Rheumatology and Rehabilitation

Part 1 – Rheumatology

April 1995
Comhairle na n-Ospidéal

Report of the Committee on RHEUMATOLOGY AND REHABILITATION

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1.1 In April 1993, the Comhairle established a committee on rheumatology and rehabilitation with the following terms of reference:

“To examine the existing consultant level services throughout the country in rheumatology and rehabilitation including the services provided by the National Medical Rehabilitation Centre and, following consultation with the interests concerned, to make recommendations to the Comhairle on the future organisation and development of both specialties. The study should take into account international trends and the latest training arrangements tending towards the separation of the two specialties which have been hitherto enjoined together. The recommendations should have due regard to the necessity for an effective service within the constraints of the current levels of funding available for the health services in general.”

1.2 The following members were appointed to serve on the committee:

Dr. Declan Sugrue (Chairman)
Dr. Jane Buttimer
Dr. Ken Egan
Professor John Fielding
Professor Muiris Fitzgerald
Dr. Mary Henry
Mr. Fred Kenny
Mrs. Mary Macnamara
Mr. Gerry Martin (Chief Officer)

Mr. Tommie Martin, Administrator, who drafted this report was Secretary to the committee. He was assisted by Ms. Colette Hickey, Executive Officer.

1.3 The committee held its initial meeting in June 1993. In pursuance of its task the committee engaged in a wide ranging information gathering and consultation programme. The committee invited each health board and appropriate public voluntary hospital to make a submission to it pertaining to its terms of reference. Virtually all those invited to do so made written submissions.

1.4 The committee also sought and received written submissions from the Irish Society for Rheumatology and the Irish Association for Rehabilitation Medicine. Subsequently the committee held separate meetings with the two bodies following which revised submissions were received.

1.5 The committee exchanged correspondence with the National Advisory Committee on Medical Rehabilitation which was established by the National Rehabilitation Board and which held its first meeting in May 1993. It is to report later this year. Its remit, which covers all aspects of rehabilitation services, is wider than that of the Comhairle committee which is concentrated on consultant-level services. The committees are being kept informed of each others progress by Mr. Gerry Martin who is a member of both. The Comhairle committee also sought submissions from the Irish Institute of Orthopaedic Surgeons, the Faculty of Public Health Medicine, the Professors
of General Practice and Consultant Paediatricians in Cork city and Galway city.

1.6 The committee visited and had detailed discussions with representatives of the Western Health Board/Merlin Park Regional Hospital, Galway; the North Western Health Board/Our Lady’s Hospital, Manorhamilton and Sligo General Hospital; the Southern Health Board/Cork University Hospital and St. Finbarr’s Hospital Cork; the South Infirmary/Victoria Hospital Cork and the National Rehabilitation Hospital formerly known as the National Medical Rehabilitation Centre (N.M.R.C.) Dun Laoghaire. A joint meeting was held in Dublin with representatives of the Eastern Health Board, the Mater, Beaumont, St. Vincent’s and St. James’s Hospitals and the F.D.V.H./M.A.N.C.H. The committee also met with representatives of those health boards and voluntary public hospitals which do not employ consultants in rheumatology and rehabilitation. The committee held a joint meeting with representatives of Our Lady’s Hospital Crumlin, the Children’s Hospital, Temple Street and the Central Remedial Clinic. Representatives of the Arthritis Foundation of Ireland also had a meeting with the committee. The committee visited St. Joseph’s Rheumatology and Rehabilitation Unit, Harold’s Cross, Dublin.

1.7 A number of international reports on various aspects of rheumatology and rehabilitation services were studied by the committee. These are listed in Appendix A. Statistical data on the incidence of strokes in Ireland was sought and received from the Economic and Social Research Institute. Information leaflets on various aspects of arthritis were received from the Arthritis Foundation of Ireland.

1.8 In order to gain an insight into and an understanding of rehabilitation medicine, to familiarise each member with the various elements of rehabilitation medicine and to get a general idea of current needs and the future development of the specialty of rehabilitation medicine, the committee had an informal discussion with Drs. P. Murray, Consultant in Rehabilitation Medicine, the National Rehabilitation Hospital; Dr. P. O’Connell, Consultant in Rheumatology and Rehabilitation, Beaumont Hospital and Dr.
A. MacNamara, Senior Medical Officer, National Rehabilitation Board.

1.9 The committee also decided to commission a literature review of the potential role of rehabilitation medicine in the Irish health care system. Dr. M. Codd, Epidemiologist, Mater Hospital was employed to carry out this review. Her report will be included in part two of the committee’s report which will be dealing with rehabilitation.

1.10 The committee wishes to record its sincere appreciation to the many people and agencies who assisted in its task by providing information/views in writing and/or through discussion.

1.11 The programme of consultation and visitation, compilation of information and consideration of submissions described above has had a significant influence on the committee’s thinking. The committee’s views on the future direction of rheumatology services have been clarified as a result of the above and are dealt with in this report. However, the committee has not yet completed its task in relation to the future organisation and development of the specialty of rehabilitation in Ireland. The committee has therefore decided to produce its report in two parts – part one, relating to rheumatology is the subject of this document. The second part relating to rehabilitation services at consultant level will follow when the committee has completed its deliberations on the matter.
SECTION 2 – Background

2.1 The impetus for the establishment of this committee by the Comhairle was the recognition that rheumatology and rehabilitation are no longer considered a single specialty by the medical profession. They are now regarded as two separate specialties each with its own service responsibilities and training programme and this is now reflected in higher professional training both in the U.K. and in the U.S.A. The handbook of the Royal College of Physicians of London entitled "Training to be a Physician" sets out in broad terms the consultant's job and the training requirements of each specialty. The relevant extracts are at Appendix B.

2.2 This international trend towards separation is also being reflected in Ireland. At its Annual General Meeting in 1992, the Irish Association of Rheumatology and Rehabilitation became defunct and the Irish Society for Rheumatology was established as the professional and scientific body responsible for the specialty of rheumatology. The Irish Association for Rehabilitation Medicine had been established independently in 1990.

2.3 However, over the past twenty years, with the exception of three posts of Consultant in Rehabilitation Medicine based in the National Rehabilitation Hospital, and one new post approved in March 1995 which reflects the recommendations in this report, the eleven other posts at consultant level in this field of activity have been designated by the Comhairle as "Consultant in Rheumatology and Rehabilitation". This designation reflected international thinking and practice during that time.

2.4 Eight of the nine consultants in post have become members of the Irish Society for Rheumatology and see themselves as pursuing the rest of their careers mainly in rheumatology. Rheumatologists in Ireland are responsible for the rehabilitation of their rheumatology patients and intend to continue doing so
in the future. They see themselves as being the leaders of multidisciplinary teams providing a total integrated package of care for their patients. This view is in line with the recent report entitled “Rehabilitation Services in Scotland” which states that “even when a separate specialty of rehabilitation exists, the rheumatologist will remain the appropriate consultant for the medical management and rehabilitation of most patients with rheumatological disorders”.

2.5 Rheumatology is predominantly concerned with disorders of the musculo-skeletal system. It is generally associated, in the public mind, with arthritis and rheumatism. However, the term musculo-skeletal disorders includes a wide range of diseases of varying severity and describes diseases affecting joints, bones, soft tissues and muscles. There are over 200 recognised conditions within this broad grouping. While a large number of these are confined to the musculo-skeletal system, many also affect other organ systems making their management complex.

2.6 Musculo-skeletal disorders can be divided into the following categories:

(a) Inflammatory joint diseases e.g. rheumatoid arthritis, juvenile arthritis, gout.
(b) Degenerative joint disease (e.g. osteoarthritis).
(c) Spinal disorders (e.g. prolapsed disc, non-specific back pain).
(d) Soft tissue rheumatism (e.g. frozen shoulder, repetitive strain syndrome).
(e) Connective tissue disorders (e.g. systemic lupus erythematosus, systemic vasculitis, myositis)
(f) Metabolic bone disorders (e.g. osteoporosis, osteomalacia).

The most common disorders are back pain, osteoarthritis and rheumatoid arthritis. Most rheumatic disorders are more common in women than men. Some disorders such as osteoporosis have a long asymptomatic period before a major clinical event occurs.
2.7 Musculo-skeletal problems affect all age groups, although the prevalence increases with age. As the number of elderly people rises over the coming decades, the number of people with such disorders will also rise as will the overall cost of care and treatment. The severity of these disorders range from the mild and self-limiting to the immediately life-threatening. Treatment can improve both the quality of life and life expectancy of people with such disorders. Many can be managed within the primary care setting. Others, however, benefit from access to specialised hospital services. Early treatment to suppress inflammation or correct deformity retards disease progression and minimises its functional consequences. Hospital referral and follow-up varies between disorders. Soft tissue rheumatism and back pain often may be managed at primary care level or require only limited hospital attendance. Inflammatory joint disease such as rheumatoid arthritis and connective tissue disorders usually result in hospital referral and often require long-term follow-up.

2.8 Hospital medical services for patients with musculo-skeletal disorders are provided by both rheumatology departments which are primarily concerned with the initial diagnosis and medical management and orthopaedic departments which supply mainly surgical treatment. Close working relationships between these departments are necessary to provide optimal care. Referral to either the rheumatology or orthopaedic service is quite clear for most disorders but not for some such as back pain. Other professionals such as physiotherapists, occupational therapists and specialist nurses have important roles to play in assessment and treatment. A team approach to the delivery of care is required. General practitioner access to these services and co-ordination with relevant community-based paramedical services are also essential. The ongoing care of many rheumatology patients following specialist diagnosis and initial medical management can be provided by general practitioners in particular by group practices. Evaluation of patients within the rheumatology unit requires appropriate access to laboratory and radiology facilities. The resource implications of expanding and developing rheumatology services are modest when compared to some other specialties which require sophisticated hi-tech equipment and facilities.
2.9 While rheumatology is primarily an out-patient specialty, in-patient beds are needed also. The number of beds required is dealt with later in this report. In addition to those patients with severe and complex rheumatological disorders who require in-patient evaluation and treatment, there are other patients who, in ideal circumstances, could be treated on an out-patient basis but because of various factors such as distance from hospital, transportation difficulties, home situation, complexity of disease and degree of disability, would benefit from in-patient care over a relatively short period.
SECTION 3 – Rheumatology Services in Ireland

3.1. Consultant rheumatology services in Ireland are with one exception located in the three major cities with medical schools i.e. Dublin, Cork and Galway. The exception is Manorhamilton which services the North-Western Health Board area. A geographically large part of the country covering four health board areas (i.e. the south east, mid-west, midland and north east has no consultant rheumatologist. One third of the population (c. 1.2 million people) live in these areas. There are eleven posts of consultant in rheumatology and rehabilitation in Ireland:— seven in Dublin, two in Cork, one in Galway, one in Manorhamilton and one new post of consultant Physician/Rheumatologist to be based in Waterford. The latter, which is a new post, was approved by the Comhairle in March 1995 in the context of the recommendations in this report. One of the two general physicians based in Ennis who has a particular interest in rheumatology provides a small number of rheumatology clinics in Limerick Regional Hospital.

3.2. The location and structure of the existing posts which, despite their title, are essentially consultant rheumatologist rather than rehabilitation posts are set out in the following table. Details regarding the numbers of non-consultant hospital doctors other than interns in each unit are also included in Table 1. Details concerning beds are in paragraph 4.4.
<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Consultant</th>
<th>Consultant</th>
<th>Registrars</th>
<th>S.H.O.'s</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Vincent's/ St. Joseph's, Harolds Cross</td>
<td>8/3 &amp; 7/4</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>St. James's/ F.D.V.H.-M.A.N.C.H.</td>
<td>9/2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>J.C.M. Blanchardstown</td>
<td>11</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Beaumont</td>
<td>11</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mater/Cappagh Orthopaedic</td>
<td>11*</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Mater/Central Remedial Clinic</td>
<td>11*</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cork University Hospital</td>
<td>11</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>South Infirmary/Victoria</td>
<td>11</td>
<td>1</td>
<td>0.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Merlin Park</td>
<td>11</td>
<td>1</td>
<td>1.5</td>
<td>3</td>
</tr>
<tr>
<td>Our Lady's, Manorhamilton</td>
<td>11</td>
<td>1</td>
<td>–</td>
<td>3</td>
</tr>
<tr>
<td>Waterford/Kilkreene</td>
<td>9/2*</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>132</strong></td>
<td><strong>12</strong></td>
<td><strong>9</strong></td>
<td><strong>15.5</strong></td>
</tr>
</tbody>
</table>

* denotes vacant at present

**EASTERN HEALTH BOARD AREA**

3.3. The rheumatology unit at St. Vincent’s Hospital functions at two locations with a small number of acute rheumatology beds, usually less than four, in St. Vincent’s Hospital for treatment of acutely ill patients and a large in-patient rheumatology rehabilitation facility at St. Joseph’s, Harold’s Cross. The two consultants also have access to about 20 general medical beds in St. Vincent’s Hospital, arising from their on-call commitments. The professorship of rheumatology in U.C.D. is based in St. Vincent’s and is held by one of the two consultants based there. Neither post is linked to Cappagh Orthopaedic Hospital where the St. Vincent’s orthopaedic surgeons perform elective orthopaedics. St. Joseph’s Unit in Harold’s Cross is a dedicated
rheumatology rehabilitation facility with 46 beds. It has been refurbished recently. It has 5 physiotherapists and 3.5 occupational therapists. The number of admissions has increased from 566 in 1990 to 633 in 1994 with an average length of stay of three weeks. Rheumatoid arthritis accounts for two-thirds of admissions. The largest proportion of admissions, up to 40%, came from the south-east Dublin catchment area and about 40% were from the rest of Leinster including other parts of Dublin. Only patients previously seen in St. Vincent's Hospital are admitted. The rheumatology unit in St. James’s is staffed by one consultant who also has a two session commitment to the Adelaide Hospital where the elective orthopaedic unit is based — other than these two sessions there is no consultant rheumatology input to the M.A.N.C.H. group. There is one consultant based at Beaumont Hospital and also one consultant in James Connolly Memorial Hospital, Blanchardstown — neither post is linked to Cappagh Orthopaedic Hospital. There are two posts based in the Mater Hospital linked to Cappagh Orthopaedic Hospital and the Central Remedial Clinic respectively but they have been vacant since 1993 and 1991 respectively. One post at the Mater Hospital is filled in a locum capacity pending financial clearance of the two permanent posts by the Department of Health.

SOUTHERN HEALTH BOARD AREA

3.4. There are two consultants in this area both based in Cork city. One is based in Cork University Hospital and the other is in the South Infirmary/Victoria Hospital. An informal cross-cover arrangement exists between them. A monthly out-patient clinic is provided in Tralee by the consultant based in Cork University Hospital. The waiting list for a new out-patient visit in Tralee is much larger than it is in Cork. Neither consultant has an involvement in the orthopaedic unit which is located in St. Mary's Orthopaedic Hospital, Gurranabraher.

WESTERN HEALTH BOARD AREA

3.5. The rheumatology unit is based in Merlin Park Regional Hospital, Galway and is staffed by one consultant who is in charge of a 40 bed general medical unit which at any time would have 4 – 10 rheumatology patients. The waiting time for
out-patients is one month for urgent and 4 – 5 months for less urgent cases. A weekly out-patient clinic is held in Castlebar. The orthopaedic unit is also located in Merlin Park.

NORTH WESTERN HEALTH BOARD AREA

3.6. The combined rheumatology and rehabilitation unit (21 beds) staffed by one Consultant in Rheumatology and Rehabilitation is based in Our Lady’s Hospital, Manorhamilton. Weekly out-patient clinics are held in Sligo, Letterkenny and Manorhamilton hospitals and also in Donegal town. Close co-operation with the orthopaedic units in Sligo and Letterkenny general hospitals exists in the form of combined orthopaedic/rheumatology clinics which are held twice-monthly. A post-operative orthopaedic rehabilitation service for patients with rheumatoid arthritis is also provided.

SOUTH EASTERN HEALTH BOARD AREA

3.7. As indicated in paragraph 3.1. the Comhairle, in March 1995, approved a new post of Consultant Physician/Rheumatologist to be based in Waterford Regional Hospital with responsibility for providing a regional service in rheumatology including, inter alia, (i) out-patient clinics commensurate with demand at Wexford, Kilkenny and Cashel/Clonmel Hospitals and (ii) a minimum input of two sessions per week to the regional elective orthopaedic centre at Kilcreene Hospital, Kilkenny. This is the first such post in the area and is currently vacant.

PAEDIATRIC RHEUMATOLOGY

3.8. There is no post of consultant paediatric rheumatologist in Ireland. Paediatric rheumatology services are provided by (a) consultant paediatricians with an interest in rheumatology; (b) adult rheumatologists with an interest in paediatric rheumatology and (c) consultant paediatricians with an interest in rheumatology jointly with the support of adult rheumatologists.

3.9. There are two posts of consultant general paediatrician with specific responsibility for medical rehabilitation/physical handicap. One is related to south Dublin and is based in Our
Lady’s Hospital, Crumlin and shared with the Cerebral Palsy Clinic in Sandymount and the Marino Clinic, Bray. This post includes commitments to the National Rehabilitation Hospital. The other is related to North Dublin and is shared between the Children’s Hospital, Temple Street and the Central Remedial Clinic, Clontarf. The Mater rheumatologist participates in joint clinics with the paediatrician in Temple Street. Although most of their work is in general paediatrics and rehabilitation, both consultant paediatricians provide specific rheumatology clinics for children with chronic juvenile arthritis and other connective tissue disorders and provide a tertiary referral service for children with severe rheumatoid arthritis.

3.10. A monthly paediatric rheumatology clinic has been held in St. Vincent’s Hospital since 1986 by the Professor of rheumatology. There is about one new referral per month. The largest source of referral is from consultant paediatricians seeking specialist advice for their patients with the most severe forms of rheumatic diseases.
SECTION 4 – Considerations for Future Development of Rheumatology Services in Ireland

CONSULTANT MANPOWER

4.1. In addition to pointing to the fact that rheumatology is now a separate and distinct specialty from rehabilitation, the main issue stressed by the health boards and public voluntary hospitals and the Irish Society for Rheumatology was the current undermanning of rheumatology at consultant level in Ireland. Half the health board areas have no consultant rheumatologist. Those health boards and public voluntary hospitals which have consultants contend that they need more. St. Vincent's is the only hospital in the country with two consultant posts which are currently filled on a permanent basis. The Irish Society for Rheumatology point out that there are fewer consultant rheumatologist posts per capita in Ireland than in any other European country including the U.K. While the validity of comparisons with mainland European countries is suspect because of the different types of medical practice and hierarchial systems, comparison with the position in the U.K. which has a broadly similar system to Ireland is valid. The Irish Society for Rheumatology states in a submission to the committee that the actual ratio in the U.K. is one Consultant Rheumatologist per 172,000 population. The Royal College of Physicians recommended ratio is one per 150,000 population. This ratio which assumes that all the necessary ancillary support services (including physiotherapy, occupational therapy and medical social services) are available, has been endorsed by the Irish Society for Rheumatology in written and oral submissions as being appropriate to the circumstances of this country. With twelve posts, the current ratio in Ireland is one per 294,000 people.

4.2. Having carefully considered the views of all those consulted on the matter and having taken on board the
issues of long waiting lists, the need for peripheral out- 
patient clinics, the geographical disparities in the distribution 
of the existing posts, the committee recommends that a ratio 
of one consultant rheumatologist per 150,000 people should 
be adopted as a target for this country. In applying a ratio of 
this scale throughout Ireland, account must be taken of the 
variations in demography, geography and health board size.

4.3. It is hoped that this target can be achieved in a 
reasonably short space of time as resources become available 
and notwithstanding competition for these resources from many 
other sources. The implementation of this target would mean 
that the existing number of consultant rheumatologist posts 
would be doubled from 12 to 24. However, due to the special 
circumstances in relation to the population of the Midland 
and North Western Health Board areas adverted to in later 
paragraph 4.9., the committee recommends a total of 26 
consultant rheumatologists. As there are already over twenty 
NCHD posts not counting interns employed in the existing 
rheumatology units, an increase in the numbers of NCHDs in 
existing units commensurate with additional consultant posts 
should not be necessary. Such an approach would be in line 
with the thrust of the "Tierney Report". During the committee’s 
consultations a much greater emphasis was placed on the need 
for additional paramedical staff, in particular physiotherapists 
and occupational therapists rather than junior medical staff. The 
committee has also been advised that nurse practitioners have 
a vital and growing role to play in the delivery of rheumatology 
services. Other than acknowledging this information and advice, 
it is not within the remit of the Comhairle to comment on the need 
for additional paramedical and nursing staff.

CONSULTANT RHEUMATOLOGISTS AND 
GENERAL MEDICINE

4.4. Table 2 gives a broad indication of the number of beds 
normally occupied by rheumatology patients and general medi-
cal patients under the care of the consultant rheumatologists.
TABLE NO. 2

<table>
<thead>
<tr>
<th>Hospitals</th>
<th>Rheumatology</th>
<th>General Medicine</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Vincent's</td>
<td>c.4</td>
<td>c.20</td>
<td>c.24</td>
</tr>
<tr>
<td>St. Joseph's, Harold's Cross</td>
<td>46*</td>
<td>–</td>
<td>46*</td>
</tr>
<tr>
<td>St. James's</td>
<td>5-7</td>
<td>15-20</td>
<td>c.25</td>
</tr>
<tr>
<td>J.C.M. Blanchardstown</td>
<td>3-5</td>
<td>8-10</td>
<td>10-15</td>
</tr>
<tr>
<td>Mater</td>
<td>5-6</td>
<td>–</td>
<td>5-6</td>
</tr>
<tr>
<td>Beaumont</td>
<td>4-5</td>
<td>18-19</td>
<td>23</td>
</tr>
<tr>
<td>Cork University Hospital</td>
<td>3-5</td>
<td>5-7</td>
<td>10</td>
</tr>
<tr>
<td>South Infirmary/Victoria</td>
<td>5-7</td>
<td>15-20</td>
<td>20-25</td>
</tr>
<tr>
<td>Merlin Park</td>
<td>4-10</td>
<td>30-36</td>
<td>40</td>
</tr>
<tr>
<td>Manorhamilton</td>
<td>21**</td>
<td>–</td>
<td>21**</td>
</tr>
</tbody>
</table>

* these are rheumatology rehabilitation beds
** includes rheumatology and rehabilitation beds

The availability of precise information on the number of dedicated rheumatology beds in each acute general hospital is complicated by the fact that the consultant rheumatologists participate to varying degrees in the general medical on-call rota. The exception is the Mater Hospital. Our Lady’s Hospital, Manorhamilton and St. Joseph’s, Harold’s Cross are not acute general hospitals. One result is that in many cases the proportion of rheumatology patients vis-à-vis general medical patients in the care of consultant rheumatologists can be relatively small. Their general medical on-call commitments vary from one night/weekend in ten in St. Vincent’s, to one in nine in St. James’s, to one in six in Beaumont and Cork University Hospital, to one in five in U.C.H./Merlin Park, to one in four in Blanchardstown and one in three in the South Infirmary/Victoria Hospital.

4.5. A concern expressed by many of the consultant rheumatologists was that the amount of rheumatology they
could practice was diluted – in some cases significantly – by their commitments to general medical on-call rotas. The Irish Society for Rheumatology in their revised submission state “consultant appointments in rheumatology should include a commitment to general internal medicine. The total proportion of time devoted to general internal medicine will depend on local arrangements, but should not be more than 30% in teaching hospitals and not more than 50% in non-teaching hospitals. The number of protected rheumatology beds will also depend on local arrangements and should not be less than ten in teaching hospitals and not less than five in non-teaching hospitals”.

The committee believes that the mix of rheumatology and general medicine should be reflected in the title of the consultant posts and therefore recommends that, henceforth, they be titled “Consultant Physician/Rheumatologist”.

LOCATION

4.6. The consensus advice which emerged from the written submissions and subsequent discussions was that rheumatology services should be based in regional units located in major general hospitals at or close to regional orthopaedic centres. Each regional unit not based in a teaching hospital should have an association with a teaching hospital where possible. The committee accepts this advice.

OUT-PATIENT CLINICS

4.7. As indicated in earlier section 2, rheumatology is primarily an out-patient specialty. The committee recommends that there should be a significant emphasis on out-patient clinics in the future development of rheumatology services. A network of out-patient clinics at appropriate hospitals throughout the catchment area would ease the burden on many patients who, because of their rheumatological disorder, age and the relatively poor public transport system, find it difficult to travel long distances. However, it is essential that such clinics should be properly planned and organised so that the correct balance is struck between the frequency of clinics and the number of
locations to be covered vis-à-vis commitments at the regional unit. The proposed increase in the number of consultant rheumatologists is intended to facilitate this development.

4.8. Anecdotal evidence to the committee suggests that very high numbers of patients continue to attend out-patient clinics over time when they may no longer need to. The high level of inappropriate referrals to out-patient clinics has also been raised with the committee. Thus access to these clinics is reduced for patients who need to be seen. While this is a problem affecting all out-patient clinics and not by any means only rheumatology clinics, the committee feels it should draw attention to the issue and comment briefly on it in this report. Several reasons have been put forward for the recurring cycle of attendances by patients varying from the alleged fact that they see an array of different junior hospital doctors on subsequent visits and may rarely be seen by the consultant after the initial visit. The N.C.H.D.’s usually spend at most 12 months and more often 6 months in a particular specialty in a specific hospital and then move elsewhere thereby adversely affecting continuity of care. This practice in turn leads to no particular junior hospital doctor taking the responsibility of discharging the patient from the clinic back to the referring general practitioner, if there is one. Some patients appear to get to rheumatology and other out-patient clinics via the Accident and Emergency Department thereby bypassing the general practitioner. Anecdotal evidence also suggests that there are great variations in referral rates and patterns by general practitioners. The committee recognises that it does not have sufficient factual information upon which to recommend a meaningful change in the behaviour of doctors and patients whereby many patients may be unnecessarily attending out-patient clinics long after there is a real clinical need to do so. The proposals in the Tierney Report for a change in hospital medical staffing towards a “consultant provided” rather than a “consultant led” service may be one part of the solution to the problem.

MINIMUM VIABILITY

4.9. As a matter of policy, the Comhairle does not favour the concept of single-handed consultant appointments in any
of the medical or surgical specialties. The Irish Society for Rheumatology concurs with this policy in relation to consultant physicians/rheumatologists. However, the committee believes that those health boards, whose population is around 200,000 and who, on population norms, justify not much more than one consultant, should start with one physician/ rheumatologist rather than rely on a service from a larger health board area and in time as the service develops and needs are quantified consider a second post.

TRAINING

4.10. As indicated in paragraph 2.1, separate and distinct training programmes in rheumatology now exist in the U.K. and the U.S.A. The relevant extract from the Joint Committee on Higher Medical Training (J.C.H.M.T.) Handbook 1994 is included in Appendix B. It should be noted that while three training options remain in the J.C.H.M.T. training programmes, a very small and declining number of aspiring consultants take up options (b) rheumatology and rehabilitation combined and (c) general physicians with a special experience and training in rheumatology. The vast majority follow the training programme designed for those intending to practice exclusively in rheumatology which includes a significant component of training and experience in general internal medicine.

PAEDIATRIC RHEUMATOLOGY

4.11 Reliable, comprehensive epidemiological information on the incidence and prevalence of rheumatological disorders has not been furnished to the committee. However, it has been advised that the incidence of juvenile chronic arthritis in developed countries is approximately 1 per 10,000 children and that the prevalence is about 1 per 1,000 children. Extrapolating from these data there should be about one hundred new cases per annum in this country and about one thousand cases overall. The epidemiology of other rheumatic diseases of childhood suggest that the prevalence of connective tissue disorders other than juvenile chronic arthritis is 0.16 per 1,000 and that the prevalence of other diseases presenting to a paediatric rheumatology service is 1 per 1,000.
4.12 The committee has been advised that the vast majority of juvenile arthritis cases can be managed properly by general paediatricians. Only about 10% of juvenile chronic arthritis is difficult to manage and would require referral to a centre with specialised expertise.

4.13 Because of the small numbers involved, the equivalent of only one whole-time consultant paediatrician with a particular responsibility for paediatric rheumatology would be warranted in Ireland. Despite the small numbers involved, the committee believes that one such whole-time equivalent post can be justified because of the special expertise that would be provided to those needing it and because the appointee(s) would be working also in general paediatrics and not exclusively in paediatric rheumatology. It has been noted that neither paediatric rheumatology nor rehabilitation are recognised sub-specialties of paediatrics by the J.C.H.M.T. – the relevant extract is included in Appendix B.
SECTION 5 – Recommendations

5.1. As indicated in paragraph 4.3, the committee regards an establishment of 26 posts of consultant physician/rheumatologist as a reasonable target for the future in Ireland. The achievement of this target will depend on the availability of resources and competing priorities at hospital level. In the following paragraphs, the committee recommends how it envisages these posts being deployed and structured.

5.2. The following table sets out the existing position by health board area and the committee’s recommendations on the distribution of the proposed 26 posts:

<table>
<thead>
<tr>
<th>AREA</th>
<th>NEHB</th>
<th>EHB</th>
<th>MHB</th>
<th>SEHB</th>
<th>SHB</th>
<th>MWHB</th>
<th>WHB</th>
<th>NWHB</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pop. (000's)</td>
<td>300</td>
<td>1,245</td>
<td>203</td>
<td>383</td>
<td>532</td>
<td>311</td>
<td>343</td>
<td>208</td>
<td>3,525</td>
</tr>
<tr>
<td>Existing Posts</td>
<td>-</td>
<td>7</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Recommended Posts</td>
<td>2</td>
<td>10</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>26</td>
</tr>
</tbody>
</table>

EASTERN HEALTH BOARD AREA

5.3. The proposed reorganisation of the E.H.B. area envisages, inter alia, five geographical units each serving a population of about 250,000. Each area will have one major general teaching hospital except north west Dublin where both the Mater and Blanchardstown Hospitals are located. The committee recommends two posts of consultant physician/rheumatologist serving each of the five areas and based in the following hospitals:—

Beaumont
Mater/J.C.M. Blanchardstown
St. James’s
Tallaght (F.D.V.H./M.A.N.C.H.)
St. Vincent’s

This will require the creation of two new posts in Tallaght, the creation of second posts in St. James’s and Beaumont
Hospitals and, subject to the agreement of all parties concerned, the restructuring of the Mater and James Connolly Memorial Hospital posts. Regular out-patient clinics commensurate with demand should be provided in St. Michael’s and St. Columcille’s Hospitals by the St. Vincent’s unit and in Naas Hospital by the proposed Tallaght (F.D.V.H./M.A.N.C.H.) unit.

5.4. In accordance with the advice of the Irish Society for Rheumatology that rheumatology units should be at or close to regional orthopaedic centres, the committee recommends that all posts of consultant physician/rheumatologist in the E.H.B. area should have a formal commitment to either of the two elective orthopaedic units at Cappagh or the Adelaide/Tallaght Hospitals in line with the organisation and delivery of elective orthopaedics.

5.5. The committee was impressed with the facilities of St. Joseph’s Unit, Harold’s Cross and suggests that there is a need for the development of similar low-tech rheumatology rehabilitation beds elsewhere in the country including north Dublin. The committee recommends that the St. Joseph’s Unit becomes the facility for all appropriate patients in the greater south Dublin catchment area and that the consultant physicians/rheumatologists not only in St. Vincent’s but also in St. James’s and (M.A.N.C.H.) Tallaght Hospitals have access to the unit and that consultant posts be structured accordingly. It has been indicated to the committee that the facilities in St. Joseph’s Unit will need to be expanded to implement this recommendation and that there will be resource implications.

NORTH EASTERN HEALTH BOARD AREA

5.6. The committee recommends the appointment, in the Louth/Meath sector, of two consultant physicians/rheumatologists to provide a regional service to the N.E.H.B. area. Both posts should have a sessional commitment to the regional elective orthopaedic unit based in Navan. Out-patient
clinics commensurate with demand should be provided in the other general hospitals in the health board area.

**MIDLAND HEALTH BOARD AREA**

5.7. The committee recommends the appointment of one consultant physician/rheumatologist at Tullamore General Hospital where the regional orthopaedic unit is based. Out-patient clinics should be provided in Mullingar and Portlaoise Hospitals. As indicated in earlier paragraphs 4.3. and 4.9. it is envisaged that this appointment would be the first of two in the area. The issue of a second post should be considered when the service has been established and functioning for some time.

**SOUTH EASTERN HEALTH BOARD AREA**

5.8. The committee recommends the appointment of two consultant physicians/rheumato logists at Waterford Regional Hospital with structured sessional commitments to the elective orthopaedic unit at Kilcreene Hospital, Kilkenny. Out-patient clinics commensurate with demand should be provided in Wexford, Kilkenny and Cashel/Clonmel Hospitals. As indicated earlier, the first post was approved recently.

**SOUTHERN HEALTH BOARD AREA**

5.9. In the context of the proposed pan-hospital structures for Cork, outlined in the recently published Comhairle review of consultant manpower in the S.H.B. area (December 1994), the committee recommends the appointment of a third additional consultant physician/rheumatologist for this area to be based in Cork University Hospital and including a sessional involvement in the South Infirmary/Victoria Hospital.

5.10. The informal cross-cover arrangements between the two existing consultants should be formalised and expanded to include the proposed third post. A formal sessional input to the Mercy Hospital should be considered by all parties in the context of the proposed pan-hospital structures referred to above. In addition, out-patient clinics should be provided
in Mallow and Bantry General Hospitals. All three consultants should have a formal commitment to the orthopaedic unit in St. Mary's Hospital, Gurranabraher. The implementation of these recommendations, which will involve the restructuring of posts, will require the agreement of the existing appointees and the hospital authorities concerned.

5.11. The committee recommends the appointment of a consultant physician/rheumatologist to Tralee General Hospital. In arriving at this decision, the committee took into account the following factors:

- the long distance (70 miles) from Tralee to Cork;
- the population of Co. Kerry (122,000) which is spread over a large geographical area, parts of which are over 100 miles from Cork city;
- the existence of an orthopaedic unit in Tralee General Hospital staffed by two consultant orthopaedic surgeons.

MID-WESTERN HEALTH BOARD AREA

5.12. The committee recommends the appointment of two consultant physicians/rheumatologists based in Limerick Regional Hospital with structured sessional commitments to the elective orthopaedic unit at Croom and regular out-patient clinics commensurate with demand at Ennis and Nenagh General Hospitals and at St. John's Hospital, Limerick. The future role in the overall rheumatology service of the Ennis based general physician with an interest in rheumatology will need to be reviewed in the context of the implementation of these recommendations.

WESTERN HEALTH BOARD AREA

5.13 The committee recommends the appointment of a second consultant physician/rheumatologist at University College Hospital/Merlin Park Hospital to be based mainly in the latter hospital. Regular out-patient clinics commensurate with demand should be provided at Portiuncula Hospital, Ballinasloe and Roscommon County Hospital in addition to an enhanced out-patient service to Castlebar. One full day rather than one
half-day per week at Castlebar has been suggested to the committee.

NORTH WESTERN HEALTH BOARD AREA
5.14 This area (population 200,000) is already served by one consultant based in Manorhamilton. A second consultant appointment in the area is envisaged as set out in earlier paragraphs 4.3. and 4.9.

PAEDIATRIC RHEUMATOLOGY
5.15 The committee recommends that one wholetime equivalent post of consultant paediatrician with a special interest in paediatric rheumatology, based in the childrens' hospitals in Dublin would, on balance, be justified for the whole country.

ACADEMIC RHEUMATOLOGY REQUIREMENTS
5.16. It should be noted that while the emphasis in this report is largely on service issues, the academic aspects have not been overlooked. The committee envisages that academic rheumatology requirements will be taken into account when decisions on service needs are being made.
6.1 In formulating the foregoing specific recommendations for the development of rheumatology services, the committee has taken account of the services which are currently concentrated in four of the eight health board areas, the populations to be served in each area and the existing hospital network. The committee believes that these recommendations are in the best interests of patients.

6.2 The committee hopes that its recommendations can be implemented over a reasonably short period as resources and competing priorities at hospital level permit. Rheumatology is relatively inexpensive when compared to other specialties such as cardiology, radiotherapy etc. It is primarily an out-patient service relying heavily on consultant and paramedical expertise rather than sophisticated and expensive equipment, large numbers of inpatient beds and junior hospital doctors. The committee feels that implementation of its recommendations will bring about an increased and more equitable distribution of rheumatology services throughout the country.

6.3 As indicated in earlier paragraph 1.11, the committee has not yet completed its task in relation to the future organisation and development of the specialty of rehabilitation medicine in Ireland. Part 2 of the committee’s report relating to rehabilitation medicine, at consultant level, will follow when the committee has completed its deliberations thereon.

APRIL 1995.
APPENDIX A

LIST OF INTERNATIONAL REPORTS STUDIED BY COMMITTEE


Rehabilitation Services in Scotland: The Scottish Office Home and Health Department/Scottish Health Service Advisory Council: 1993.


APPENDIX B

Extracts from Training to be a Physician: a handbook of the Royal College of Physicians of London 1993.

Rheumatology

Rheumatology is predominantly concerned with disorders of the musculoskeletal system, affecting people of any age, but many rheumatic diseases are multisystem disorders and a wide experience of general medicine is important. The scope of rheumatic diseases is such that, whilst many doctors specialise in rheumatology alone, others choose to be involved in fields such as immunology, general (internal) medicine or rehabilitation (disability) medicine.

The Consultant's Job

Most established consultant posts are in rheumatology alone, especially in southern England, but some districts seek a general physician with a special expertise in rheumatology or a rheumatologist with experience in rehabilitation. The latter may be sought less often as more specialist training in rehabilitation (disability) medicine develops. Whether to select a post offering single or dual accreditation should be given careful consideration before embarking on higher medical training.

Life-threatening crises and long-term care of patients with rheumatic disease require skilled management and close cooperation with colleagues in other disciplines and professions. Good organisation and teamwork are important. Much of the work is done in outpatient clinics and may be supported by clinical assistants rather than junior staff in training. As many doctors have little training in rheumatology, teaching skills and willingness to participate in postgraduate training are also valued.

Training Requirements.

Experience of research and study towards a higher degree is expected. There is still much to discover about the aetiology, pathogenesis and treatment of these chronic disabling diseases. Research may be clinical or laboratory based, covering such diverse fields as biochemistry, biomechanics, epidemiology,
immunology, molecular biology and pharmacology. Academic units and other large rheumatology centres have specialist interests and will be able to advise on funding and supervision of work in their field. The British Society of Rheumatology (BSR) organises scientific meetings and basic and advanced educational courses. It continues to liaise closely with other bodies on manpower levels and training requirements. Trainee rheumatologists meet regularly and are represented on the BSR council and its subcommittees. There are also links with training in Europe.

**Career Prospects**

The prospects in rheumatology have improved recently as senior registrar numbers have been reduced and the consultant grade slowly expands. There is scope for further expansion, as there are still districts with little or no rheumatological service. Rheumatologists may serve more than one district and it may be an advantage to have some training and experience in administration.

**Rehabilitation Medicine**

The lack of specialist care for adults with disabilities is a notable defect of today's health service. In 1972 the Tonbridge report recommended that there should be a consultant in rehabilitation medicine in every district. In November 1989 the Department of Health formally recognised rehabilitation medicine as an independent specialty in England and Wales, though it has been well established in Scotland for some fifteen years.

**The Consultant's Job**

The consultant practising in rehabilitation medicine will have to work closely with colleagues of all disciplines as well as with the many other professionals in health and social services. Useful qualities to possess are clear thinking, good communication skills, the ability to work as a member of a team, unlimited patience and political and managerial skills. The constant fight for extra resources and facilities for disabled people is a time-consuming but important part of the job.
Rehabilitation medicine is a broad specialty which can encompass some specialist areas, such as amputee rehabilitation and rehabilitation after spinal injury. At a district or community level, priorities for this specialty are young disabled people in the transition from school to adult life, those with multiple disabilities, including cognitive impairment (such as those with traumatic brain injury), those requiring special training or support in order to remain in their own home or at work, and requiring specialised equipment particularly in relation to orthosis, special seating, environmental control equipment and specialised wheelchairs. It is envisaged that most consultants will practise exclusively in rehabilitation medicine (RM). A small minority will probably have sessions in other specialties related to rehabilitation medicine such as neurology or rheumatology, but specialists with dual qualifications will be expected to spend at least six sessions a week in rehabilitation medicine. Those involved in more specialist areas will normally be full-time in the specialty.

Training Requirements
Rehabilitation medicine is one of the more expedient specialties for those who wish to pursue part-time training. Apart from the need for basic training in general medicine, experience in other specialties such as neurology, rheumatology, psychiatry, mental handicap and geriatric medicine is an advantage.

There can be few areas of medicine where there is such scope for research of direct and practical relevance to patient care. The full potential of new materials and technology has yet to be realised in the treatment of disabled people and there are many established rehabilitation techniques which would benefit from scientific evaluation. The Society for Research in Rehabilitation is the foremost academic society in rehabilitation in Europe. It is an interdisciplinary society which holds regular meetings at which such work can be presented. The British Society for Rehabilitation Medicine is open to medical graduates of all grades and specialties interested in the field of rehabilitation medicine. It holds scientific meetings as well as representing the political interests of those training and practising in the field.

Career Prospects
There is a growing appreciation of the need for new training posts in this field and at the time of writing it is proving difficult to fill all the consultant posts that are being advertised.
The number of senior registrar posts approved for full-time training in RM was increased in 1990 to 25 in England and Wales. A further 15 posts are currently approved for joint training in rehabilitation medicine and rheumatology, but in future the balance is likely to shift strongly in favour of full-time RM posts.

Extracts from Joint Committee on Higher Medical Training (J.C.H.M.T.) Handbook 1994

RHEUMATOLOGY

General Professional Training
General professional training will be similar to that of general (internal) medicine. Some experience in immunology, orthopaedics, rehabilitation medicine or rheumatology would be advantageous.

Higher Specialist Training
Higher specialist training will normally extend over a period of four years in a recognised Senior Registrar appointment(s).

(a) For those intending to practise exclusively in Rheumatology:

(i) General experience: In the training period provision should be made for continuing wide experience in general (internal) medicine.
(ii) Obligatory experience: Since rheumatology is that branch of medicine concerned with connective tissue disease and with medical disorders of the locomotor system, the central theme of training should be the diagnosis and management of these conditions. Such experience must include: responsibility for the care of in-patients and out-patients; a knowledge of the facilities required for the rehabilitation of patients suffering from these disorders; the collaborative care of patients undergoing associated surgery; and experience in dealing with all the social aspects of rheumatological problems.
(iii) Recommended experience: Research in fields complementary to rheumatology, e.g. immunology; working in a related branch of medicine or gaining experience in rehabilitation medicine.
(b) For those intending to practise in Rheumatology and Rehabilitation Medicine:

Such posts involve developing and co-ordinating rehabilitation services; training of medical and other health care personnel; assessing and advising in the rehabilitation of disabled patients other than rheumatological. Trainees for such posts are advised to undertake Senior Registrar training programmes approved for higher specialist training in both rheumatology and rehabilitation medicine.

(c) For those intending to practise as a General Physician with special experience and training in Rheumatology:

Consultant posts may be filled by General Physicians with special experience and training in Rheumatology. Trainees for such posts are advised to undertake Senior Registrar training programmes which include the management of medical emergencies and are approved for higher specialist training in both general (internal) medicine and in rheumatology.

**REHABILITATION MEDICINE**

Whilst all physicians are responsible for rehabilitating their own patients, whatever their specialty, some will take a special interest in this aspect. Such a physician could continue to practise in his own specialty, but accept responsibility for developing and co-ordinating rehabilitation services; integrating and training of medical and paramedical personnel; advising in difficult rehabilitation problems; promoting research; and being involved with a specific service. A few physicians could practise exclusively in the specialty of Rehabilitation Medicine, probably pursuing a particular clinical interest such as to provide the service in a Young Disabled, Spinal Injury, Prosthetic/Orthotic, employment, academic or other specialised unit.

**General Professional Training**

This would be similar to that for General (Internal) Medicine. Some experience in certain surgical specialties and psychiatry might be included, while experience in cardiology, geriatrics, neurology, neuro-surgery, orthopaedic surgery, paediatrics, respiratory medicine or rheumatology would be particularly relevant.
Higher Specialist Training

(a) Physician to take only part-time responsibility in rehabilitation medicine:

Such physicians are likely to be seeking joint accreditation in specialties like geriatric medicine, neurology, occupational medicine, paediatrics and rheumatology, for which they would have to satisfy the requirement. Surgeons and psychiatrists could also train for joint accreditation. Training would normally extend over two years undertaking clinical duties approved for training in rehabilitation to gain some of the experience outlined below. Some of this could be gained within their main specialty training. The training may be specific to particular topics like prosthetics and orthotics or spinal paralysis.

(b) For those intending to practise exclusively in the specialty:

(i) General experience: The training period will be for four years in approved posts which should combine clinical, research, teaching, organisational and administrative experience.

(ii) Obligatory experience: The central theme of training shall be the diagnosis and management of physical disability with particular emphasis on the rehabilitation and resettlement of patients with both temporary and long-term handicaps. The trainees must acquire:

(a) a wide knowledge of rehabilitation facilities and services required, be they provided in hospitals, rehabilitation units or the community by health, social and employment services.
(b) Experience in the organisation, development and evaluation of rehabilitation services in hospital and the community whether statutory or voluntary.
(c) Experience in leading a multi-disciplinary clinical team.
(d) Experience in research methods including problems of measurement and data processing.
(e) A knowledge of working conditions in industry.
(f) An understanding of the intellectual and emotional problems of illness, injury and disability as they affect the patient and the family.

(iii) Recommended experience: Up to two years may be spent in relevant clinical disciplines, e.g. cardiology,
general (internal) medicine, geriatric medicine, neurology, orthopaedic surgery, psychological medicine, respiratory medicine and rheumatology, in a spinal injuries unit, in a department concerned with prosthetics and orthotics or in full-time relevant research.

**PAEDIATRICS**

**General Professional Training**

This should be primarily a training in the general medicine of infancy and childhood and should normally occupy three years after completion of the pre-registration year. This training should largely be in approved posts giving broad experience of paediatrics both in and outside hospital and should include some experience of caring for adult patients. The trainee would be wise to fulfil the obligatory requirement to spend at least six months as a resident house physician in a children’s hospital or children’s unit of a general hospital early in this period and to obtain the MRCP as soon as possible. At this stage experience of community paediatrics or communicable diseases in childhood is highly desirable. Other acceptable experience could include general practice, general medicine of adults, community medicine, psychiatry, obstetrics, paediatric surgery, accident & emergency medicine or research. A period of paediatric practice in a developing country is considered to be of value.

Experience gained during general professional training may not need to be repeated during higher specialist training, but the total content of paediatric experience in general and specialist training must not be less than four years whole-time or the equivalent in part-time training.

Enrolment, higher specialist training and accreditation may be in:

a. general paediatrics
b. general paediatrics with a special interest e.g. communicable diseases
c. a specialty wholly contained within paediatrics – perinatal paediatrics
d. a paediatric system specialty
e. a combination of general paediatrics and c or d above.
Higher Specialist Training
This should be individually designed according to the previous experience and predicted future of the trainee. It must include the obligatory experience detailed below, unless this has been obtained during general professional training.

(a) General Paediatrics:
   (i) Obligatory experience: At least six months as a resident house physician in a children’s hospital or children’s unit of a general hospital. In-patient and out-patient care of ill children including emergency work, to a total of at least two years in the post-registration period. Neonatal and community paediatrics (the latter to include development assessment and surveillance and the care and habilitation of handicapped children).
   (ii) Recommended experience: Child psychiatry; communicable diseases; experience of one or more of the paediatric system specialties. Research in paediatrics or a related discipline.
   (iii) Acceptable experience: General medicine of adults, social and community medicine, accident & emergency medicine; overseas experience.

(b) General paediatrics with a special interest:
The programme of HST outlined above should be varied to include at least two years in the chosen special interest subject.
   Special interests hitherto recognised, with appropriate training programmes are neonatal medicine; communicable diseases; community child health.
   The development of other ‘special interest’ training programmes is under discussion.

(c) Specialisation within paediatrics: perinatal paediatrics
   It is envisaged that the great majority of trainees will also seek accreditation in general paediatrics. Hence the period of HMT will be lengthened to meet the requirements for dual accreditation.

(d) Paediatric system specialties:
   Where accreditation as a specialist in a paediatric system specialty is sought the trainee is required to fulfil the criteria specified in order to be accredited for exclusive practice in this field.
While some trainees will wish to be accredited in a paediatric system specialty only, most will seek accreditation in general paediatrics as well. For such dual accreditation, the training period may need to be lengthened to meet the requirements of both specialties.

Training programmes for the following system specialties have been approved:

- paediatric accident & emergency medicine
- paediatric cardiology
- paediatrics with a special interest in infectious diseases
- paediatrics with a special interest in community child health
- paediatric endocrinology
- paediatric gastroenterology
- paediatric haematology
- paediatric metabolic medicine
- paediatric nephrology
- paediatric neurology
- paediatrics with a special interest in neonatal medicine
- paediatrics with a special interest in respiratory medicine
- perinatal paediatrics
- paediatric oncology