provision in place for front of pack labelling such as the UK traffic light system. Both of these measures has been found to be effective in supporting individuals to make healthier food choices.
- **Robust legislation** is needed to ensure that the healthy choice is the easy choice, Industry self-regulate has been found to be of little benefit to public health and
- **The Government must also consider the social determinants of health** that influence health outcomes including the conditions in which people are born, grow, work, live and age, and the wider set of forces and systems shaping the conditions of daily life. The IMO urges the Government to examine how poor health, including obesity and overweight, is influenced by the social and commercial determinants of health. The IMO called for the establishment of a cross-departmental group to address the social, environmental and commercial determinants of health and health inequality including obesity.
- **The Department of Health and the HSE should negotiate and fund a GP-led national obesity service,** integrated into primary care, with clear pathways to specialist care. The IMO are proposing a tiered, model-drive, medication-agnostic GP-led approach initially targeted at specific patient subgroups, ensuring continuity, flexibility, and responsiveness to emerging pharmacotherapies.

Mental Health Legislation and Services

In 2025, the IMO continued to monitor developments in relation to Mental health Services including the Mental Health Bill 2024 and the development of National Standards for Child and Adolescent Mental Health Services (CAMHS).

Oireachtas Committee on Health – Priorities and Concerns in relation to the Mental Health Bill (2024)

The IMO met with Fianna Fail Spokesperson for health , Dr Martin Daly TD and Professor Matthew Sadlier and Professor Brendan Kelly me with the Oireachtas Joint Committee on Health in relation to our priorities and concerns in relation to the Mental Health Bill (2024) particularly the criteria for involuntary admission and the procedure for patients who lack decision making capacity and decline treatment.

The IMO highlighted that patients who require voluntary or involuntary admission to a psychiatric unit are among the most ill and vulnerable in our society and require timely and accountable care. And while the intention of the Bill is to ensure the protection of patients' rights in relation to autonomy, the provisions which create a dual process for involuntary admission and consent to care, are legally, clinically and logistically impractical and could deny patients with serious mental illness the right to timely and often life-saving medical treatment.

There are already significant workforce deficits and these provisions will place further strain on our already under-resourced mental health services. Based on our current population we need about 760 Consultant Psychiatrists (WTEs). But of 570 approved posts, almost 30% are unfilled or filled on a temporary basis.

Ove 400 amendments were discussed at Committee Stage including amendments to closer align the procedure for involuntary admission and treatment. The IMO continues to monitor the legislation as it passes through the Houses of the Oireachtas.

Mental Health Commission Scoping Consultation on National Standards for Child and Adolescent Mental Health Services (CAMHS)

The IMO made a submission to the Mental Health Commission Scoping Consultation for the Development of National Standards for Child and Adolescent Mental Health Services (CAMHS). The IMO recommended the following be considered in regard to developing standards:

- The standards must clearly define what "a Child" is and this definition must be adopted across all health services.
- Access to CAMHS has reached a critical point with under-resourcing and difficulties recruiting and retaining medical staff leaving children and families particularly vulnerable. Therefore, standards must assure the appropriate resourcing of CAMHS including appropriate consultant and multidisciplinary team staffing, and provision of inpatient beds based on population need.
- Standards must lay-out clear and consistent referral pathways across health regions to a child Psychiatrist where a GP has serious concerns about a child and, in their clinical judgement, feel the urgent opinion of a specialist is required. Furthermore, there should be a clear referral pathway to support young people transitioning from CAMHS services to adult services.
- Standards must ensure that CAMHS services are available 24/7 including appropriate out-of-hours and on-call arrangements in place. Relative to this, more clarity is needed in regard to which hospitals provide which treatments and what times those services are available.

Digitalisation of the Health Services

The IMO continued to engage with the Oireachtas Health Committee and HIQA in relation to the digitalisation of health Services.

Oireachtas Joint Committee on Health on Progress in the Delivery of the National Framework for the Full Digitalisation of Irish Healthcare Records and Information Systems

The IMO contributed a submission to the Oireachtas Joint Committee on Health in relation to the digitalisation of Irish healthcare records and information systems. In the submission, the IMO noted the progress to date in relation to Healthmail, Healthlink, NIMIS (National Integrated Medical Imaging System) , MedLIS (Ireland's National Laboratory Information System), ePrescribing and the roll out of Individual Health Identifier (IHI) but highlighted that Ireland continues to be an outlier in Europe and the OECD in terms of the adoption of electronic health records.

The IMO is currently working with the HSE and the Department of Health on providing a Shared Care Record for each patient to ensure that Electronic Health Records and other eHealth solutions are fit for purpose in a busy clinical environment and that:

- Information for electronic health records must be auto-populated from GP practice management systems.
- Electronic Health Records must be user friendly and the salient information easily retrievable from the patient record. They must not create additional administrative workload taking away from clinical time spent with patients.
- Further clarification is needed on issues in relation to patient consent, security and access to patient records for healthcare professionals, certifications in relation to who is the controller of patient information.

HIQA Consultation on the Revised Standards for Hospital Discharge Information

The IMO welcomed the use of standardised discharge information that supports the safe transfer of patients from the hospital to the GP and other community healthcare setting, however, the IMO again noted that in a busy healthcare environment it is vital that discharge summaries are concise and do not pose an unnecessary additional administrative burden on clinicians nor pose a risk to patient safety.

Quality of clinical information is paramount to the provision of safe, effective care. The key data elements including patient details, diagnosis, hospital tests and procedures, medication changes, follow up plan are included in the discharge information dataset however the excessive level of detail required in the document, even if pre-populated from the electronic health record, risks clogging the summary record with irrelevant information and the salient points will be lost with consequent risk to patient safety.

The reality is that the vast majority of hospitals in Ireland are still working off paper-based records and considerable backlogs in discharge summaries exist across many hospitals. In absence of patient records, a requirement to fill 180 data fields of a discharge summary is impractical and risks further delaying the safe discharge of patients to the community.

The IMO also called for a sperate standardised discharge summary for deceased patients in order to ensure the proper HIPE coding of patients who die in hospital.

IMO Submissions 2025

- Submission to the HIQA Review to inform the Decision-Making around the Design and Delivery of Urgent and Emergency Healthcare Services in the Mid-West region of Ireland.
- Submission to the Online Health Taskforce Stakeholder Survey.
- Public Consultation on section 4 of the Adequate Minimum Wages Directive and the promotion of Collective Bargaining – Letter to Minister for Enterprise, Tourism and Employment calling for tax relief on trade union subscriptions.
- Submission to the HIQA Consultation on National Framework for the Responsible and Safe Use of AI in Health and Social Care Services.
- Public Consultation on Ireland’s First National Public Procurement Strategy – letter to the Minister of State with responsibility for Public Procurement, Digitalisation and eGovernment, on ensuring procurement policies comply with International Court of Law rulings and international law.
- Opening Statement to the Joint Committee on Health - Priorities and concerns (including those relating to involuntary admission) in the context of the Mental Health Bill 2024.
- Submission to the Dept of Health Consultation on the Development of Protection of Liberty Safeguards Legislation.
- HIQA Consultation on a National Standard for a Demographic Dataset for Health and Social Care.
- Submission to the DOH on a New National Obesity Strategy.
- IMO Pre-Budget Submission 2026.
- HIQA Consultation on a revised Draft National Standard for Hospital Discharge Information.
- Submission to the Oireachtas Committee on Health on progress with Digitalisation of the Health Services.
- Mental Health Commission Scoping consultation to inform the development of State’s first national standards for CAMHS.

Advocacy 2025

- Meeting with HIQA - Review of the Design and Delivery of Urgent and Emergency Healthcare Services in the Mid-West region of Ireland.
- Meeting with the Medical Council on the Review of the General Division.
- Meeting with Fianna Fail health Spokesperson, TD Martin Daly on the Mental Health Bill 2024.
- Meeting with the Joint Committee on Health - Priorities and concerns (including those relating to involuntary admission) in the context of the Mental Health Bill 2024.
- Motion on Health Inequalities passed at the ICTU Biennial Delegates conference.

8 International Affairs Committee 2025

Prof Ray Walley
Chair

International Affairs Committee **2024/2025**

Prof Ray Walley (*Chair*)
CPME and UEMO

Dr Ina Kelly
CPME

Dr Clive Kilgallen
UEMS

Prof Nash Patil
UEMS

Dr Michael Kelleher
UEMO

Dr Darragh McKeon
EJD

The IMO represents the medical profession in Ireland across a number of European Medical Associations and the World Medical Association. We ensure that the voice of Irish doctors is heard on policy and legislative proposals and other matters affecting medical profession in Europe and worldwide.

CPME - Standing Committee of European Doctors

CPME Members Conference on Workforce Planning

The CPME Spring meeting began with a members conference in the European Parliament on Workforce Planning on the 19th March. Dr Ina Kelly participated in a panel discussion and highlighted the difficulties in Ireland where our specialist medical workforce is below the OECD average and where we experience significant recruitment and retention issues. The IMO highlighted the need to have a fully funded workforce plan that is capable of meeting the needs of a growing population.

In particular the IMO highlighted the lack of compliance with the European Working Time Directive (EWTD) for our NCHDs and the need for more flexible family friendly arrangements with access to childcare in line with working hours.

Policies adopted at the CPME Spring General Assembly include:

- **CPME Statement on Implementing a User-Friendly European Health Data Space (EHDS)** - CPME remains a constructive partner in implementing the EHDS. However, it is important to address concerns with workload and the economic burden digital tools place on doctors. Usability measures must be adopted to evaluate effectiveness, efficiency and doctors' satisfaction when using Electronic Health Record (EHR) systems, and the administrative burden. Essential 'user-friendly' features of EHR systems should be available without additional cost. Healthcare software industry must only place on the market systems that are 'user-friendly' and functional.
- **CPME Statement on medical devices and in-vitro diagnostics regulations** underlines that having high quality standards for medical devices is essential to ensure patient safety. All necessary efforts should be made to ensure that access to medical devices is guaranteed in all member states, leaving no one behind. CPME also stress that a future revision of the regulatory framework on medical devices and in-vitro diagnostics should provide the European Medicines Agency with the necessary responsibilities and resources to ensure an appropriate implementation of the legislation, to streamline processes and avoid duplication of work.

Policies adopted at the Autumn General Assembly included:

- **CPME response to consultation on a future Biotech Act** stressing the need to maintain high standards on clinical trials and ensure effective implementation of the Clinical Trials Regulation. CPME also emphasis on ethical considerations in early-stage or pre-clinical development and in pre-commercial testing or clinical trials, and alignment with the WMA Declaration of Helsinki and Declaration of Taipei.
- **CPME response to the European Commission's consultation on the proposal for a Council Directive on the structure and rates of excise duty applied to tobacco and tobacco related products.** The response supports the Commission proposal to increase the minimum tax and extend the scope of the directive to new tobacco and nicotine products. It also highlights counteracting the tobacco and nicotine industry tactics to interfere in policy-making.

CPME Working Groups:

- The Working Group on Professional Practice continue to work topics of Safe Staffing, Optimisation of the Workforce and Mental Health Supports for doctors.
- Working Group on Public Health continues to work on a draft CPME policy on Gambling, European Climate Resilience and Risk Management, and health disinformation.
- Working Group on Digital Health continued to participate in the Joint Action TEHDAS developing guidelines in relation to European Health Data Space.

UEMO - European Union of General Practitioners

The recognition of General Practice/Family Medicine as a European Specialty was a key focus of UEMO activity this year with a number of statements issued including

- **UEMO-UEMS joint statement for the recognition of General Practice / Family Medicine at the European level.** UEMO issued a joint statement with UEMS calling on the European Commission to place the specialty of General practice/Family Medicine on a par with other specialties and to add General Practice/Family Medicine as a new specialty to Annex V 5.1.3 of the Professional Qualifications Directive. UEMO also issued statements in support of the recognition of the specialty of family medicine in North Macedonia and in Luxembourg.

- **UEMO statement on the role of GPs/Family Physicians in the provision of Palliative Care.** In this statement UEMO , affirms that palliative care is an integral part of General Practice / Family Medicine and should be recognized as a core responsibility of GP/ FM across Europe, Palliative care must be embedded in undergraduate and postgraduate Family Medicine training and in continuing professional development. UEMO Position Statement on Artificial Intelligence (AI) in Family Medicine UEMO recognise that AI is transforming healthcare and in this policy outlines a framework for the safe, effective, ethical, and equitable integration of AI into family medicine, ensuring it augments rather than replaces the essential human elements of care. It lays out guiding principles for the safe use of AI in General Practice and highlights ethical and governance imperatives. It also called for concerted action, including investment in robust infrastructure and AI literacy training for clinicians, the co-design of AI tools with physicians and patients to meet real-world needs, and the establishment of funding mechanisms to ensure equitable access.

EJD - European Junior Doctors

The following policies and statements were adopted at the EJD Spring meeting:

- **EJD Policy on Postgraduate Training**, is a comprehensive document including recommendations on improving access, supervision, mobility, and training quality across Europe. It also emphasizes trainee wellbeing and supports a shift toward competency-based education.
- **EJD Policy on Workforce-led Optimization in Healthcare**, stresses that healthcare improvement initiatives should be led by professionals within the system, not imposed externally. It highlights the need to reduce administrative burdens and protect time with patients.
- **EJD Policy on Gender Equality in Healthcare**, outlines persistent gaps in leadership, workplace safety, and work-life balance, and makes recommendations with the aim of creating safer and more inclusive environments for all genders.
- **EJD Statement on Healthcare Resilience**, calls for the recognition of healthcare as a core component of European security, urging governments to invest in preparedness, infrastructure, and workforce capacity.

- **EJD Statement on Evidence-Based Medicine** advocates for stronger safeguards against unproven practices and calls for better integration of evidence-based care in medical education, regulation, and clinical standards.

The Mental Health of Junior Doctors was the main topic at the EJD Autumn meeting in Vienna. Following on from the *WHO MeND - Report 'Mental Health of Nurses and Doctors survey in the European Union, Iceland and Norway in October,* EJD published its *REST Report – Research on European Doctors Satisfaction and Working Time* -which shows that junior doctors in Europe work 57 hours per week on average - breaching the 48-hour limit of the EU Working Time Directive. The results of these surveys reflect the findings of the IMO's 60 second surveys on the working times, conditions and mental health of NCHDS in Ireland. These surveys are used to advocate for better working conditions for junior doctors across Europe.

UEMS – European Union of Medical Specialists

The UEMS represents approximately 1.6 million medical specialists across Europe with the principle objectives to study, promote and harmonise of the highest level of training of the medical specialists, medical practice and health care within the European Union. As a member of the UEMS Council, the Imo is responsible for endorsing delegates from Ireland to the UEMS Sections and other bodies.

European Training Requirements (ETRs)

The following European Training Requirements (ETRs) were adopted in 2025:

- Professional Development Module for Anaesthesiology in Geriatric Patients
- ETR for Child and Adolescent Psychiatry
- ETR for Subspecialty of Gynaecological Oncology
- ETR for the Specialty of Laboratory Medicine
- ETR for training in Paediatric Haematology and Oncology
- ETR for Wound Healing
- Professional Development Module for the Competence in Obstetric Anaesthesiology
- ETR for the Speciality of Geriatric Medicine
- ETR for Competence in Reproductive Medicine
- ETR for the Competence in Transitional Care of Adolescents and Young Adults
- ETR for the Specialty of Pathology

2025 also saw the creation a Thematic Federation for Artificial Intelligence and the winding up of the Thematic Federation for Vertigo. A new Multi-disciplinary Joint Committee (MJC) for perinatal and infant mental health and a new MJC for Disaster Medicine were established. A new UEMS Section for Cardiac Surgery replaced the Section for Cardiothoracic Surgery. UEMS also revised their timeline for the approval of ETRs and agreed a new UEMS CPD Charter.

UEMS Working Group for Ukraine

The UEMS Working Group for Ukraine is an initiative proposed by former IMO President Dr Clive Kilgallen with the aim to foster and enhance education between Ukraine Specialists and the UEMS Specialist groups, to encourage the adoption of UEMS European Training Requirements and European UEMS post-graduate examinations. Another important function is to disseminate the learnings and experience of the Ukrainian medical Specialists they have learned over the last four difficult years, to the European medical community.

Some achievements to date are: forming an alliance between RCSI Simulation medicine and Ukrainian Association for Simulation in Healthcare, a consignment of microscopes were donated by RCSI to University of Kyiv and Bogomolets National Medical University, several meetings between Ukrainian Specialists and UEMS Specialists. At present we are starting a project in antimicrobial stewardship, meeting with the Lancet Commission on the future of Ukrainian healthcare, the working group is part of the new MJC in disaster medicine and exploring the possibility of integrating Ukrainian military medical expertise into surgical training.

IMO President Dr Anne Dee

WMA - World Medical Association

The General Assembly of the World Medical Association took place in Porto in October 2025. President elect Dr Jacqueline Kitulu, of Kenya was installed the new WMA president 2025-2026 Dr JungYul Park from South Korea was elected as President for 2026-2027.

Main policy items adopted:

- WMA Statement on Aesthetic Treatment (revised)
- WMA Statement on Ageing (revised)
- WMA Statement on Artificial and Augmented Intelligence in Medical Care
- WMA Statement on Conflict of Interest (revised)
- WMA Statement on Dementia
- WMA Statement on Ethical Considerations in Global Clinical Electives (revised)
- WMA Statement on Ethical Guidelines for the International Migration of Physicians (revised)
- WMA Statement on Nuclear Weapons (revised)
- WMA Statement on Obesity
- WMA Statement on Physician Mental Health Care
- WMA Statement on Physicians Well-Being (revised)
- WMA Statement on Providing Health Support to Children in Street Situations (revised)
- WMA Statement on Scope of Practice, Task Sharing and Task Shifting (revised)
- WMA Statement on the Protection of Reproductive Health Rights of Women and Girls
- WMA Statement on Trans People (revised)
- WMA Resolution on Ageing Physicians
- WMA Resolution on Health Workforce at the World Health Organisation (WHO)
- WMA Resolution on Public Health Funding Worldwide
- WMA Resolution on the Role of Physician Associates and Other Non-Physician Providers in the United Kingdom and Other Countries
- WMA Resolution on the Use of Riot Control Agents and Human Rights Violations against Protesters in Turkey (revised)
- WMA Resolution to Uphold the Ethical Framework of Healthcare
- WMA Resolution Calling on the Israeli Government to Comply with the Geneva Conventions and Other Applicable Instruments of Humanitarian Law

Ahead of the World Medical Association General Assembly in Porto, the IMO joined with other National Medical Associations including the Turkish Medical Association (TMA) and the British Medical Association (BMA) in signing a Joint statement on the Healthcare Crisis in Gaza calling on national medical associations and the WMA to join calls in denouncing the horrors faced by our colleagues in Gaza and to stand in solidarity with them.

The IMO joined the TMA and BMA in the working group to ensure the strongest possible consensus statement could be reached with a focus on supporting peace in the region. The WMA unanimously adopted the following *WMA Resolution Calling on the Israeli Government to Comply with the Geneva Conventions and Other Applicable Instruments of Humanitarian Law.*

9 IMO Annual General Meeting 2025

Panel Discussions

Social and Commercial Drivers of Health Inequality in Ireland

Panellists: *Dr Anne Dee, IMO President and Consultant in Public Health Medicine.*

Professor Mark Bellis, Director of Research and Innovation at Liverpool John Moores University.

Ms Brigid Quinlan, Project Manager Kerry Travellers Health Development Project.

Dr Norah Campbell, Associate Professor, Trinity Business School.

Dr Dee spoke to the fact that poverty is a major factor in poor health outcomes and that deprivation is linked to chronic illness and early death. Dr Dee outlined how basic access to healthcare services accounts for just 20% of the factors determining health outcomes and that to improve health we must tackle the wider issues impacting on negative health outcomes and ensure doctors have all the supports they need to close the gap of health inequality.

Professor Bellis spoke of his research on Adverse Childhood Experiences and their effects on society and disease.

He discussed how such experiences not only have a negative psychological impact but also negatively impacts on physical health with those with ACES being more than 30% more likely to have suicidal ideation and age ten years faster than the rest of the population. Ms Brigid Quinan spoke to her own lived experience as a traveller and her work to improve Traveller Health and Well Being.

As a community Travellers are blighted by persistent health inequalities, with metrics on life expectancy, suicide, physical and psychologic health all worse than that of the general population. Dr Norah Campbell examined how business activities can effect population health and referenced WHO data which shows there are 7,400 deaths every day linked to smoking, sugary/ultra processed foods, alcohol and fossil fuels. She noted how brands effectively market their harmful products so as to make them appear as benign as possible. The panel of experts all agreed that this is a system wide issue that needed to be addressed by government through the establishment of a cross departmental group tasked with data driven solutions and legislation to combat all the factors determining health inequality.

Ms Ruth Breslin, Ms Ingrid Miley, Mr Eoghan Cleary, Dr Madeleine Ní Dhálaigh

The Malign Force of Pornography in Fueling Sexual and Gender Based Violence

Panellists: *Ms Ruth Breslin, Director, Sexual Exploitation Research and Policy Institute.*

Mr Eoghan Cleary, Teacher and Assistant Principal Temple Carrig Secondary School.

Dr Madeleine Ní Dhálaigh, GP, Castlerea, Co Roscommon.

Ms Breslin presented the results of the Facing Reality survey which addressed the role of pornography in the epidemic of violence against women and girls. Research suggests that 90% of pornographic scenes contain physical aggression with 94% of that aggression directed towards women who were then depicted as responding neutrally or with pleasure to such aggression. Ms Breslin noted that the porn industry was generating €90 billion globally and was shaping harmful sexual behaviours with AI being at the frontier of the commercial sex trade.

Mr Cleary referenced shocking data that shows 10% of nine year olds have been exposed to pornography and that there has been a six-fold increase in sexual crimes in Ireland over the last 15 years with 462 instances reported in 2024. Mr Cleary teaches a module to Transition Year students and when asked to list the traits they felt were expected of them during sexual transactions the results overwhelmingly followed the pornography scripts with males using words like “dominant” and “aggressive” and females using words like “submissive” and “do what he says/likes”. Dr Ní Dhálaigh spoke to the increased number of presentations in general practice relating either directly or indirectly to pornography where sexual violence and coercion is normalised with disregard to the health and safety of young women. The panel emphasised the need for age verification for porn websites, geo-blocking of harmful sites and education on the harms of pornography especially to our young people.

Dr Sarah O’Dwyer, Dr Loran Martin, Prof Matthew Sadlier, Ms Ingrid Miley

Confronting the Care Deficit for Patients with Severe and Enduring Mental Illness

Panellists: *Prof Matthew Sadlier, Consultant in Old Age Psychiatry and Chair, IMO Consultants Committee.*

Dr Lorcan Martin, Consultant in General Psychiatry and President of the College of Psychiatrists.

Dr Sarah O'Dwyer, Consultant in General Adult and Old Age Psychiatry, St Patricks Hospital.

Prof Sadlier opened the session with a discussion on the importance of psychiatry but that despite this fact the views of the profession were not recognised appropriately in the context f developing mental health policy. He outlined that the dispersion of psychiatry to community care has led to governance issues, recruitment issues and poor health outcomes for patients in many cases. All panellists agreed that psychiatry was increasingly being treated as a primary care service rather than a specialist secondary service. Both Dr Lorcan Martin and Dr Sarah O'Dywer focused on concerns around the proposed Mental Health Bill. They expressed concern that the Bill as proposed would do considerable harm, with the process for consent to treatment being their chief concern. Dr Martin noted that under the new proposals where a patient does not have the insight or capacity to consent to treatment, only a judge will be able to start the process. Dr O'Dwyer spoke to the harm and negative outcomes for patients caused by delay in treatment and that the current proposals are not grounded in clinical reality and as such is not fit for purpose. The panellist also discussed the under resourcing of the mental health budget noting that in 1984 it was 13% of the total health budget – and now it is barely 7%. As a direct result of under resourcing services like CAMHS were operating with 25% fewer community teams than what is required and only half of those teams are fully resourced.

HOT TOPICS @ AGM

The Medical Council – Striking the Right Balance for Patients and Doctors

Dr Lisa Cunningham, Consultant in Emergency Medicine rejected the idea that the Medical Council is striking the right balance. Dr Cunningham spoke to her own traumatic experience when she sought to address concerns about the working practices of a colleague.

Dr Cunningham noted that throughout this very difficult time only the Gardai were helpful, colleagues were supportive but that the HSE, Data Protection Commission and the Medical Council had, in her view, handled the case very poorly.

Dr Lisa Cunningham and Dr John Duddy

The Costs of Overdiagnosis and Investigation

Dr John Duddy, Consultant Neurosurgeon took the example of back pain where over 80% of the population will experience lower back pain at some point in their lives and half will have an episode of back pain in any one year – he posed the question is this a health problem or merely a part of life? He outlined the facts around the doubling of the GP Community Diagnostic Access Scheme which has more than doubled in 4 years and that fact that in 2024 over 1000,000 more scans were performed that were planned for. Doctors operate within the boundaries of a legal system that leaves them in fear and this is undoubtedly a factor leading to over diagnosis and investigation, coupled with the influence of private healthcare.

Access to Medicines in Ireland, Challenges on the Way

Prof Michael Barry, Clinical Director of the National Centre or Pharmacoeconomics spoke of the rising levels of expenditure in Ireland – in 2023 it hit €3 billion and it is estimated it is now running at €4 billion. In terms of current challenges he noted that:

- 20% of orphan drugs cost over €200,000 per patient per treatment cost.
- With up to one million people in Ireland having a BMI over 30 the cost to the State of providing weight loss medicines could see the State's medicine expenditure rise to €10 billion.

Professor Michael Barry

- Delays in patient getting access to new cancer drugs or medications for rare diseases were heavily influenced by the time taken by pharma companies in seeking reimbursement, delays in engaging with the HSE process and subsequent delays in price negotiations.

Communicating with Neurodivergent Patients

Dr Anna Beug, GP and Assistant Director North Dublin City GP Training Scheme spoke of the difficulties patients who are neurodiverse can experience when dealing with the health system. She spoke of the importance for doctors to engage in effective listening and encouraged doctors to take time to understand the context of a patient's visit and to signpost exactly what will happen and what is coming next. Simple, clear language is key to the communication process with doctors adopting cautions and empathetic approach to better understand and address the needs of neurodiverse patients.

Dr Anna Beug

Question Time

with HSE CEO, Mr Bernard Gloster

Mr Gloster began by addressing delegates and focusing on HSE and Department of Health objectives around access, reform, trolley numbers, waiting lists, electronic health records and the need to improve public confidence in the health system. Following his address IMO delegates raised a number of issues of concern to the membership around:

- Consultant rosters and the need for a whole of hospital approach to extended working week
- Acute bed capacity and the slow pace in delivering the required bed capacity to meet current levels of patient demand and is a driving factor in trolley numbers and waiting lists for treatment.
- CAMHS and Primary Care pathways and the fact that GPs cannot refer patients in need of this service in a timely manner and that in many circumstances referrals are refused.
- NCHD Working Hours whereby the HSE are in breach of the Organisation of Working Time Act with NCHDs routinely working in excess of 48 hours per week. Delegates also highlighted difficulties for NCHDs who are pregnant or new mothers and the lack of supports available.
- Clinical Guidelines and Protocols for GPs were new guidelines are issued by the HSE without any discussion on the resourcing implications for GPs.
- Valuing, Resourcing and Supporting the vital work of Community Doctors

Over the course of the AGM all specialty committees held National Meetings and delegates debated motions on a wide range of topics.

10 Healthcare on the Margins

Welcome and Opening Remarks: Dr. Anne Dee, President of the IMO and the Mayor of Limerick, Mr John Moran

Dr. Anne Dee opened the conference by acknowledging the legacy of advocates like the late Sister Stanislaus Kennedy and emphasising the importance of radical action to tackle health inequalities. Dr. Dee said she was "inspired by those willing to take risks to help people on the margins", urging attendees to turn words into action.

The Mayor of Limerick, Mr. John Moran followed with an address on leadership and local empowerment. Mr. Moran spoke candidly about his experience running for mayor and the lessons he has learned about inequality in Limerick. He spoke about the difficulty of Limerick "having some of the richest neighbourhoods in the country a wall away from some of the poorest". He argued that empowering local leaders who "live in the place and understand the community" delivers better outcomes.

Dr Rachel McNamara, Dr Anne Dee, De Ina Kelly

Mayor of Limerick, Mr John Moran and IMO President Dr Anne Dee

Mayor of Limerick, Mr John Moran

Session 1:

Closing the Gap on Inequalities in Health

Session 1 explored how health inequalities emerge from the social determinants of health and how targeted, community-led approaches can close the gap.

Professor Diarmuid O'Donovan, Director of National Health Improvement with the HSE, delivered a presentation on the social determinants of health, reminding attendees that healthcare accounts for only 20% of a person's overall health. Quoting from a recent WHO report on health Inequalities he said "Social injustice is killing people on a grand scale".

He also warned against neglecting the middle ground, highlighting stark inequalities through data – for example, that men in deprived areas of England have mortality rates 2.8 times higher than those in affluent areas, rising to 12 times for the most excluded groups. He said that prevention is far more cost-effective than intervention. Prof. O'Donovan closed by reminding the audience that healthcare must work with others to address the wider determinants of health.

Dr. Mai Mannix, Regional Director of Public Health Mid-West, examined local data from Limerick, where she outlined that levels of extreme disadvantage have nearly tripled between the last two census periods.

She described the work of the Limerick Health Equity Oversight Group, a multi-agency initiative aiming to give every child the best start in life and helping the mid-west "be the first region in Ireland where we have a multi-agency approach to health".

Quoting Sir Michael Marmot, Dr. Mannix asked "what good does it do to treat people and send them back to the conditions that made them sick?" She concluded that "a dream will remain a dream unless you start implementing action".

Taken together, the discussion showed that tackling health inequality demands action far beyond the confines of the hospital. Collaboration between healthcare providers, local authorities, and communities will be essential to create lasting change.

Prof Diarmuid O'Donovan, Director of National Health

Dr Mai Mannix, Regional Director of Public Health

Dr Mai Mannix, Dr Anne Dee and Prof Diarmuid O'Donovan

Q&A Session 1

Members expressed interest in topics such as health equity, the long-term impact of deprivation on health, and what the IMO can do to set standards that address systematic issues in health and care.

Dr. Dee spoke about how particular focus is necessary for the Travelling community in relation to community engagement, and how attention is needed in the 0-3 age group so that every child can have the same opportunities during their childhood.

Dr. Mannix said the IMO must play a strong role in shaping strategies for health equity and emphasised the need to equip local authorities with resources to foster genuine culture change.

Prof. O'Donovan answered an audience question about the importance of leaving no one behind by saying that the complexity of poverty necessitates partnership in intervention and prevention. He spoke about an increased need for accurate population data and how such data would improve health outcomes for disadvantaged populations.

The Q&A ended with a strong call for strengthened ties between healthcare providers and their communities. Dr. Dee encouraged a whole of society approach to health.

Session 2:

Reframing the Narrative on Inequality

Senator Lynn Ruane reframed the conversation on inequality, focusing on language, narrative, and systemic barriers. She warned that "language can keep people out of the room", urging inclusive communication. She rejected the notion of personal blame, saying people in disadvantaged areas "aren't jumping into the river, we're being dragged in by systemic failures".

Senator Ruane called for restorative approaches and warned that fictionalised narratives "cause harm". She urged radical action, saying of the audience that "unless we are willing to lose something and share privilege", nothing will change.

Ms. Tanya Ward, CEO, Children's Rights Alliance, focused on breaking the cycle of child poverty. She spoke about the difficulty that comes with fostering creativity in children who are in poverty, and how important having one supportive adult in a child's life is to overcome these systemic challenges.

She presented evidence on the long-term impacts of deprivation, from poor educational outcomes to reduced life expectancy. Ms. Ward championed early intervention such as free early childhood education, healthcare, and adequate housing as being essential to eradicating child poverty, adding that early supports can reduce inequality from the outset. Data showed children who receive in-kind benefits fare significantly better than those who do not.

Ms. Ward concluded by saying that if you "get your income supports right and your social services right at the same time you can break the cycle of poverty".

The session highlighted that language, perception, and storytelling shape public attitudes toward inequality.

Senator Lynn Ruane

Ms Tanya Ward, CEO Children's Rights Alliance and Senator Lynn Ruane

Q&A Session 2

Senator Ruane and Ms. Ward spoke about the importance of restorative justice and care, and continued support being vital to communities unlocking their own services and resources.

Session 3:

Delivering Healthcare on the Margins

Session 3 focused on those on the margins of society, and how healthcare professionals can utilise their skills to serve them as best they can.

Dr. Patrick O'Donnell, GP illustrated the challenges of general practice in deprived areas with the story of a patient juggling COPD, diabetes, depression, and housing insecurity. "These circumstances mean things will get missed," he explained, underscoring the complexity of care when multimorbidity intersects with social adversity.

Dr. O'Donnell highlighted the Inverse Care Law, which states that inequity in healthcare results in unfair social inequalities, and showcased the Deep End Ireland initiative, which fosters collaboration between GPs and academics to develop equity-focused solutions. Some of his recommendations included expanded primary care teams, and measures to improve recruitment and retention of GPs in disadvantaged areas.

Dr. Siobhan Neville, Consultant Paediatrician at UHL, spoke about paediatric inclusion health and trauma-informed care. Dr. Neville described the efforts her practice has taken to make services accessible and welcoming for children in precarious circumstances. "My goal is to see my service closed because systemic inequities no longer exist," she said.

Dr. Neville encouraged cultural competence, and practical innovations such as simplified appointment letters to reduce non-attendance. She highlighted the importance of advocacy and partnership and said that there is a need to work across health, education, and social services to address the impact of social determinants in childhood and across the lifespan of an individual. Dr. Neville showed from her own practice that paediatric inclusive health can bring reduced costs, improved patient experience and outcomes, and trainee opportunities.

The panel made clear that effective healthcare for marginalised groups requires structural reform, not just goodwill.

Dr Patrick O'Donnell, GP

Dr Siobhan Neville, Consultant Paediatrician, UHL

Session 4:

Overcoming Addiction and Homelessness – The Road to Recovery

The fourth and final session of the day focused on those with lived experience of exclusion in society and was a thought-provoking experience for those in attendance.

Ms Stacey Quinn, of Limerick-based approval housing body Novas, shared her lived experience of addiction and recovery, adding she was "sick of being judged and sick of being a number". Her contribution underscored the transformative power of consistent and compassionate support.

She spoke about the supports that she sought out "reminding me I am a good person, and eventually I believed them". Ms. Quinn urged those in similar circumstances to seek help and said, "don't be afraid, use the services, they're there to be used".

Ms Julie McKenna of Novas reflected on the evolving landscape of homelessness and addiction, citing the rise of crack cocaine in Limerick over the COVID lockdowns and its devastating health impacts. She called for trauma-informed practice and housing-first approaches.

"We cannot expect someone to leave a facility and return to the environment that harmed them," she said. Ms. McKenna warned of the intergenerational toll of poverty and addiction and called for systemic investment in housing, detox facilities, and wraparound supports. "Without these, we are creating service users of the future," she warned.

The session emphasised that recovery is not simply about treatment but about dignity, stability, and belief. Sustainable progress will depend on trauma-informed, housing-first models that offer people a real chance to rebuild.

Ms Stacey Quinn and Ms Julie McKenna of Novas

Closing Reflections

Dr. Anne Dee closed the conference with a message of partnership and persistence. The event's recurring message was clear that health equity is both a process and an outcome, demanding collaboration across sectors and sustained commitment to addressing the root causes of disadvantage.

From early childhood interventions to inclusive healthcare and housing-first strategies, the path forward requires coordination and a shared vision for the benefit of disadvantaged sections of the population.

11 Doolin Memorial Lecture 2025

Saturday, 6th December 2025 at Royal College of Surgeons in Ireland, Dublin

Lecture Title: The Power of Story Telling in Healthcare

Speaker: Dr Suzanne Crowe, President of the Irish Medical Council

Consultant in Paediatric Intensive Care, Crumlin Hospital, Children's Health Ireland

Dr Suzanne Crowe opened her lecture by stating that we humans have always been story tellers. Storytelling is a biological necessity. It is the vehicle used to transmit knowledge, express empathy, and to determine the best course of action. Stories capture who we are and they help to shape us.

Stories predate science and writing. Every community had a storytelling process. The ability to recount our day-to-day experiences is what gave us our biological advantage. It provides us with the platform to warn, teach and enquire. Any one of us, using the story format, can in a matter of minutes compress our life experiences.

When a patient tells their medical story, it lights up different parts of the listener's brain. It is well recognized that an individual patient's story can transform a doctor's thinking and approach to the delivery of medical care. Data shifts one's mind and stories shift one's heart. The story leads and drives the commitment to the provision of holistic care.

Dr Crowe gives the example of an 8-year-old child who was admitted to the ICU from a peripheral hospital with a history of tachycardia and abdominal pain. His mother was extremely concerned that he may have sepsis. Fortunately, the investigations were normal and ultimately the diagnosis was severe constipation which was readily treated. Following further discussions with his mother, the true story was unlocked. The child had autism and a severely restricted diet and would only eat bread and butter, the cause of his constipation. The mother's only other child had died from neonatal sepsis which explains her deep concerns that infection was the cause of her son's symptoms.

Pictured: Dr Suzanne Crowe and Dr Anne Dee

Pictured: Dr Suzanne Crowe

The case illustrates that one needs both knowledge and understanding in order to give the delivery of clinical care its proper shape.

There are fundamental principles that all doctors know and apply in their daily practice. Consent is a story based on trust and the recognition of patient's dignity and self-determination. Hand-washing in the prevention of patient cross-infection, one of the corner-stones of good healthcare, is based on the hard lessons that have been learned from previous hospital outbreaks. We teach medicine in this way. The medical story arc is the narrative journey of a patient's illness using the sequence of presentation, the key issues, the treatment and the resolution. It is not only what happened but also what mattered. Stories blend the details into a recognizable shape.

Our brains love stories. Memory scaffolds are important. They are the structures on which we can lay other stories. Students will remember the patient, and they will remember the patient's story. The storyteller in Irish culture knew that the lesson would not be forgotten. Mountpellier, the world's oldest practicing medical school, was established in the 12th century. The sharing of medical wisdom, however, is much older and is based on stories and storytelling. Every good story captures the consequences of the actions that were taken. We like things demonstrated rather than dictated. When information is assimilated into a story, it can be applied more readily to the individual patient's case.

A frequent scenario in the workplace is when colleagues stop one and say, 'let me tell you what happened last night, why it matters, and what the consequences were'. This sharing of a recent clinical experience is very important because working with patients can be very hard in terms of witnessing their distress during acute illness. One is also sustained by their bravery in the face of adversity. Their adherence to hope is inspiring.

Dr Crowe gives the example of the dynamics frequently at play in the narrative between the patient and the doctor. When undertaking pre-operative assessments of adult patients admitted for elective orthopaedic surgery, she found that it was informative to reflect on their verbal interactions. Some would discuss their plans after the surgery including going on a holiday or being able to actively mind their grandchild again. On the other hand, there were others who would express fears about how they would cope with post-operative pain and their ability to recover. This latter group were often the ones that struggled the most after the surgery. Patients don't tell us any details accidentally. They are not accidental communications. Expressions like 'I'm not yet back to my normal self' are very meaningful.

Medical adverse incident reviews are structured investigations into what happened, why and how to prevent a recurrence. The format may currently be incomplete. While the facts and the timelines are documented, the story has been removed. The narrative that connects the objective data is not available. The staff do not give their background personal accounts. The family's circumstances are not transmitted. We are ignoring how people learn when we remove the details of the story. The learning and the important messages are not clearly identifed. In these circumstances, the accident is likely to be repeated.

Sharing an offce with colleagues is very beneficial. They assimilate each other's stories about on-call experiences and they listen without judgement. Dr Crowe provides a personal example. When on call in the ICU, an ill child rapidly deteriorated and died. Very shortly, a matter of minutes before her demise, an E. coli positive blood culture was communicated by the laboratory to the ICU. The staff found the child's sudden demise and the events around it upsetting.

Pictured: Dr Suzanne Crowe, Doolin 2025

Her colleagues sat down, listened and concluded that the additional information was not available in a meaningful time-frame and nothing else could have been done to change the outcome. This was very reassuring. In situations like this, stories are able to connect things up in a meaningful way.

In hospitals, there are many different story telling sources including doctors, nurses, patients and the local culture. There are many other cultural differences in society. The commonly encountered ones are deprivation, homelessness and drug addiction. The stories of these patient groups need to be listened to if we are going to provide them with the care that they need.

In current paediatric practice, it is recognised that the parent brings profound knowledge about their child. This has been highlighted by the introduction of Martha's rule, now in place in many UK hospitals, which supports the right of parents to get a rapid review if they feel that their child's condition is deteriorating. The healthcare systems now in place are based on teamwork. The patient stories must go across the team. The handover from shift to shift and the inciteful comments about the patient's progress are at the centre of good care.

The WHO surgical checklist, introduced by Atul Gawande, has proven to be an important worldwide safety tool. However, the theatre remains an impersonal environment. Most of the staff have not met and do not know the patient who is about to undergo surgery. In Crumlin Children's Hospital, in an attempt to add a human touch, a personal note is added such as 'the patient has asked Santa for a bike'.

The purpose of intensive care is to keep the patient physiologically stable until recovery takes place. There is a constant need to ask what we are doing. If the patient is not going to recover, it is important to meet the family at an early stage and discuss the alternative options. If there is a relative travelling back from abroad, the decision may be to continue ICU care for a period of time. Otherwise, it is advisable to redirect care and allow the patient to have a natural death.

Finally, Dr Crowe mentioned the late Dr John Pritchard at St. James's Hospital and his excellent teaching skills. Dr Prichard constantly told the students that the patient is telling you what is wrong with them. The human body is the story that the spirit is trying to tell. Stories are the telling pathway. When we tell stories, we are doing what is clinically important even in the era of technology. Medicine, at its core, remains an oral art.

The audience, which consisted mainly of clinical doctors, listened to Suzanne Crowe with rapt attention. Her message resonated with what they encounter every day in their interactions with patients. The lecture was timely. In an era of rapidly developing technology, it provides a blueprint on how the patient's story is kept at the centre of their clinical journey.

J.F.A. Murphy
Editor

12 IMO in the Media

The IMO issued 21 statements in 2025, covering a wide variety of topics from the dangers of social media, to chronic capacity issues to war in Gaza.

- IMO warns that flu has hit Ireland "fast and hard"

RTÉ | 100 News Sport Entertainment Business Lifestyle Culture Gaeilge

News Politics Regional Ireland Middle East Climate Nuacht World Programmes

IMO warns that flu has hit Ireland 'fast and hard'

- IMO President warns early intervention crucial to address major problem of health inequality
- IMO response to Budget 2026
- IMO calls for whole of Government response to 'chronic problem' of health inequality
- Irish Medical Organisation response to HIQA report on HSE Mid West
- Irish Medical Organisation statement on Donald Trump's autism announcement
- IMO Statement on Gaza
- Medical Council Reports confirm growing crisis amongst doctors and serious threat to health and safety of both doctors and patients
- IMO warns delay in alcohol labelling a 'serious threat' to public health

Ireland

'A serious threat to public health': Doctors warn about delay to mandatory alcohol health labels

The labels were due to be introduced in May 2026 have been postponed due to tariff threat

- IMO response to revised National Development Plan funding
- IMO warns weekend rostering alone will not solve patient delays and trolley crisis
- IMO warns 'critically low' GP numbers will not improve without major systemic change
- IMO warns proposed Mental Health Bill could deny patients life-saving medical treatment
- IMO writes to Taoiseach to call for urgent action on crisis in Gaza
- IMO warns 'dumbing down' of psychiatric services having adverse effect on patients

Features

Concerns growing among psychiatrists about incoming legislation

By David Lynch - 05th May 2025

- IMO warns regulation critical to combat 'malign force of pornography'
- IMO AGM to hear how inequality in Ireland is impacting public health
- IMO: Hospital staffing levels must increase if standard weekend working is introduced
- IMO congratulates Jennifer Carroll MacNeill on her appointment as Minister for Health
- IMO: New Programme for Government lacks detail on funding for capacity and workforce in health services
- IMO: Government formation talks must focus on health as a priority and address chronic capacity issues in public health services

HSE

Seven-day rosters in hospitals is 'robbing Peter to pay Paul', say consultants

Consultants warned that weekend rostering cannot come at the expense of weekday treatment.

IMO Voices In The Media

"General Practice was decimated by the Fempi cuts during the recession and has not yet fully recovered some 16 years later. As a result we have a severe lack of younger GPs and those who do enter the specialty are hampered by a range of factors – in particular the costs associated with setting up and running a practice."

Prof Tadhg Crowley, IMO GP Chair

"A new contract is an opportunity to equip NCHDs with the tools and training to be in a position to meet future demands and crises. It is an opportunity for shaping and securing a sustainable workforce, and positioning Ireland as an attractive place for medical graduates to train and be retained. We hope that this opportunity to do better will not be squandered by thinking small and by not being ambitious around what a well-resourced and sustainable workforce could look like."

Dr Rachel McNamara, IMO NCHD Chair

"The IMO is not ideologically opposed to extended services, but their introduction cannot be based on robbing Peter to pay Paul where there may be a reduction in services on other days. If the HSE and Government want extended services, they must invest in workforce and capacity and ensure that all services are safe for those working in them and using them."

Prof Matthew Sadlier, IMO Consultant Chair

"With this delay, we are seeing health being ignored in favour of corporate interests and profiteering. It will result in preventable incidences of cancer, increased incidences of liver disease, and harm to children because of a refusal to fully enact a bill signed into law seven years ago."

Dr Anne Dee, IMO President

13 IMJ Annual Report for 2025

The Irish Medical Journal (IMJ) is a monthly clinical and medical journal published by the Irish Medical Organisation. As one of the leading medical publications in Ireland, it seeks to keep the profession in Ireland informed through scientific research, review articles and updates on contemporary clinical practice.

In 2025, there were 10 issues of the Irish Medical Journal (IMJ). There was a total of 179 papers published which consisted of 10 commentaries, 68 original papers, 13 short reports, 38 case reports, 29 letters, 7 occasional pieces, 5 editorials, 8 abstracts of scientific meetings, and 1 winner student essay. The content was wide-ranging, medically important, and educationally informative. The following is selection of this year's published papers.

O'Doherty et al. in 'Assessment of increased general access to diagnostic imaging' found that their responses were positive including improved efficiency and better patient satisfaction. Ahmed et al. in 'Consequences of the crisis in social care for older hospital in patients with frailty' reported that for every additional dayolder patients wait to get discharged home, the HAC (hospital associated complication) increased by 4%.

For February, Hussain et al. in 'Peripheral intravenous (IV) cannulation should be avoided in the stroke affected upper limb' outlined the potential risks and disadvantages of siting an IV cannula in the affected limb in stroke patients. O'Connell et al. in 'Delayed presentation and diagnosis of testicular torsion- insights from 10 years of cases' report 15 cases of orchidectomy due to testicular torsion. In 12 cases, a delay in diagnosis was due to late presentation. In 3 cases, the patient presented in time but were initially discharged with an alternative diagnosis.

Herlihy et al in 'Skin of colour dermatology: a national study on the confidence of Irish primary care providers' surveyed 121 GPs about dermatological problems in patients with skin of colour. Almost two-thirds were not confident in the management of these cases. Harford et al. in 'Serum drops for ocular surface disease: a national perspective' report on the use of serum eye drops in a series of 102 patients, the most common indication being refractory dry eye disease.

McKenna et al in 'Alcohol-associated hepatitis: a national point-in-time survey' stated that 51 liver transplants are performed annually. AA hepatitis is a relative contraindication and in a survey over a 2-week period, only 1 patient met the criteria for an early transplant. Hoolahan et al in 'The burden of neonatal late-onset sepsis' reported a series of 37 babies with confirmed infection. There were 18 deaths, 70% cultured gram-negative bacilli.

Rotem et al. in 'Delivery trends after obstetric anal sphincter injuries' compared the delivery patterns in two time periods, 2007–2012 and 2018–2022, for women in the subsequent pregnancy after a previous obstetric anal sphincter injury. Over the two time periods, the caesarean section rate increased from 37% to 56.5%. Mohammed et al. in 'Clinical outcomes for emergency department patients diagnosed with proximal humeral fractures' reported on a series 96 patients. There was a preponderance of older female patients with a greater length of hospital stay.

Dockery et al. in 'Admission care for children admitted with first presentation of type 1 diabetes' reported on 182 children with a first presentation of type 1 diabetes. 74 children were metabolically unstable and had an 8.1 nights length of stay. The 108 children who were metabolically stable had a 6.4 nights length of stay. Underwood et al. in 'Ex-vivo blood delivery to offshore vessels by drone: a maritime feasibility study' transported units of blood from land to a boat 500 meters offshore using a drone. The findings were positive and indicate that drones are suitable for this type of emergency transport.

Cooper et al. in 'Assessment and management of acute epididymo-orchiditis in the emergency' found that the antibiotic prescription rate improved from 74.5% to 96% between the first and second loops of the audit. Mamai et al. in 'Access to primary healthcare by Ukrainian beneficiaries of temporary protection in rural communities' audited the medical needs of 491 Ukrainians attending a rural GP medical centre. There was a preponderance of female patients and 31% were children. The workload was significant with 3551 consultations, an average of 7 per patient over 2 years. Most interactions required an interpreter.

Meenaghan et al. in 'All-Ireland congenital heart disease network referrals to tertiary centres' describe the success of the PEC (paediatricians with expertise in cardiology) programme. The number of children requiring referral from the regional centres to the tertiary centres has decreased from 1348 to 466 (65%) between 2018 and 2024. Hattingh et al. in 'E-scooter related presentations to an urban trauma centre: a two-year analysis of patient volume, injury patterns, and healthcare burden' report on 380 patients who suffered an e-scooter injury: 351 riders, 29 pedestrians. The major injuries were 11 intracranial haemorrhages, 45 operations for limb and facial injuries, and 1 pedestrian fatality.

Smyth et al. in 'Surgical timeliness in acute appendicitis: evaluating systemic and demographic factors affecting time to theatre' state that the guideline is that appendicectomy should be performed within 24 hours of diagnosis in acute cases. Among 183 patients over a 12-month period, the median time to theatre was 13 hours and within the recommended time frame for 83% of cases. Tewari et al. in 'A retrospective review of spinal cord injuries among trauma patients to appropriately forecast future service requirements at a national trauma centre' describe 148 cases of traumatic spinal cord injury. The most common causes were falls (64%), road traffic accidents (14%), and injuries to cyclists (5%).

IMJ Student Essay Competition

In November, the IMJ Student Essay Competition asked medical students studying in Ireland to explore the topic "How medical research contributes to health and patient care". The winner was Andre Samir Ramkaran (RCSI), 2nd place Daniel Gray (UCD) and 3rd place Seon O'Grady (UL). The winning essay has interwoven the clinical journey of an acute stroke victim with how modern scientific advances and medical interventions can positively intervene in a patient's outcome.

Thanks to all the authors who submitted papers to us and to the referees who reviewed them.

JFA Murphy
Editor

14 IMO Financial Services

Board Members **2025/2026**

Prof Ray Walley
Chairperson

Dr Brian O'Doherty
Non-Executive Director

Ms Mary Hutch
Independent Non-Executive Director

Mr James Brophy
Independent Non-Executive Director

Mr Willie Holmes
Independent Non-Executive Director (resigned April 2025)

IMO
FINANCIAL SERVICES

IMO Financial Services, a wholly owned subsidiary of the Irish Medical Organisation, specialises in providing financial solutions to the medical profession. IMO Financial Services is regulated by The Central Bank of Ireland.

Our Commitment to Members

For more than three decades, IMO Financial Services has dedicated its work to the financial wellbeing of doctors and their families. Our objective is to support doctors throughout their professional lives, from graduation through to retirement and beyond. We have a deep understanding of how a doctor's career develops and how financial priorities evolve over time.

Connecting with our Members

2025 Webinar Series

Know your HSE Benefits: IMOFS along with the IMO IR Team gave detailed presentations on HSE benefits, the limitations of HSE terms and how to mitigate against the gap in pensions, income protection and life cover.

Essential Retirement Tips for Public Health Consultants: A tailored session for public health consultants who may be considering retirement over the coming years with a focus on their pension benefits under the POCC and new rules around the Standard Fund Threshold.

Autumn Financial Planning: The focus of this webinar was around pension tax saving tips for all members

New Pension Auto-Enrolment Scheme: In view of the new auto-enrolment pension savings scheme introduced by the Government, this webinar provided advice and tips to employers who do not already have an employee pension scheme in place.

2025 Seminars and Presentations

Financial Planning and Investing in Volatile Times

At the IMO AGM in April 2025 IMOFS ran a financial planning seminar where the meeting received presentations from Fran McGrath of IMOFS and Richard Temperley, Head of Investment Development at Zurich Life. Fran McGrath presented on the principles of building a robust and flexible financial plan designed to adapt to volatile conditions. In a world defined by global tension, trade disputes and economic instability, the role of financial planning has grown in significance. Richard Temperley, Head of Investment Development at Zurich, discussed the current state of investment markets with a particular emphasis on market volatility. His presentation also looked at the global economic landscape.

NCHD Intern Induction Meetings

Along with our colleagues from the IMO Team we took part in a series of Intern Induction Meetings around the country to welcome our new Interns and to make them aware of the many ways in which we in IMOFS can support them. IMOFS also were in a position to offer our Interns reduced life and illness benefit cover with our group schemes specially designed for doctors.

GP - Transition to Retirement Seminar

In September 2025 IMOFS hosted an in-person seminar for GP members who intend to retire in the next five years. The well attended event heard from speakers on Managing Succession in the GMS, Preparing for a Practice Sale, State Pension and Associated Benefits, Options for GMS and Private Pensions in retirement.

Rural, Island & Dispensing Doctors Conference

IMOFS were delighted to support the 38th RIDDI Conference in October 2025 where we presented on financial planning with a particular focus on rural GP matters.

Beyond The Bleep – an IMO NCHD Conference

Our team were delighted to support and be on hand to assist NCHDs in all financial matters at the Beyond the Bleep conference where we dealt with a wide range of issues including mortgage applications, life and protection cover and savings and investment options for NCHDs.

Our team were also delighted to support and attend a number of other events including GP Buddy Study Day, RCSI Women's Conference and ICGPs NEGs conference.

Individual Personal Financial Planning Consultations

IMO Financial Services looks after approximately 3,500 clients - doctors, spouses and practice staff.

A big part of IMOFS' engagement with doctors is to establish a financial plan. A financial plan is a comprehensive and strategic plan that outlines a doctor's financial goals and steps needed to achieve those goals over a specified period. IMO Financial Services guides doctors through the process and ensures that the plan is tailored to the doctor's needs and goals.

In 2025, IMO Financial Services conducted approximately 2,000 individual financial planning consultations and assisted doctors with their financial portfolio across protection, pensions, mortgage and savings products.

Group Schemes

IMO Financial Services operates a range of schemes for IMO members including group life, income protection and GMS pension protection. The IMO established protection products which have been created with the financial needs of the medical profession in mind.

We offer bespoke group income protection that aligns to the HSE sick pay arrangements for both HSE employees and GMS contract holders. We also offer a product that uniquely protects the GPs GMS Superannuation funding and agreed with HSE that the payment for this product could be completed via deduction from the PCRS. Finally, a death-in-service protection product taking advantage of income tax relief opportunities for some members was also devised.

IMO's group schemes have a combined membership of just under 2,000.

Claims

To date the combined scheme has paid over €45m in benefits to over 250 doctors providing them and their families with financial support at times of illness, disability or death.

1. Death Benefits

Since inception, just over €20m has been paid to 75 families.

2. Income Protection Benefit

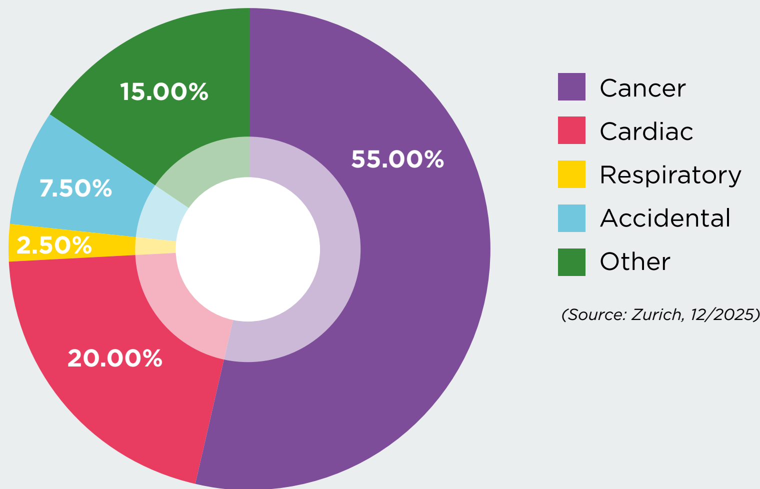
To date, the IMO income protection scheme has paid out over €20m in benefits to 140 doctors.

3. GMS Pension Protection

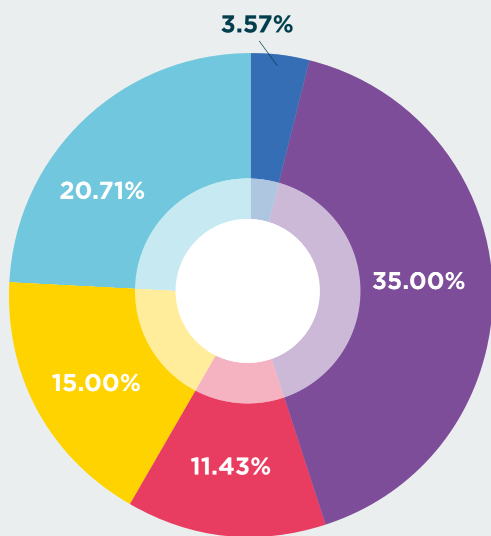
43 doctors received over €3.9m in payments to protect their GMS pension expectation at retirement.

Most common disability benefit claims are:

Group Life Claims



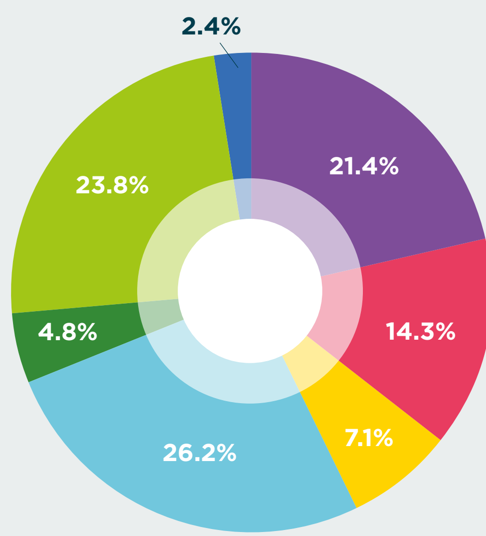
Income Protection Claims



- Cancer
- Heart/Blood Related
- Musculoskeletal
- Mental Health
- Gastrointestinal

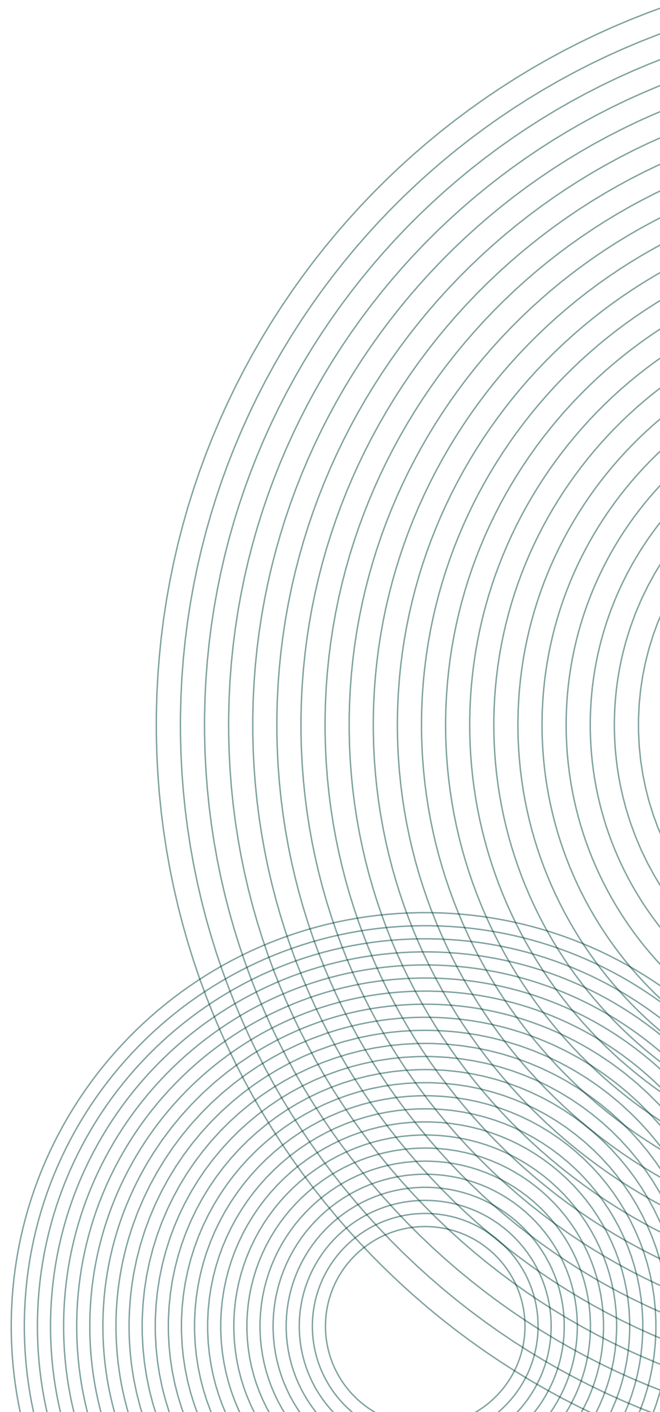
(Source: Zurich, 12/2025)

GMS Pension Protection Claims



- Cancer
- Heart/Blood Related
- Musculoskeletal
- Mental Health
- Other
- Neurological/Brain
- Gastrointestinal

(Source: Zurich, 12/2024)



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