When Dr Paula Gilvarry was elected President of the Irish Medical Organisation in April this year, she became its honorary head at a time when a stark measure of job dissatisfaction among doctors appeared: a survey published in an IMO benchmark paper, which stated that 31% of doctors would not choose medicine if they were to start their career again.1 This survey looked at the opinions of NCHDs, consultants, GPs and public health doctors, for whom the IMO is the only national representative medical organisation linking all branches of the profession in Ireland. As well as being President of the IMO, Dr Gilvarry is also the senior area health officer for the Sligo-Leitrim area, and the mother of two teenagers. She comes from a medical family (her father was the Resident Medical Intendant and Chief Psychiatric Consultant of St Mary’s Psychiatric Hospital, Castlebar), and despite her own success in medicine, she remains down to earth, practical and approachable.

Negotiation and co-location
At the time of writing, agreement has not yet been reached on contract negotiations between consultants and the Health Service Executive (HSE), as there are still many issues to be resolved. I wondered about the IMO’s perspective on disagreements with the HSE and the Department of Health (DOH). Dr Gilvarry remains worried about the effects of proposed co-location, particularly with regard to funding of public hospitals. “We don’t necessarily agree with co-location in the model that Mary Harney is looking at, but we have to compromise. If we refuse to negotiate we’ll be excluded, so we have no choice. My personal vision is that I’d like to see doctors more attuned to management of the health service, to managing our own service.”

Minister Harney’s position is that private hospitals will take the pressure off public ones and subsidise them, while public hospitals will...
continue to receive state funding. The IMO agrees that traditional public sector procurement practices are inefficient, but believes that the co-location model in its current form may not be the best solution. In a recent position paper on co-location, the IMO offered some alternative ideas, suggesting that the not-for-profit voluntary hospital tradition (similar to the endowed charitable trusts in the US) has a long track record in Ireland and should be adopted to develop independent hospitals. If this model does not prove to be appropriate, another suggestion is that profits obtained in a for-profit model should be capped and the additional monies acquired re-invested by the state in healthcare.

Staffing is another concern of Dr Gilvarry’s. “There’s a huge risk that public hospitals will be underfunded, and end up understaffed. The best and the brightest will vote with their feet, and that’s not just doctors, that’s nurses, technicians, and managers.” This seems highly likely if salary and working conditions are clearly inequitable between the public and private systems. Another point she focuses on is the regulation of private hospitals and the care they provide. The recent scandal in Barrington’s private hospital in Limerick, where breast cancer services were suspended due to concerns over the adequacy of care in the management of ten patients, highlights this worrying issue. It is clearly an area of concern, where many questions remain unanswered and details require clarification.

Singing from the same hymn sheet?
Our conversation returns to the issue of communication and co-ordination between all stakeholders in the Irish healthcare system. “It comes back to the old adage that all issues are communication issues,” Dr Gilvarry points out. “If hospital doctors, from consultants down – and
consultants in particular – had knowledge of the community, if the community doctors had knowledge of the hospitals, we would have a much better ability to co-ordinate our services. The biggest problem in the health service is lack of co-ordination: it’s people working in silos, not wanting to give away any power, any resources, instead of us all working together. And the poor patient is stuck somewhere in between.”

Dr Gilvarry describes this as happening against a background of depersonalisation and an uncertain future. As medical science advances and we have become less generalist and more specialist, are we less capable of relating to one another? Then there is the issue of representation. The Irish Hospital Consultants Association is an alternative representative union for consultants here in Ireland. They have been known to take a different approach to negotiation, sometimes being pegged as more hard line. While there are thousands of consultants with varying opinions and representative affiliations, this raises a problem in terms of the function of these organisations at this time of uncertainty. There is one voice from the HSE and the DOH but the sound bites from the other side of the argument are fragmented and often confusing. Dr Gilvarry describes how negotiations with the HSE are further complicated by difficulties in finding common ground with other representative organisations. This common ground is necessary for the formulation of a strong and cohesive argument to bring to the table, the media and the public. Finally, we have the familiar issue of struggle between doctors and management within hospitals. “There’s a deep-seated and long-standing animosity with managers,” Dr Gilvarry points out. “We speak completely different languages, we have completely different educational backgrounds. But for doctors and managers to work together, we’re all going to have to give a little. We’re going to have to start speaking a common language.” She refers to the new ‘Transformation’ project being headed up by the HSE, the purpose of which is to make all health service staff look at how they work together to benefit the patient and to provide a service of which they can be proud.

Strategies for the future

Dr Gilvarry is enthusiastic about engaging medical students in change, and she is proposing that the IMO have a medical student meeting. “At the British Medical Association annual representative meeting in the UK, the students were incredibly competent and very involved. They have their own committee, they stand up and speak at the AGM, and they’re encouraged to do so. I want to push that here, because if you’re involved at the student stage you’ll stay involved.” She feels that there is a case for formal education in management skills from medical school to specialty training. “Every doctor should have management skills and a thorough knowledge of the service.” She brings it back to communication and co-ordination: it can only help doctors to relate better to hospital, community, management colleagues and patients. She also feels strongly about the common lack of knowledge of the health system and its structures among doctors and medical students, and suggests beginning at grass roots level by educating students, stressing that medical professionals have a responsibility to patients to understand the running of the service. Dr Gilvarry is sympathetic about the pressure of existing workloads on students and doctors, but wants everyone to look up from their books and patient charts and see what is happening in the health service.

Dr Gilvarry is positive and ready for action. At no point does she seem overwhelmed by the complex issues she faces in her new position. “I see an awful lot of doctors frustrated by what they can and can’t do. But the day of sitting down and whingeing is gone. We have to now say: how can we get around this? How can we find some way of sorting it out?”

Acknowledgements

I would like to thank Dr Gilvarry for taking time out of her busy schedule to talk to me and for being so open and candid.

Editor’s note: It was originally planned to also interview the HSE, in order to provide a balanced view of the issues discussed above. However, Professor Brendan Drumm was unable to find time to be interviewed.

References

2. IMO. Position paper on co-location and acute hospital beds – increasing capacity, preventing inequity, 2007.