



Anaesthesiologists in Ireland

Role profile

The College of Anaesthesiologists of Ireland

Anaesthesiologists in Ireland – Role Profile

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8. Helsinki Declaration on Patient Safety + 10 years on
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10. Critical Care Capacity and Activity Report 2024
11. CAI EGM 2024 Minutes
12. Anaesthesiology Medical Workforce in Ireland 2023-2038
13. CAI SA Training Curriculum
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Notes

Critical Care versus Intensive Care – Definitions

The terminology can be confusing. The specialty is Intensive Care Medicine and the term *intensive care* usually refers to job titles. Critical Care is an umbrella term that comprises high dependency care, post anaesthesia/surgical care, coronary care and intensive care for adults and children. This document uses the terms intensive care and intensive care medicine.

Repetition within the document

It is expected that individual sections of the document may be read separately. Therefore, some points have been intentionally repeated between sections e.g., anaesthesiology and intensive care medicine.

Model 3 and Model 4 Hospital Survey

The survey of model 3 and model 4 hospitals does not include all hospitals in Ireland, therefore the data although providing useful information must be considered incomplete. Census 2024 data is presented in addition.

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Foreword

President CAI

In June 2024, the Medical Council of Ireland mandated a significant change to the nomenclature of the certificate awarded upon successful completion of the Specialist Anaesthesiology Training Programme of the College of Anaesthesiologists of Ireland (CAI). The certificate, which previously reflected the breadth of training in Anaesthesiology, Intensive Care Medicine and Pain Medicine, will henceforth be titled *Certificate of Satisfactory Completion of Specialist Training (CSCST) in Anaesthesiology*. This regulatory decision, driven by legal obligations under the Medical Practitioners Act 2007 and European Directive 2005/36/EC, prompted both concern and reflection within the profession.

In response, this document has been developed to clearly define and articulate the current and evolving role of anaesthesiologists in Ireland. The scope of practice for graduates of the CAI Specialist Training Programme encompasses not only anaesthesiology but also substantial and integrated training in intensive care medicine and pain medicine—domains essential to the safe and effective delivery of care across the Irish health system. Our curriculum, endorsed by the HSE and accredited by the Irish Medical Council, is among the most comprehensive in Europe, reflecting the complex demands of modern perioperative, critical care, and pain medicine services.

This role profile aims to clarify and reaffirm the competencies and responsibilities of anaesthesiologists in Ireland. It aligns with national healthcare strategies, the Model of Care for Anaesthesiology, the Model of Care for Adult Critical Care, and the needs of our patients, ensuring that anaesthesiologists continue to serve as critical leaders in multidisciplinary teams across a wide variety of clinical settings.

We offer this document as a definitive statement of professional standards, scope of practice, and training excellence in anaesthesiology in Ireland. It is intended to support consultant appointment bodies, hospital managers, policymakers and our colleagues across the health system as we navigate this period of transition with clarity and purpose.

Professor Donal Buggy

President, College of Anaesthesiologists of Ireland

Foreword

CEO, CAI

As Chief Executive Officer of the College of Anaesthesiologists of Ireland (CAI), I welcome this updated Role Profile of Anaesthesiologists in Ireland—a vital and timely document that defines the current and future contribution of our specialty across the Irish healthcare system. This document is more than a description of clinical duties; it is a declaration of purpose and a strategic blueprint, affirming the breadth and depth of anaesthesiology and its integral role in Ireland’s present and future models of care.

Today, anaesthesiologists are at the centre of some of the most complex and critical areas of patient care, from the operating theatre and intensive care unit to pain medicine, perioperative planning and preoperative assessment. Their work demands not only technical excellence but also leadership, adaptability and an unwavering commitment to patient safety. As we navigate the challenges ahead: increasing service demands, workforce pressures, technological innovation and the drive toward integrated care, anaesthesiologists are uniquely positioned to lead and shape the future of healthcare delivery in Ireland.

This role profile will be central to our strategic priorities in the years ahead. It clearly articulates the capabilities, responsibilities and value of anaesthesiologists across clinical, academic, managerial, and leadership domains. It also highlights the importance of both generalist expertise and subspecialisation within the specialty. This clarity supports robust workforce planning, responsive training, and informed service design.

Central to that vision is our ongoing commitment to work in partnership with the Health Service Executive (HSE) to strengthen our anaesthesiology workforce. We fully support and are aligned with the requirements outlined in the HSE National Anaesthesiologist Workforce Plan, including the urgent need to increase the number of consultant anaesthesiologists. Meeting this target is essential to ensuring safe, high-quality patient care across the hospital system and to enabling the kind of flexible, consultant-delivered service that modern healthcare demands.

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As always, our College remains committed to advocating for our specialty, supporting our members, and enabling the next generation of anaesthesiology leaders through world-class training and professional development. As we look ahead, CAI remains steadfast in our commitment to collaborate with the Health Service Executive (HSE) to increase consultant anaesthesiologist numbers and deliver on the ambitions set out in the national workforce plans. This profile will support that mission—providing clarity to policymakers, appointment bodies and our health service colleagues as we work together to strengthen capacity, protect patient safety and ensure the sustainability of anaesthesiology-led services into the next decade.

Mr Martin McCormack

Chief Executive Officer, College of Anaesthesiologists of Ireland

Anaesthesiologists in Ireland – Role Profile

The trainee perspective

Chair, committee of anaesthesiology trainees

Anaesthesiology trainees on the CAI SAT programme receive modular training across a variety of different subspecialties, e.g., cardiac anaesthesia, neuro-anaesthesia, regional anaesthesia. A minimum volume of experience is required to achieve competency in each of these areas.

Trainees spend a considerable proportion of training time in intensive care medicine (ICM). This training is undertaken in model 3 and in model 4 hospitals across Ireland during the six year SAT programme. Provision of ICM in Ireland is heavily dependent on the contribution of anaesthesiology trainees and exclusion of these trainees from ICM services would cause major staffing issues in ICUs across the country. A review of the logbooks of year 6 trainees showed that the number of hours spent in ICM during training was significantly in excess of the minimum volume of practice required to achieve competency in ICM.

The training in ICM received by Irish SAT trainees results in the production of skilled and competent anaesthesiologists that are valued and recognised internationally.

In a survey of 192 SA trainees conducted in September 2024 (Appendix I), the primary concerns expressed regarding ICM were:

- 1) The change in CSCST nomenclature to exclude ICM does not accurately reflect the significant training received in ICM.
- 2) The change in CSCST nomenclature to exclude ICM does not reflect the considerable service provision to ICM and the burden of on-call time spent in ICM, particularly compared to non-anaesthesiologists practising ICM, causing many trainees to feel undervalued and underappreciated.
- 3) Concerns about potential litigation issues that could arise in the future if/when these trainees practise ICM as consultants.
- 4) Concerns about international recognition of the (new) CAI CSCST impacting trainees' ability to achieve positions on overseas fellowship programmes and ultimately CAI trainees' competitiveness in applying for consultant posts.

There are variations in trainees' long-term intentions to practice ICM after CSCST. The survey found that:

1. 25% of trainees indicated their wish to exclusively practise anaesthesiology as a consultant without ICM commitments
2. 45% of trainees indicated an intention to practise ICM in some capacity as a consultant either in a tertiary or regional or paediatric centre or (a minority) overseas.

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3. 30% were undecided as to whether they wished to practise ICM longer-term. This cohort's practice will undoubtedly be influenced by requirements of specific consultant job descriptions.

The majority of those who indicated a preference to practice ICM wished to do so in addition to regular anaesthesiology commitments, with 3% indicating a preference for an exclusive ICM practice.

Dr Paul Ryan
CAT Chair

Anaesthesiologists in Ireland – Role Profile

Foreword

Working group chair - role profile: anaesthesiologists in Ireland

The requirement for defining a Role Profile including Clinical Practice of Anaesthesiologists in Ireland has arisen from the decision (June 2024) by the Medical Council of Ireland (MCI) to change the wording on the certificate of successful completion of specialist training (CSCST) awarded to graduates of The College of Anaesthesiologists of Ireland (CAI) Training Programme (TP). CSCST is the certificate that allows a doctor to be registered by MCI and to practice as a consultant in the Irish Healthcare System.

Specifically, MCI has mandated elimination of Intensive Care Medicine/Critical Care Medicine (ICM) and Pain Medicine (PM) on the certificate – currently the certificate reads *CSCST in Anaesthesiology, Intensive Care Medicine and Pain Medicine*.

The change made by MCI to the nomenclature of the CSCST given to those completing training in anaesthesiology in Ireland led to widespread and profound disquiet among a significant number of CAI fellows. The primary concern is that in Ireland the anaesthesiology and intensive care medicine services are delivered for the most part by Anaesthesiologists and comprise a large part of the out-of-hours work in all acute hospitals.

The programme offered by CAI, trains doctors to deliver a clinical service that incorporates care of critically ill adults and children presenting at any hospital ED, care of deteriorating patients on hospital wards as well as care of patients admitted to ICUs, carried out in conjunction with providing anaesthesiology services. CAI training is therefore of necessity protracted and delivered to a very high standard. This is reflected in the current CSCST conferred at the end of training that includes anaesthesiology, intensive care medicine and pain medicine. The (2030) CSCST nomenclature *Anaesthesiology* will not in the view of fellows, comprehensively reflect the extensive training undertaken by doctors on the CAI training programme or the clinical services provided by anaesthesiologists in Irish hospitals.

The primary objective of this working group is to role profile the post of a consultant in anaesthesiology in Ireland. The aim is to ensure that the role aligns with the *Model of Care for Anaesthesiology* and with the *Model of Care for Adult Critical Care*, maintaining the highest level of patient care and professional integrity. This document aims to emphasise clearly and comprehensively the key role played by anaesthesiologists in Ireland in the provision of elective, emergency and out of hours intensive care medicine and anaesthesiology services.

The profile describes an anaesthesiologist at the conclusion of general anaesthesiology training on the CAI SAT programme.

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Specialisation in intensive care medicine, pain medicine, in aspects of obstetric anaesthesia or in regional anaesthesia may be undertaken in addition to the certification of completion of specialist training obtained at the end of CAI training.

HSE Human Resources (HR) Division has invited CAI to define the role of anaesthesiologists within our own community of anaesthesiologists, pain medicine physicians and intensive care physicians, for endorsement by HSE HR, by memorandum to The Consultant Appointments Advisory Committee (CAAC), and, to all hospitals and other consultant appointment bodies.

HSE has consistently endorsed and reinforced the current clinical practice of anaesthesiologists through *The National Clinical Programme for Anaesthesiology* that references *The Model of Care for Anaesthesiology*, *The Model of Care for Adult Critical Care*, *The HSE National Critical Care Programme* and *The National Office of Clinical Audit*.

This anaesthesiologist's role, particularly in many model three hospitals in Ireland, includes assessment and management of critically ill patients, stabilising patients in anticipation of transfer to other hospitals and provision of anaesthesia for emergency surgery including category one caesarean section.

This document describes the extent of the consultant anaesthesiology role, emphasising the solicitation of anaesthesiology fellows that their competencies and skills be reflected in CSCST nomenclature.

I extend my gratitude to the members of the working group for their time, experience and diversity of thought that enhanced the extensive discussions involved in drafting this document, also to those who contributed individual submissions and analysed data for inclusion and in particular to the Chairs of Anaesthesiology Departments throughout the country who provided survey data that effectively illustrates the expanding and consequential spectrum of the anaesthesiologist's role in Irish hospitals.

Dr Deirdre McCoy

Vice President/Honorary Secretary, CAI

The Medical Council of Ireland Directive: A Registration Issue

(see Appendix II)

MCI (communication with CAI) made its decision on the nomenclature used on CSCST for the purposes of registration, believing it to be in line with legal obligations. Titles and designation of qualifications granted in the state by MCI that enable a medical practitioner to be registered on the Specialist Division of the Register of Medical Practitioners must comply with the terms of Section 89(2) of the Medical Practitioners Act 2007: *“The Council shall specify, in relation to each medical specialty recognised under subsection 1, the titles and designations of qualifications in specialised medicine granted in the state which may be required to enable a medical practitioner to secure registration in the Specialist Division in respect of that specialty.”* (MPA 2007 s89(2)), and with the terms of the EU Directive on mutual recognition of professional qualifications (EU Directive 2005/36/EC).

Legal advice received by MCI was that CSCST nomenclature should mirror the speciality simplicitor of the section of the MCI register to which a training programme, once completed satisfactorily, granted automatic entry.

The unilateral decision by MCI to change CSCST nomenclature therefore relates to MCI’s legal purpose, i.e., registration on the correct specialist register.

MCI (following CAI representation) temporarily removed the mandatory compliance recommendation (above) having accredited CAI’s SA training programme, and simultaneously sought confirmation from the Department of Health, the State Claims Agency (SCA) and from the HSE that a CSCST nomenclature change was not likely to negatively impact recognition of qualifications, employment or indemnity.

MCI stated its satisfaction with reassurance issued by HSE that the clinical practice of a consultant anaesthesiologist trained in Ireland would be unchanged following the MCI mandated CSCST nomenclature change. SCA also confirmed this position to MCI.

On receiving these assurances MCI abruptly ordered immediate implementation of the change in CSCST nomenclature. However, in response to CAI’s communication of grave concerns, MCI acceded to a period of transition delaying implementation to 2030.

In making this decision, MCI confirmed to CAI awareness of its moral obligation to consider the issues CAI had raised: clarity on clinical practice, concerns about an individual consultant’s liability or indemnification and perceived lack of recognition of anaesthesiology services to ICM. Of even greater concern remains the risk that consultant anaesthesiologists could withdraw from IC commitments in addition to concerns about future appointments to consultant posts and CAI training programme recruitment.

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Clinical Practice

There is a need for anaesthesiologists trained in Ireland to be competent and qualified in pain medicine and in intensive care medicine. This is in line with Union Européenne des Médecins Spécialistes (UEMS, The European Union of Medical Specialists) and with the organisation of ICM services in a European context.

HSE has endorsed and reinforced this requirement consistently in publications e.g.,

1. *The National Clinical Programme for Anaesthesia*, including the published and endorsed *Model of Care for Anaesthesia*, *HSE Critical Care Programme* and *The National Office of Clinical Audit*.

2. *The National Clinical Programme for Critical Care: Model of Care for Adult Critical Care*

3. National Workforce Strategies:

A) *Critical Care Workforce Planning 2020* outlines current ICM service delivery in Ireland (Executive Summary ps vi-viii, Introduction ps 5-11), clearly distinguishing among "Consultant Anaesthesiologist with rostered commitment to ICM", "Consultant with SI in ICM" and "Consultant Intensivist"

B) *Anaesthesiology Medical Workforce Plan 2023- 2038*

The Model of Care for Anaesthesiology in Ireland requires qualified anaesthesiologists to provide at least 80% of the services to intensive care units in Irish hospitals. Therefore, the CAI includes modules of ICM and PM in the specialist anaesthesiology training programme curriculum with explicit learning outcomes achieving competency in ICM and pain management in line with the *Model of Care for Anaesthesiology* in Ireland. These learning outcomes have been and continue to be supported and approved by the HSE and accredited by MCI.

The CAI (short-life) working group

was convened to

- provide a draft document to CAI, ***Anaesthesiologists in Ireland: Role Profile***, to contribute to the work of a (larger) White Paper Discussion Group on the future of Anaesthesiology and ICM training and clinical services, including all aspects of perioperative medicine and pain medicine in Ireland
- promote and maintain the standards of care for anaesthesiology service providers in line with the Model of Care for Anaesthesiology and with the Model of Care for Adult Critical Care, including perioperative clinical care, resuscitation, care of critically ill or injured patients, ICM, PM, transport of critically ill patients, obstetric analgesia and anaesthesia.

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TERMS of REFERENCE

- To agree an accepted description of *Anaesthesiology*, for the purpose of Irish Healthcare Services
- To undertake a review of clinical sites in Ireland to gain a complete understanding of services that are currently delivered
- To develop a profile of anaesthesiologists currently practising in model 3 and in model 4 hospitals
- To submit a draft document to CAI Council for approval

Anaesthesiologists in Ireland – Role Profile

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Anaesthesiologists in Ireland – Role Profile

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Anaesthesiologists in Ireland

Clinical activities that are provided by anaesthesiologists are outlined in this document. These include but are not limited to provision of high quality and safe patient care within and outside operating theatres.

In addition, professional roles, management roles, research, audit and education are all clearly recognised as important responsibilities of anaesthesiologists.

The role of an anaesthesiologist in Ireland over four decades has expanded (*Tables 1 and 2*) to provision of extensive perioperative services so that in addition to anaesthesia for elective surgical procedures in the operating theatre, anaesthesiologists provide critical care, resuscitation, pain management, pre-operative patient assessment and optimisation, anaesthesia for radiological, cardiac, psychiatric and multiple other procedures outside the theatre environment, diagnostic or therapeutic procedures performed at non-operating room locations within the hospital, manage critically ill or deteriorating patients in Intensive Care Units, on in-patient wards, on labour wards, and, in emergency departments, in addition to providing maternity analgesia, obstetric anaesthesia, and managing transport of critically ill patients.

This document highlights the role of the anaesthesiologist in assessing and managing critically ill patients on wards and in EDs, stabilising patients in anticipation of transfer by a retrieval team or by a team from the referring hospital. Frequently this work is undertaken while the on call anaesthesiology/critical care team is also responsible for patients requiring anaesthesia for emergency procedures, including emergency obstetric procedures e.g., category one caesarean section (i.e., anaesthesia must commence within thirty minutes of the decision to proceed).

Table 1. Anaesthesiology Services for Elective Surgery
Survey Data Model 3 and Model 4 Hospitals

Surgical Specialties

Hospital	U	GS	OE	Br	OT	A	Gy	Op	ENT	D	UGI	CR	Pl	V	T	MF	N	P	C	HB	Tx
Model 3	✓	✓	✓	0	✓	✓	✓	0	0	✓	0	0	0	0	0	0	0	0	0	0	0
Model 3	✓	✓	✓	0	✓	✓	✓	0	✓	✓	0	✓	0	0	0	0	0	✓	0	0	0
Model 3	✓	✓	✓	✓	✓	✓	0	0	0	✓	0	0	0	0	0	0	0	✓	0	0	0
Model 3	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	0	✓	0	✓	0	0	0	✓	0	0	0
Model 3	0	✓	✓	0	✓	✓	✓	0	0	✓	0	0	0	0	0	0	0	✓	0	0	0
Model 3	✓	✓	0	0	0	✓	0	0	0	0	✓	✓	0	✓	0	0	0	0	0	✓	0
Model 3	✓	✓	✓	✓	✓	✓	✓	✓	✓	0	0	✓	0	✓	0	0	0	✓	0	0	0
Model 3	✓	✓	✓	✓	✓	✓	✓	✓	✓	0	0	✓	0	✓	0	0	0	0	0	0	0
Model 4	✓	✓	✓	0	✓	✓	0	✓	✓	✓	✓	✓	✓	0	✓	✓	✓	NA	✓	✓	✓
Model 3	0	0	0	0	0	✓	✓	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Model 3	0	0	0	0	0	✓	✓	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Model 4	✓	✓	✓	✓	✓	✓	✓	✓	✓	0	✓	✓	✓	✓	✓	0	0	0	0	✓	✓
Model 4	✓	✓	✓	✓	✓	✓	✓	✓	✓	0	✓	✓	✓	✓	0	✓	✓	0	0	0	0
Model 3	0	✓	0	0	0	✓	✓	0	0	✓	✓	✓	0	0	0	0	0	0	0	0	0
Model 3	✓	✓	✓	0	✓	✓	✓	✓	✓	✓	0	✓	0	0	0	✓	0	✓	0	0	0

U Urology, GS General Surgery, OE Orthopaedic Elective, Br Breast, OT Orthopaedic Trauma, A Ambulatory, Gy Gynaecology, Op Ophthalmology, ENT, MF Maxillofacial, UGI Upper GI, CR Colorectal, Pl Plastics, V Vascular, T Thoracic, N Neurosurgery, P Paediatrics, C Cardiac, HB Hepatobiliary, Tx Transplant

Table 2. Anaesthesiology Services outside the Operating Theatres
Survey Data Model 3 and Model 4 Hospitals

Hospital	Model	IR	PAC	CV	ECT	R A P	T/F A P	LWD	Epidural %	C/S %
1	3					25A		NA	NA	NA
2	3	✓	1	150	0	-	-	1200	60	42
3	3	-	3	-	-	600	100	1800	19	40
4	3	✓	6	-	200	-	-	4000	-	-
5	3	-	1	30	40	-	33/10	1500	37	40
6	3	✓	5					NA	NA	NA
7	3	-	12	-	0	-	-	-	-	-
8	3	✓	5	250	200	-	-	1800	72	18
9	4 (P)	✓	2	0	0	-	-	NA	NA	NA
10	3	0	4	0	0	10A	-	8800	76	39
11	3	0	5	0	0	-	5A	6974	39.9	37.9
12	4	✓	5	-	36	-	-	NA	NA	NA
13	4	✓	2	300	0	100A	65A	NA	NA	NA
14	3		4	50	0	33A	-	1500	65	36
15	3	✓	5					1198	43	42

IR Interventional Radiology, PAC Preoperative Assessment Clinics number per week, CV Cardioversion, ECT, R Resuscitation, P Paediatric, A Adult per year, T Interhospital Transfer, P Paediatric, A Adult. number per year, LWD Labour Ward Deliveries per year, Epidural Rate, C/S Caesarean Section Rate

Anaesthesiologists in Ireland – Role Profile

Anaesthesiology Training in Ireland

Specialist anaesthesiology training (6 years) is delivered by CAI, subject to MCI accreditation of the training curriculum. Training includes at least 6 months intensive care medicine training and two months training in pain medicine. The curriculum comprises defined competencies that in combination with 2 examinations (MCAI and FCAI) leads to CSCST Anaesthesiology ICM and PM and allows admission to the MCI specialist register in the specialist division Anaesthesiology.

Many anaesthesiologists take up further training opportunities in Ireland or in other countries. The specialties allied to anaesthesiology are intensive care medicine and pain medicine. Although MCI does not recognise subspecialties, within the medical professions one year of training in a special interest area (a fellowship year) with or without an examination is recognised as a subspecialty i.e., one year of training in intensive care medicine as well as the JFICMI fellowship examination confers a special interest (SI) in intensive care medicine. Two years training in either of these areas with a subspecialty examination (Fellowship JFICMI or Fellowship FPM) is required to achieve dual certification i.e., Anaesthesiology and Intensive Care Medicine, Anaesthesiology and Pain Medicine.

While ICM and PM are full specialties in their own right it could be argued that they also coexist as subspecialties within Anaesthesiology. The 12 month plus examination option within the SAT programme allows a very real and robust subspecialty designation for ICM. For PM the option (to date) is dual specialty recognition.

The Perioperative Physician Role

As physicians with long and extensive training, anaesthesiologists are qualified to make anaesthesia related perioperative medical decisions, are primarily responsible for the safety and well-being of patients before, during and after surgery, including administration of general anaesthesia, regional anaesthesia or sedation, provision of continuous pain relief and support of critical functions throughout surgical, obstetric or medical procedures.

The concept of professional roles for anaesthesiologists beyond the operating room continues to expand, coordinating multidisciplinary teams to optimise patient care from the pre-anaesthesia clinics to the intensive care unit, thereby reducing postoperative morbidity and mortality.

Subspecialty Interests

Anaesthesiologists may also after one or more additional fellowship years of specialty training have a special interest, expertise and qualifications in specific areas such as pain management, cardiac anaesthesia, paediatric anaesthesia, paediatric intensive care medicine, neuro-anaesthesia, obstetric anaesthesia or adult intensive care medicine.

The Model of Care for Anaesthesiology

The Model of Care for Anaesthesiology states that a comprehensive anaesthesiology and critical care service ideally requires a team structure enabling delivery of an elective service and emergency anaesthesia/critical care services on a 24-hour basis and frequently requiring simultaneous management of more than one emergency e.g., category-1 caesarean section or cardiac arrest in the emergency department, the intensive care unit or on a hospital in-patient ward, as well as transfer of critically ill patients between hospitals, in addition to managing emergency surgical cases in the operating theatre (see Appendix III, Consultant Anaesthesiologist Job Description Model 3 Hospital).

Clinical duties

- Provision of anaesthesia (general and regional) and perioperative medical services
 - anaesthesia for elective surgery including high volume ambulatory surgery
 - anaesthesia for emergency surgery
- Clinical management and organisation of pre-anaesthesia assessment clinics and preparation/optimisation of patients for surgery
- Supervision of patients in recovery rooms/post-anaesthesia care units (PACUs)
- Provision of appropriate post-operative care with emphasis on acute pain
- Management of post-operative surgical patients in intensive care units (ICUs) and in high dependency units (HDUs)
- Provision of acute cardiac and respiratory resuscitation services for all emergencies, including retrieval services
- Management of critically ill medical patients, trauma patients and surgical patients in ICUs
- Transport of critically ill patients
- Administration of anaesthesia in remote locations e.g., emergency departments, medical imaging departments, psychiatric units, cardiac and vascular investigatory laboratories and coronary care units where facilities meet standards for safe administration of anaesthesia (*Model of Care for Anaesthesiology; NCP Anaesthesia, 15. Planning and Provision of Facilities for Anaesthesiology*)
- Participation in pain medicine services (acute, chronic and cancer pain)
- Communication, leadership, and decision-making skills.

Education/training

- organisation of and participation in appropriate institutional and departmental educational activities e.g., quality and safety case based discussions, departmental journal clubs, anaesthesiology, intensive care/critical care medicine and (hospital)

Anaesthesiologists in Ireland – Role Profile

multidisciplinary grand rounds, echocardiography and airway management workshops, and, in situ simulation training for

- trainees
- anaesthesiology colleagues
- medical students
- anaesthesia nurses
- PACU nurses
- operating room nurses
- other allied health professionals
- participation in continuing medical education in compliance with CAI's continuing professional development standards and promoting uptake of best clinical practice
- examination preparation for trainees and NCHDs

Quality improvement and patient safety

Anaesthesiologists' commitment to emerging patient safety science evidence substantially impacts the function of multidisciplinary teams in which they work, improving standards, linking best practice to care delivery, using initiatives that encompass systems improvements, incident reporting and root-cause analysis.

Examples of these activities include:

- Participation in peer review and quality improvement activities to ensure quality of patient care
- Contribution to activities of professional associations, hospital committees, and other relevant state, national and international organisations
- Advocacy, in particular in those areas relating to perioperative safety and quality patient care
- Participation in programmes to safeguard personal wellbeing in addition to the wellbeing of colleagues, trainees and related professionals
- Contribution to national and international audit activity

Management

- Anaesthesiology Department/ICU management includes rota organisation, ensuring emergency service provision, maintenance of equipment and environmental safety standards as well as valid record keeping systems
- Supervision of clinical anaesthesia services in the role of the daily duty co-ordinator
- Management of the anaesthesia component of the day surgery unit in collaboration with a multidisciplinary team
- Management of clinical service in the intensive care unit
- Supervision of anaesthesia trainees and other staff as required
- Managerial duties within the hospital including perioperative units, pre-anaesthesia clinics, operating theatres and post anaesthesia care units (PACUs)

Anaesthesiologists in Ireland – Role Profile

- Organisation and clinical management of acute, chronic and outpatient pain medicine services

Academic activity

- Participation in research and reviews on matters relevant to anaesthesiology, perioperative medicine, pain medicine, resuscitation and intensive/critical care, that may include assistance to trainees with academic activities, and/or pursuit of higher degree qualification(s)
- Contribution to post graduate examinations including question writing, standard setting, script-marking and examining in MCAI, FCAI, FJFICMI, FPM, EDIC and ESRA examinations

Preoperative assessment and perioperative planning

An anaesthesiologist responsible for preoperative assessment, undertakes an evidence based objective evaluation process that considers the individual patient's current medical status and the planned surgical procedure, drafts a management plan that includes optimally safe anaesthesia, blood transfusion therapies and a postoperative pain management programme.

Additionally, anaesthesiologists include organisational and clinical aspects of the preoperative anaesthesia assessment to evaluate patients at high risk of postoperative complications requiring intensive care using preoperative scores and biomarkers to select appropriate preoperative laboratory testing and imaging, to assess risks and to anticipate and plan necessary postoperative respiratory, cardiovascular or renal support.

The role emphasises rational consideration of resource use, prompt patient assessment optimisation of modifiable conditions and provision of an overall clinical risk assessment that is suitable for discussion with patients during the consent process to assist shared and informed decision making.

The growing demand for this element of an anaesthesiologist's role mirrors the increasing number of procedures performed outside the operating theatre, e.g., in endoscopy suites or interventional radiology units where an anaesthesiologist is asked to provide anaesthesia or sedation for an expanding number of available treatments and for an increasing number of patients with comorbidities made worse by ageing and long-term chronic disease survival.

In addition to assessing patients' clinical conditions, the anaesthesiologist works collaboratively with multidisciplinary clinical and operational teams to coordinate high-quality perioperative care arrangements, to match low-risk procedures (surgical/nonsurgical) and high risk medical conditions that cannot be modified or optimised

Anaesthesiologists in Ireland – Role Profile

The role of an Anaesthesiologist in providing a Regional Anaesthesia Service

Ioham G.

All anaesthesiologists in Ireland who have achieved a CSCST are proficient in regional anaesthesia techniques, providing targeted analgesia or surgical anaesthesia. The role and responsibilities of the regional anaesthesiologist span key areas in perioperative care, acute pain management and chronic pain services.

1. Preoperative Role

- Patient Assessment to determine suitability for regional anaesthesia based on medical history, risk factors and surgical procedure.
- Informed Consent including explanation of the technique, benefits and risks.
- Planning the most appropriate regional technique (e.g., nerve block or neuraxial techniques) for surgery.

2. Intraoperative Role

- Perform peripheral nerve blocks, spinal anaesthesia or epidural anaesthesia/analgesia (anatomical landmarks, nerve stimulation or ultrasound guidance).
- Assessment to ensure efficacy
- Sedation management
- Monitoring

3. Postoperative Care

- Pain Management e.g., catheter-based infusions or long-acting blocks
- Block Assessment
- Safety Advice: monitoring and mobilisation
- Multimodal Analgesia: combining medication and regional/nerve blocks

4. Further Roles and Responsibilities

- Training/Education for fellows and trainees in techniques and safety protocols
- Innovation, research and development of newer approaches and technologies
- Development and Implementation of Quality and Safety Protocols/Guidelines to ensure institutional safe practice

The Role Of The Anaesthesiologist in Obstetric Care

Tan T.

CAI trained anaesthesiologists who have achieved a CSCST are capable of providing perioperative care to the pregnant woman requiring anaesthesia or analgesia. This includes women who require anaesthesiology input for antenatal care, during labour, for peripartum operative procedures, critical care during pregnancy or in the peripartum period or for obstetric procedures during pregnancy.

Anaesthesiologists in Ireland – Role Profile

In general, the role of the anaesthesiologist providing obstetric care in Ireland is to:

- provide anaesthesia and analgesia to the pregnant woman during labour, delivery, operative deliveries and for surgical management of post-partum complications
- identify risk factors in the pregnant woman and collaborate with a multidisciplinary team on clinical optimisation
- provide early management/stabilisation of critically ill pregnant or post-partum women
- provide care in the management of obstetric emergencies

This is the situation in the vast majority of model three hospitals.

Additional training and skills for sub-specialised roles in obstetric anaesthesiology or as clinical leads for obstetric anaesthesiology in dedicated maternity hospitals may be undertaken as fellowship programmes or equivalent training. However, the specific requirements for these sub-specialised roles are discretionary to the needs of the employing hospital.

The role of the anaesthesiologist in interhospital transfers of critically ill adults and children (see Appendix IV)

Doherty, D

The interhospital transfer of critically ill adults and children presents a complex challenge, demanding a high level of skill, experience and coordination. Because of their advanced skillset in the management of critical illness, anaesthesiologists play a crucial role, ensuring the safety and stability of patients during transit.

A collaborative approach to inter-hospital critical care transfer services in Ireland involves

- Transfer Teams of the National Ambulance Service Critical Care and Retrieval Services (NASCCRS): Neonatal (NNTP), Paediatric (IPATS) and Adult (MICAS)
 - teams of anaesthesiologists, intensivists, emergency medicine physicians, neonatologists, nurses and paramedics
 - standardised protocols and specialised transport/critical care equipment
- Non-Specialist Transport Teams organised by referring hospitals
 - team drawn from anaesthesiology/ICM (+/-Paediatrics), nursing and NAS paramedic
 - locally agreed protocols and equipment procured by local hospital

Current Service Demands (excluding neonatal)

Critically Ill adult transfers: approximately 850/year (NOCA 2022) between ICUs, 44% at night, 29% at weekends. Approximately 50% are undertaken by specialist retrieval teams (NASCCRS). The remainder (out of hours in particular) are undertaken by referring hospital

Anaesthesiologists in Ireland – Role Profile

teams (above) and are typically more complex and less stable than the general ICU population. These figures do not include private hospitals, hospitals outside the INCUA/NOCA audit network or ED to ED transfers and therefore most likely underestimate the total.

Paediatrics Transfer Service Requirements: 11 acute hospitals in Ireland (outside CHI) provide acute paediatric care generating approximately 450 (non-neonatal) PICU transfers per year, 40-50% of which are undertaken by specialist retrieval teams (NASCCRS) and the remainder by the referring hospital.

Anaesthesiology Training for Inter-hospital Transfer of Critically Ill Adults and Children

- Adult Critical Care Training (ACCT) is an outreach team-based training program delivered by NASCCRS in hospitals and by CAI. MICAS team training is available for trainees participating in MICAS services
- A one-year fellowship training programme in adult retrieval is offered by NASCCRS
- Paediatric Outreach Training is offered to paediatric hospitals outside CHI by NASCCRS
- Fellowship in Paediatric Anaesthesiology plus Retrieval, or Fellowship in PICM plus Retrieval is delivered by NASCCRS in partnership with CHI

Medical Workforce Projections

Adult retrieval medicine services will largely be drawn from anaesthesiology, emergency medicine and intensive care medicine. The projected workforce requirement is 15 WTE consultants, 6 WTE registrar posts and 4 fellowship posts

Paediatric Retrieval will largely be drawn from anaesthesiology and paediatric intensive care. The projected number of consultants WTEs is 6-7 with 4-6 training positions aligned with paediatric intensive care, paediatric anaesthesiology and paediatric emergency medicine.

Pain medicine – the role of the Anaesthesiologist in Pain Medicine services

Hearty C.

All anaesthesiologists are trained in evaluating and caring for patients experiencing acute, chronic and cancer related pain, particularly in the perioperative setting.

Anaesthesiologists who have developed an interest in the area can undertake further specialised training in pain medicine. These clinicians have expertise in interventional procedures and device implantation, crucial in minimising chronic pain patients' symptoms and maximising quality of life.

A key component of the role of an anaesthesiology specialist in pain medicine is leading a collaborative team of healthcare professionals including mental health specialists,

Anaesthesiologists in Ireland – Role Profile

psychologists and physiotherapists, that delivers pain management education, develops personalised treatment plans including lifestyle changes and coping techniques, in addition to interventional and pharmacological strategies.

Intensive Care Medicine and Anaesthesiology in Ireland 2025

Intensive Care services are provided by an amalgam of consultants in intensive care medicine and consultant anaesthesiologists with and without a special interest in intensive care medicine.

The anaesthesiologist described in the *Model of Care for Anaesthesiology* remains essential to safe service and roster provision especially for model 3 hospitals with smaller IC patient volumes, lower acuity case mix and a need to provide for anaesthesia, intensive care, emergency obstetric anaesthesia and the frequent requirement for interhospital transfer of critically ill or injured children and adults (see above *The Role of the Anaesthesiologist In Interhospital Transfers of Critically Ill Adults and Children*, Appendix IV).

(<https://www.hse.ie/eng/about/who/cspd/ncps/anaesthesia/moc/model-of-care-for-anaesthesiology>)

Model of Care for Anaesthesiology 4.1(b) Consultant staffing: *“Because Anaesthesia and Critical Care are both 24/7 services, consultant staffing levels are dictated by both elective requirements and out-of-hours requirements. In many institutions these numbers may match. However, this may not always be the case, particularly where smaller hospitals are required to provide anaesthesia care to surgical emergencies or obstetric emergencies, along with having responsibility for critical care services.”*

Anaesthesiology Services

Scheduled anaesthesiology services in model 4 hospitals typically include pre-, intra- and postoperative anaesthesia care as well as a dedicated amount of time for administrative, teaching and educational activities. Intensive Care Units have designated intensive care consultant and trainee cover 24/7 and separate daytime and out of hours cover.

Model 3 hospitals, in general, have anaesthesiologists providing either sessional care in ICU, or daytime cover with out of hours ICU services provided by the on call anaesthesiologist.

Model 3 hospitals admit several critically ill patients (including children) out of hours who require urgent transfer to another centre for specialised care. These transfers of critically ill adult or paediatric cases require an anaesthesiologist to accompany the patient.

Anaesthesiologists in Ireland – Role Profile

Consultant Posts

Currently there are 4 categories of posts for consultants in Intensive Care Medicine in Ireland:

1. Consultant Anaesthesiologists with a rostered commitment to IC, mainly in model 3 hospitals out of hours where 2 consultants cover anaesthesiology, obstetric analgesia/anaesthesiology services and the intensive care unit (in varying combinations determined by the individual anaesthesiology departments) (Table 2)
2. Consultant Anaesthesiologists with a Special Interest in ICM
3. Consultant in Intensive Care Medicine (on the Specialist Division of the Medical Register in ICM, *ICM Workforce document 2020*)
4. Consultants with dual specialist registration, one of which is in ICM. Most consultants in this group are Anaesthesiologists but also includes doctors who are on the specialist register in medicine and in emergency medicine.

What qualifications are required for these posts in Anaesthesiology/Intensive Care?

Up to 2024 (and until 2030 for current CAI SATs) CSCST from CAI included Intensive Care Medicine and Pain Medicine as well as Anaesthesiology. The CAI training programme includes development of competencies in intensive care medicine, both daytime (modules) and out of hours experience. Further intensive care training and examination qualifications are awarded by the Joint Faculty of Intensive Care Medicine of Ireland (JFICMI), a faculty of the College of Anaesthesiologists of Ireland. Candidates who have completed 2 years of satisfactory ICM training in ICUs recognised by the JFICMI for training and have been successful in the JFICMI examination may apply for specialist registration in intensive care medicine with MCI.

Recognition of Outcomes of Training

- 2 years recognised ICM and all mandatory requirements and JFICMI examination = Specialist Registration in ICM
- 1 year recognised ICM and all mandatory requirements and JFICMI examination = Fellow of JFICMI
- evaluation of training deemed to be equivalent to 1 year of recognised ICM and equivalent test of knowledge (e.g., EDIC) = Fellow ad eundum of JFICMI
- CAI SAT programme doctors (a large group) complete 6-12 months recognised ICM without sitting the examination and are awarded CSCST Anaesthesiology which (from 2030) does not include ICM

What is the current Intensive Care/Critical Care capacity in Ireland?

Irish hospitals provide 7.5 intensive care beds per 100,000 of the population compared with an average of 11.5 per 100,000 of the population for European countries. However, although funded, not all these beds are currently operational; of 358 adult IC beds, 22 are non-

Anaesthesiologists in Ireland – Role Profile

operational (2024). Therefore, it can be anticipated that when and if IC bed capacity expands to meet demand and that increased capacity is appropriately funded/staffed to meet JFICMI and international standards, a parallel significant increase in requirement for consultants trained in ICM can be expected.

Table 3.

Critical Care Capacity Workforce and Activity Report 2024 – Intensive Care Beds (total)

National Adult Critical Care Capacity, Workforce and Activity Census, Critical Care Programme, Office of The Chief Clinical Officer, HSE

Level 3	Level 2	Total	Model 4	Level 3	Level 2	Total	Model 3	Level 3	Level 2	Total
272	64	336	Open	194	42	236	Open	78	22	100

Open: ICU bed is open, funding is available, and the bed is operational daily

The Model of Care for Adult Critical Care describes the hub (of which there are eight) and spoke model for Irish hospitals. Most of the consultants working in Ireland’s ICUs are anaesthesiologists, very few having a full-time commitment to ICU, most provide critical care in addition to delivering an anaesthesia service.

The Model of Care for Anaesthesiology and The Model of Care for Adult Critical Care recommend that provision of a comprehensive intensive care medicine service with appropriate out-of-hours cover for ICUs in model 3 hospitals (the 2 plus 2 model being a recommended minimum) requires sufficient number of doctors who have completed CAI SA training and therefore have acquired appropriate ICM and Anaesthesiology skills (CAI, in conjunction with JFICMI). It is this group of trained CAI Anaesthesiologists with CAI CSCST that for the most part provides both services in Irish hospitals.

Table 4. Critical Care Capacity Workforce and Activity Report 2024

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*ICU bed numbers Model 3 and Model 4 Hospitals (May 2024)
Level 3 and Level 2 beds (spaces, funded, open)*

TABLE 3: CRITICAL CARE BED CAPACITY CENSUS 2024	Total No. of bed spaces in your unit	Total No. of funded critical care beds	Average No. of critical care beds open week -Mon 22nd May)	Bed spaces present but not open over one week (week Mon 22nd May)	No. of Level 3 ICU Beds	No. of Level 2 HDU beds
ICU DAILY BIS ON 22ND MAY 2024 = 325						
HSE Dublin and Northeast (RCSI HG)	109	108	99	9	86	22
Total critical care beds Level 2 & 3= 108						
Mater Hospital	52	52	43	9	36	16
Beaumont Hospital ICU	30	30	30	0	30	0
Cavan Hospital ICU	5	5	5	0	3	2
Drogheda Hospital ICU	10	10	10	0	8	2
Connolly Hospital ICU	7	7	7	0	7	0
Navan Hospital ICU	5	4	4	0	2	2
HSE Dublin and Midlands (DMHG)	86	85	82	4	80	5
Total beds – Level 2&3 =85						
Tallaght ICU	26	26	26	0	26	0
St James Hospital Burns ICU (not included in daily ICU BIS)	2	2	2	0	2	0
St. James GICU	29	29	26	3	29	0
St James Hospital Cardiothoracic	8	8	7	1	8	0
Naas	4	4	4	0	4	0
Portlaoise Hospital ICU	4	4	4	0	2	2
Tullamore Hospital ICU	7	6	7	0	4	2
Mullingar Hospital ICU	6	6	6	0	5	1
HSE Dublin and Southeast (IEHG)	48	47	44	4	43	4
Total beds Level 2 & 3= 47						
St. Vincents University Hospital	18	21	18	3	21	0
Waterford Regional Hospital ICU/HDU	14	10	10	1	6	4
Kilkenny Hospital ICU	6	6	6	0	6	0
Wexford Hospital ICU	5	5	5	0	5	0
Tipperary University Hospital	5	5	5	0	5	0
HSE Southwest (SSWHG)	53	41	40	1	41	0
Total beds level 2 & 3 = 41						
Cork University Hospital CTICU	10	7	7	0	7	0
Cork University Hospital General ICU	26	23	22	1	23	0
Mercy University Hospital ICU	6	6	6	0	6	0
Kerry General Hospital ICU	11	5	5	0	5	0
HSE West and Northwest (Saoita HG)	54	49	45	4	32	17
Total Level 2 & 3 beds - 49						
University College Hospital Galway	24	20	18	2	14	6
Letterkenny General Hospital ICU	6	6	6	0	6	0
Mayo General ICU	8	8	7	1	4	4
Sligo General Hospital ICU	8	8	7	1	4	4
Portiuncula	8	7	7	0	4	3
HSE Mid-West (ULHG)	28	28	28	0	12	16
Total Level 2&3 beds = 28 beds						
University Hospital Limerick	28	28	28	0	12	16
Total Adult Critical Care Beds		358	338	22	294	64
Temple Street	9	9	9	0	0	0
Crumlin	23	23	21	2	20	3

Table 5. Critical Care Capacity Workforce and Activity Report 2024

Total number of patients admitted to intensive care units (including HDUs) per annum

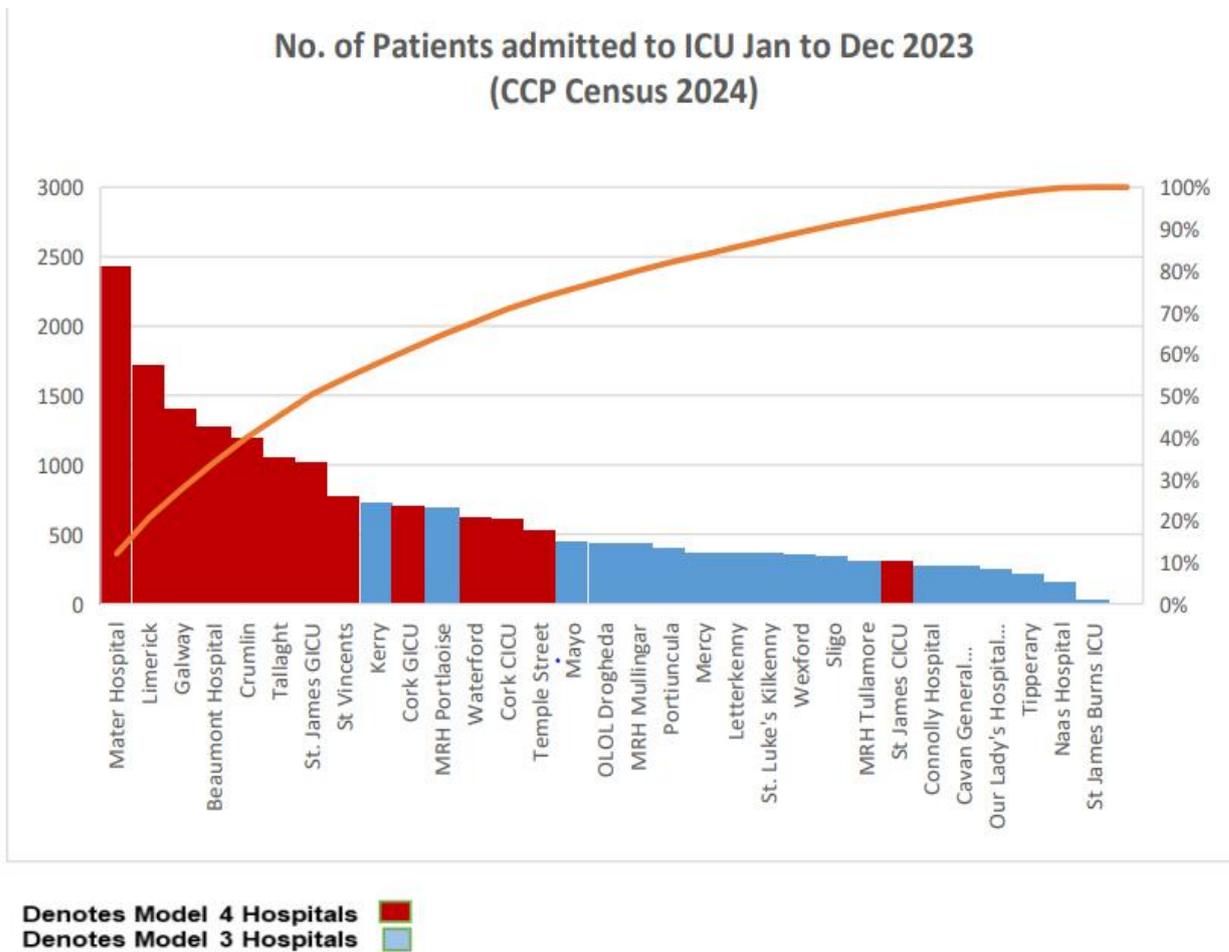


Table 6. Critical Care Capacity Workforce and Activity Report 2024

Total number of patients who received invasive ventilatory support Jan-Dec 2023

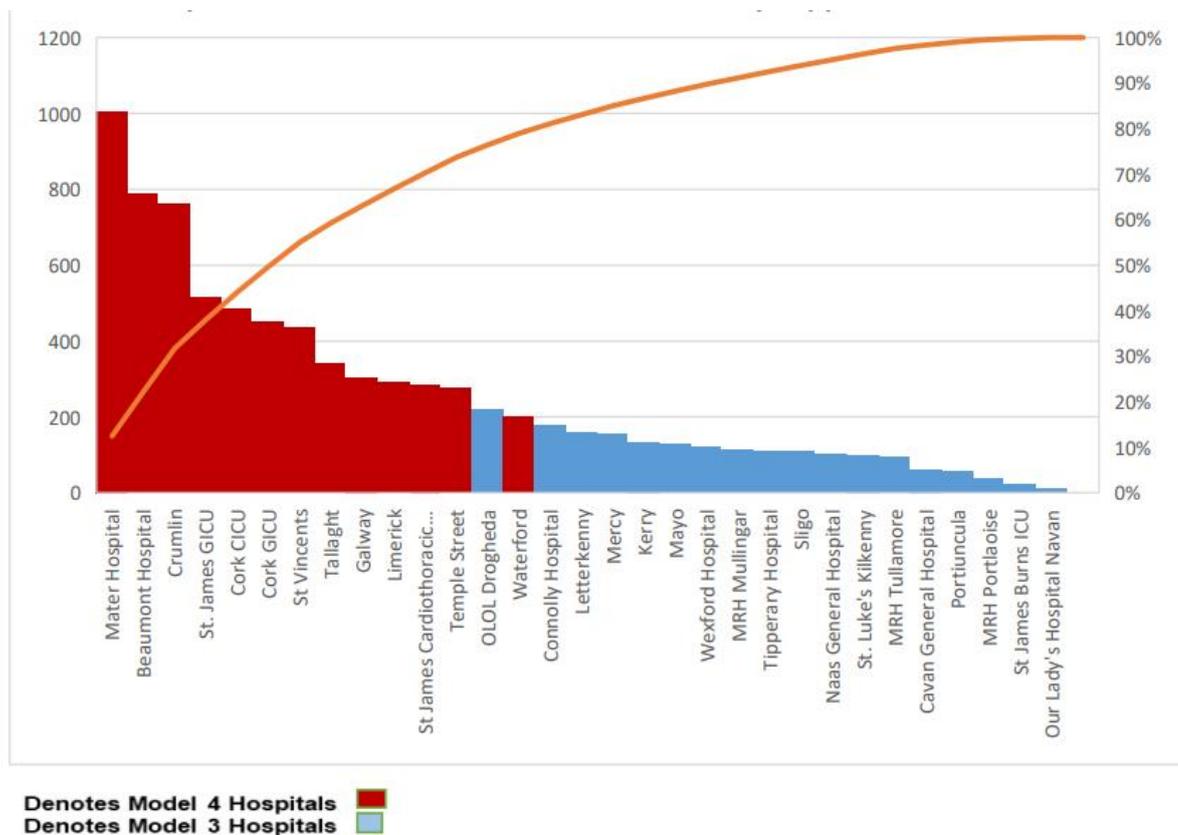


Table 7. Hospital Capacity Survey Data Model 3 and Model 4 Hospitals with ED

Hospital Capacity, ICU and HDU bed numbers, ED service						
	Hospital	Bed Capacity	ICU Beds	HDU Beds	24/7 ED	
1	Model 3	407	7	0		Y
2	Model 3	220	5	5		Y
3	Model 3	390	5	1		Y
4	Model 3	600	12	16		Y
5	Model 3	300	8	-		Y
6	Model 3	330	6	-		Y
7	Model 3	-	10	-		Y
8	Model 3	550	10	-		Y
9	Model 4	-	9	-		Y
10	Model 3	-	0	-		Y
11	Model 3	149	0	3		Y
12	Model 4	600	20	-		Y
13	Model 4	909	30+10N	-		Y
14	Model 3	235	5	-		Y
15	Model 3	307	4	4		Y

Table 8. Hospital Capacity Survey Data Model 3 and Model 4 Hospitals

Hospital Capacity, Operating Rooms, ICU, HDU, LW Capacity, ED service										
	Hospital	Total Bed Capacity	ORs	ICU Beds	HDU Beds	LW Beds	24/7 ED			
1	Model 3	407	4(5)*	7	0	0	Y			
2	Model 3	220	5	5	5	4	Y			
3	Model 3	390	6+1**	5	1	4	Y			
4	Model 3	600	19(22)+2***	12	16	8	Y			
5	Model 3	300	4	8	-	4	Y			
6	Model 3	330	4	6	-	0	Y			
7	Model 3	-	7+3****	10	-	6	Y			
8	Model 3	550	11+1**	10	-	4	Y			
9	Model 4	-	5	9	-	0	Y			
10	Model 3	-	4	0	-	11	Y			
11	Model 3	149	5	0	3	13	Y			
12	Model 4	600	12	20	-	0	Y			
13	Model 4	909	15	30+10N	-	0	Y			
14	Model 3	235	3	5	-	8	Y			
15	Model 3	307	8	4	4	3	Y			

*working ORs (total ORs)

** ORs + LW ORs

***working ORs (total ORs) + LW ORs

****main hospital ORs + secondary site ORs

Who is providing ICM services in model 3 and model 4 Hospitals in Ireland?

Anaesthesiologists in Ireland – Role Profile

Critical Care Capacity: Workforce and Activity Report 2024

Critical/Intensive Care is delivered in 28 hospitals of which 11 (including Paediatrics) are designated model 4 hospitals, and 17 are designated model 3 hospitals.

217.5 consultants work across anaesthesiology and ICM.

The combined total WTE Anaesthesiology and Intensive Care Medicine consultant number in model 3 and model 4 hospitals in Ireland (May 2024), is 436.36, several of whom work only in anaesthesiology.

Most consultants working in ICM in model 4 hospitals in Ireland (101.5) have a SI in intensive care medicine. This consultant group comprises mainly anaesthesiologists and includes physicians in emergency, respiratory and renal medicine.

109 anaesthesiologists working in model 3 hospitals provide sessional ICM services and/or rostered on-call support to the intensive care units. This reflects the flexible approach to ICM services in Ireland; many consultants retain a practice in their core specialty and have scheduled sessions in ICM.

There are 7.5 WTE specialist intensive care consultants working in ICUs in Ireland, 1.5 WTE of these work in model 3 hospitals.

The Model of Care for Anaesthesiology recommends that provision of a comprehensive intensive care medicine service with appropriate out-of-hours cover for ICUs in model 3 hospitals (the 2 plus 2 model being a recommended minimum) requires sufficient numbers of trained CAI anaesthesiologists to provide intensive care medicine services (CAI, in conjunction with JFICMI).

Anaesthesiologists practice in various types of intensive care units, including mixed medical/surgical, postoperative surgical and burn ICUs. Many anaesthesiologists practice in more than one type of ICU, approximately 42 practice in cardiothoracic surgical ICUs, mixed medical/surgical ICUs (436), and neurosurgical ICUs (60).

Table 9. Critical Care Capacity Workforce and Activity Report 2024

Consultants in Intensive Care Units in Irish Hospitals (model 3 and model 4)

Critical Care Medical Workforce Census 2024						Day time Cover		Out of Hours Cover	
Model 3 Hospitals (Bed Capacity Level 2 & 3 = 102)	Total No. of Consultants (WTE) in Anaesthesiology and Critical Care in your hospital	No. of Consultants working full time (WTE) in Critical Care in your hospital	No. of Consultants (WTE) who work across Anaesthesiology and Critical Care	Breakdown of WTEs for Anaesthesiology/ Critical Care e.g.60/40 - 50/50	No. of Consultant posts across both Critical Care and Anaesthesia funded but unfilled	How many Consultants are rostered to the Critical Care Unit to provide daytime cover in your hospital each weekday?	No. of Consultants (WTE) rostered solely for Critical Care out of hours?	Do Anaesthesiology Consultants simultaneously cover both Critical Care and Anaesthesiology areas out of hours? Yes/No	
Connolly Hospital (7)	10.5	0	3	60/40	0	1	0	Yes	
Our Lady's Hospital Navan (4)	No WTE see OLOLH Drogheda for cross cover	0			0	1	1	Yes	
Naas General Hospital (4)	3	0	2		0	1	0	Yes	
Midland Regional Hospital Portlaoise (8)	3 + 3 locums	0	3	70/30	2	1	0	Yes	
Midland Regional Hospital Tullamore (6)	10	0	8		0	1	0	Yes	
Cavan General Hospital (5)	5	0	5	70/30	1	1	0	Yes	
Our Lady of Lourdes Drogheda Hospital (10)	25 (cross cover Monaghan/Navan)	0	20 (Cross cover Monaghan/Navan)		0	1 (cross cover Monaghan/Navan)	0	Yes	
Midland Regional Hospital Mullingar (6)	6	0	4	60/40		1	0	Yes	
St. Luke's Hospital Kilkenny (6)	7	0	3	60/40	0	1	0	Yes	
Wexford University Hospital (5)	4	0	4	50/50	4	1	0	Yes	
Tipperary University Hospital (5)	5	0	5	70/30	0	1	0	Yes	
Mercy University Hospital (6)	9.5	0	9.5		0	1	0	Yes	
Model 3 Hospitals (Bed Capacity in brackets)	Total No. of Consultants (WTE) in Anaesthesiology and Critical Care in your hospital	No. of Consultants working full time (WTE) in Critical Care in your hospital	No. of Consultants (WTE) who work across Anaesthesiology and Critical Care	Breakdown of WTEs for Anaesthesiology/ Critical Care e.g.60/40 - 50/50	No. of Consultant posts across both Critical Care and Anaesthesia funded but unfilled	How many Consultants are rostered to the Critical Care Unit to provide daytime cover in your hospital each weekday?	No. of Consultants (WTE) rostered solely for Critical Care out of hours?	Do Anaesthesiology Consultants simultaneously cover both Critical Care and Anaesthesiology areas out of hours? Yes/No	
University Hospital Kerry (5)	8 (inc. 1 temporary post)	1	7		0	1	0	Yes	
Letterkenny University Hospital (6)	13	0.5	13		2	1	1	Yes	
Mayo University Hospital (8)	12	0	12	100	0	1	0	Yes	
Sligo University Hospital (8)	17	0	4	75/25	3	1	0	Yes	
Portlinculla University Hospital (7)	7	0	7	50/50	0	1 shared with theatre	0	Yes	
Children's Health Ireland									
Temple Street (9)	17.16	5.16	2		0	1 to 2	1	No	
Crumlin (23)	29	7	1		0	2	1	No	
Critical Care Medical Workforce Census 2024						Day time Cover		Out of hours cover	
Model 4 Hospitals (Bed Capacity Level 2 & 3 = 256)	Total No. of Consultants (WTE) in Anaesthesiology and Critical Care in your hospital	No. of Consultants working full time (WTE) in Critical Care in your hospital	No. of Consultants (WTE) who work across Anaesthesiology and Critical Care /other	Breakdown of WTEs for Anaesthesiology and Critical Care e.g.60/60 - 50/50	No. of Consultant posts across both Critical Care and Anaesthesia funded but unfilled	How many Consultants are rostered to the Critical Care Unit to provide daytime cover in your hospital each weekday?	No. of Consultants (WTE) rostered solely for Critical Care out of hours?	Do Anaesthesiology Consultants simultaneously cover both Critical Care and Anaesthesiology areas out of hours? Yes/No	
Mater Misericordiae University Hospital (52)	36.33 + 2 (Pain)	0	10.5 + 3 (Medicine/ED)	66/33	1	4	1	No	
Tallaght University Hospital (26)	32.03	2.5	8	70/30	2.5	3	1	No	
Beaumont Hospital (30)	34	0	12	70/30	0	2	1	No	
University College Hospital Galway (20)	29	1	14	75/25	0	2	2	No	
St James Hospital Burns (2)									
St. James ICU (29)	31 + 5 locums	1.5	8	33/66	2	3 to 4	1	No	
St James Hospital Cardiothoracic (8)	See GICU report		7			1 cardiothoracic anaesthetist cross covers theatre and cardiothoracic ICU	0	Yes, cardiothoracic anaesthesia on call to theatre and cardiothoracic ICU	
University Hospital Waterford (11)	17	0	9		3	1	1	No	
St Vincents University Hospital (21)	38	1	9	65/35	0	2	1	No	
Cork University Hospital GICU/Cardiothoracic (30)	38	0	10	75/25	0	2	1	No	
Limerick University Hospital (28)	24	0	11	4 x ¼ and 8 x ½	3	2	1	No	

Table 10. Trainee/NCHD IC medical workforce census 2024

Anaesthesiologists in Ireland – Role Profile

Model 4 Hospitals (bed capacity in brackets)	How many Anaesthesiology NCHDs (WTE) in total in your hospital?	How many Anaesthesiology trainees (NCHDs on the national training scheme for anaesthesiology) in your hospital?	How many Critical Care NCHDs (WTE) in total in your unit	How many critical care trainees (NCHDs on the national critical care training scheme) in your unit?	How many critical care trainees (WTE) from other training schemes in your unit e.g. ED Surgery etc?	COVER			COVER	
						How many (WTE) NCHDs are rostered to the critical care unit to provide daytime cover in your hospital each weekday?	How many doctors undertaking CAI approved post CCST fellowship in CCM?	How many doctors who are not on a national training programme working in critical care?	How many NCHDs (WTE) are rostered to the critical care unit during out-of-hours shifts in your hospital	Do Anaesthesiology NCHDs simultaneously cover both Anaesthesiology and Critical Care areas out of hours? Yes/No
Beaumont (30)	41 + 1 intern	18	1	1	0	6 to 7	1	23	2	No
Tallaght (26)	41	23	2	2	1	4	2	13	2	No
St. James Hospital (39)	43	23	8	2	6	4	2	16	2	No
Mater Hospital (52)	52	20	8	1	7	8 to 10	2	32	4	Yes
St Vincents (21)	38	18	11	4	1 to 2	4 to 5	2 to 4	12	2	No
Waterford (11)	26	8	8	0	1	2	0	11	1	No
Cork (CUH) (30)	71	23	23	1	0	6 to 7	1	17	2	No
Galway UHG (20)	48.5	24	2	1	1	5	1		1.5	No
UHL Limerick (28)	40	17	5	3	2	5	1	22	2	No

Model 3 Hospitals (Bed capacity in brackets)	How many Anaesthesiology NCHDs (WTE) in total in your hospital?	How many Anaesthesiology trainees (NCHDs on the national training scheme for anaesthesiology) in your hospital?	How many Critical Care NCHDs (WTE) in total in your unit	How many critical care trainees (NCHDs on the national critical care training scheme) in your unit?	How many critical care trainees (WTE) from other training schemes in your unit e.g. ED Surgery etc?	How many (WTE) NCHDs are rostered to the critical care unit to provide daytime cover in your hospital each weekday?	How many doctors undertaking CAI approved post CCST fellowship in CCM?	How many doctors who are not on a national training programme working in critical care?	How many NCHDs (WTE) are rostered to the critical care unit during out-of-hours shifts in your hospital	Do Anaesthesiology NCHDs simultaneously cover both Anaesthesiology and Critical Care areas out of hours? Yes/No
										Yes/No
Mercy (6)	15	5	0	0	0	1	0	11	1	No
Kerry (9)	15	0	0	0	0	1	0	15	1	Yes
St. Lukes Kilkenny (6)	10	0	0	0	0	1	0	10	1	No
Wexford (5)	12	2	0	0	0	1	0	0	0	yes
Tipperary (5)	9	0	0	0	0	0.4	0	9	0.5	Yes
Letterkenny (6)	17	6	0	0	0	1	0	15	1	Yes
Mayo (8)	16	7	0	0	0	2	0	9	1	Yes
Sligo (8)	16	6	0	0	0	2	0	7	1	No
Portlincula (7)	18	0	0	0	0	2	0	0	2	Yes

Table 7: Model 3 Hospitals (bed capacity in brackets)	How many Anaesthesiology NCHDs (WTE) in total in your hospital?	How many Anaesthesiology trainees (NCHDs on the national training scheme for anaesthesiology) in your hospital?	How many Critical Care NCHDs (WTE) in total in your unit	How many critical care trainees (NCHDs on the national critical care training scheme) in your unit?	How many critical care trainees (WTE) from other training schemes in your unit e.g. ED Surgery etc?	How many (WTE) NCHDs are rostered to the critical care unit to provide daytime cover in your hospital each weekday?	How many doctors undertaking CAI approved post CCST fellowship in CCM?	How many doctors who are not on a national training programme working in critical care?	How many NCHDs (WTE) are rostered to the critical care unit during out-of-hours shifts in your hospital	Do Anaesthesiology NCHDs simultaneously cover both Anaesthesiology and Critical Care areas out of hours? Yes/No
Cavan (5)	9	0	0	0	0	1	0	8	1	Yes
OLOL Drogheda (10)	33	11	13 (cross cover Monaghan/ Navan)	0	0	3 (cross cover Monaghan/ Navan)	4	22	1 (cross cover Monaghan/ Navan)	No
Connolly (7)	16	4	0	0	0	1	0	7	1	No
Naas (4)	5	0	0	0	0	1	0	5	1	Yes
MRH Portlaoise (8)	7	0	0	0	0	1	0	7	1	No
MRH Tullamore (6)	9	0	0	0	0	1	0	9	1	Yes
MRH Mullingar (6)	14	2	2	0	0	2	0	9	1	Yes
OLG Navan (4)	See OLOL Drogheda	0	0	0	0	1	0	4	1	No

Anaesthesiologists in Ireland – Role Profile

Different groups of consultants (Tables 9 and 11) provide care in ICUs in Ireland with varying core specialty background training, higher specialist training in ICM and additional ICM examination qualifications. All of these doctors are eligible to practice at the level of a consultant in Ireland. (*ICM Workforce Planning Document 2020*)

**Table 11. Survey Data Model 3 and Model 4 Hospitals
Consultants in ICUs in Ireland**

Consultants in ICU Model 3 and Model 4 Hospitals						
Hospital	WTE Anaesthesiologists	Anaesthesiologists in ICU	Anaesthesiologists with SR ICM	Fellowship JFICMI	IC Director Y/N with SR ICM Y/N	ICM Specialists
Model 3	11.5	11.5	1	4	N	1
Model 3	7+1 locum	8	1	3	YY	0
Model 3	13	13	1	1	YN	1
Model 3	26 (30)	26	5	5	YY	0
Model 3	9 (12)	9	2	4	N	0
Model 3	9.5	9.5	2	2	YY	0
Model 3	24	24	5	5	YY	0
Model 3	19	19	1	3	YY	0
Model 4	12.8	-	1	1	YY	-
Model 3	7.6	NA	1	1	NA	0
Model 3	6.2	NA	0	0	NA	0
Model 4	15+4 locum	7	7	8	YY	1
Model 4	31.66	10	10	-	YY	2
Model 3	8	8	1	1	YY	1
Model 3	14	8	0	5	YY	0

- no data
NA not applicable

These groups are (Table 11 above):

1. Consultant Anaesthesiologists with a rostered commitment to ICM
2. Consultant Anaesthesiologists with a Special Interest in ICM
3. Consultant in Intensive Care Medicine (on the ICM Specialist Division of the Register MCI)
4. Consultants with dual specialist registration, one of which is in ICM (anaesthesiologists comprise the majority along with physicians and emergency medicine physicians).

Table 12. CAI SATs and Non-Consultant Hospital Doctors in ICUs in Ireland
Survey Data Model 3 and Model 4 Hospitals

Hospital	Total NCHDs	CAI SATs	CPS	NCHDs in ICU day (total)	Number on-call each day Anaesthesia, ICU, LW, other or combinations	Non anaesthesiologists in ICU Y/N number on call for ICU
Model 3	14	05-Apr	3	1	1 (A+IC)	N
Model 3	15	0	0	1	2 (1LW, 1A+IC)	Y 1 medical registrar HDU (day)
Model 3	17	6	2	1	2 (1A, 1LW+IC)	N
Model 3	40	19	0	4	3 (1LW, 1A, 1IC)	N
Model 3	16	7	2	1	2 (1LW, 1A+IC)	N
Model 3	15	7	0	1	2 (1A, 1IC)	Y 1 ED trainee in ICU (day)
Model 3	33	10	3	2	4 (1A, 1IC, 1LW, 1senior)	N
Model 3	25	10	0	2	3 (1A, 1IC, 1LW)	N
Model 4	18.5	-	0	3	2 (1A, 1IC)	Y 2 paediatric trainees
Model 3	16	8	0	NA	2 (1A, 1LW)	NA
Model 3	20	6	0	NA	2 (A+LW)	NA
Model 4	44	-	-	6	5 (2IC, 3A)	Y 2 any specialty in ICU (day O/C)
Model 4	43	21	-	6	4 (2IC, 2A)	Y 1 respiratory registrar (day O/C)
Model 3	12	0	0	1	2 (1LW, 1A+IC)	N
Model 3	17	11	-	1	3 (1A+LW, 1IC, 1transfers)	N

Intensive Care Medicine Training in Ireland

(Tables 10, 12 and 13)

Consultants providing ICM services in Ireland have followed a number of training pathways albeit with varying core specialty backgrounds

1. CSCST Anaesthesiology, ICM and PM (current): CAI SAT programme that includes one mandatory 6 month ICM module or a 4 month ICM module plus 18/12 IC on call within SA training
2. CAI SAT programme culminating in CSCST Anaesthesiology (2030)
3. CAI SAT programme including 12 months ICM training
4. CAI SAT programme including 12 months ICM training and success at Fellowship JFICMI examination
5. CAI SAT programme or other training programme (e.g., Internal Medicine, Emergency Medicine, Surgery) with completion of 2 years JFICMI training and success at FJFICMI examination

Anaesthesiologists in Ireland – Role Profile

A Special Interest in Intensive Care Medicine is not in the strictest sense an outcome of training. A trainee on the CAI SAT programme who completes 12 months of recognised ICM training, satisfies mandatory requirements (e.g., courses and ITAs) and is successful in the JFICMI examination, is eligible to be a Fellow of the JFICMI. This allows application for consultant posts with a special interest in ICM. Fellow of JFICMI is the outcome of training and this doctor may apply for a SI ICM consultant post. Alternatively, she/he may choose to apply for a consultant anaesthesiologist post.

Anaesthesiologists are formally trained in intensive care medicine and can evaluate and treat all populations of critically ill patients in any type of ICU. However, in contrast to other critical care training pathways, anaesthesiologists acquire an intimate knowledge of the management, physiologic stresses and complications of patients during surgical and perioperative periods and during the peripartum period. These contextual factors have strongly contributed to intensive care practice for anaesthesiologists in Irish hospitals

The curriculum for ICM is based on the CoBaTriCE model from the European Society of Intensive Care Medicine (ESICM) and has been adapted from the JFICMI's current curriculum. It is intended to introduce the anaesthesiology trainee to the skills, knowledge and attitudes required in ICM, such that the trainee can provide appropriate care to a critically ill patient and recognise the need for more specialised care. These skills can be further developed in subspecialty training.

Prior to a year of critical care fellowship, anaesthesiology trainees are required to complete a minimum of 6 months of critical care and a minimum of one month of cardiothoracic anaesthesia, during which many acquire proficiency training in basic transthoracic and transoesophageal echocardiography skills by the end of the anaesthesiology training programme. These are minimum requirements, and many trainees and fellows obtain much more experience.

A doctor training in anaesthesiology therefore may plan for preferred career choices as follows:

- I. a doctor with a career interest in ICM may endeavour to complete 12 months of ICM within SA training and complete the FJFICMI examination to be eligible to be a Fellow of the Joint Faculty of Intensive Care Medicine of Ireland and apply for consultant posts with a special interest in intensive care medicine (SI ICM)
- II. an anaesthesiology registrar with a strong ICM interest or who may wish to present a more competitive CV at interview, may complete the second (SAT 7) year of ICM in Ireland and complete the FJFICMI examination, alternatively she/he may instead choose to do an ICM fellowship in another country and sit a comparable test of

Anaesthesiologists in Ireland – Role Profile

knowledge examination (e.g., EDIC). These doctors are eligible to apply for specialist registration in ICM and eligible to subsequently apply for consultant in intensive care medicine posts

- III. trainees without a strong interest in ICM may choose to do the minimum requirements during SA training (6 months ICM and on-call requirements), i.e., not seeking substantive employment in a model 4 hospital ICU but appropriately qualified to apply for consultant anaesthesiologist posts that specify some ICM sessions in the job description

How is training in ICM assessed in Ireland?

Up to 2030 a CSCST in Anaesthesiology includes CSCST in Intensive Care Medicine and Pain Medicine and allows registration with MCI on the specialist division - Anaesthesiology.

Further ICM training (above) with ICM examination(s) allows entry on the specialist division – Intensive Care Medicine, of the MCI register.

However, when a doctor is awarded “specialist registration” in a clinical discipline, this implies that training has been achieved consistent with that of a specialist. It is a declaration of past performance and of satisfactory completion of all necessary training requirements. And while this award – the record and outcomes of training – clearly influences a doctor’s career trajectory and job selection, the specifics of a consultant post (the job description) and the role of the doctor occupying that post (the scope of practice) are dictated by each department’s (and hospital’s) clinical requirements and the doctor’s skills and preferences. Accordingly, the contract between the doctor and the employer is paramount in defining the roles and duties of a hospital consultant.

This explains why there are consultants with specialist registration in ICM currently working in model 3 hospitals, and, why there are consultant anaesthesiologists with a rostered commitment to IC working in model 4 hospitals.

It is therefore not within the remit of this SLWG to list discrete competencies for each type of intensive care consultant in Ireland.

CAI SAT and JFICMI Curricula (Appendix IX)

The CAI SAT programme allows 12 months in ICM, thereby offering a facility to complete half of the two year training time within the programme and facilitate an onward SAT 7 completion option so that any trainee can achieve dual certification in 7 years

Anaesthesiologists in Ireland – Role Profile

Therefore, an anaesthesiology trainee completing 12 months ICM within 6 years of SAT training, in addition to a SAT 7 ICM year (and success in the FJFICMI examination) has achieved comparable training to a JFICMI trainee completing 2 years of JFICMI training. They are, closely aligned and, in all respects, considered equivalent.

However, as there are differences in ICM training requirements between the competency based *Curriculum for the National Specialist Anaesthesiology Training Programme (CAI 2020)* “...to introduce the trainee...to the basic skills, knowledge and attitude required in intensive care medicine, such that they are able to provide appropriate care to a critically ill patient and to recognise the need for more specialised care, skills that can be further developed in sub-speciality training,” and, the *JFICMI Curriculum and Minimum Requirements (JFICMI 2024)*, it is not feasible to accurately map these training outcomes to the role profile of consultant posts.

The SLWG therefore cannot use this information to define the roles and duties of consultants working in intensive care medicine practice in Ireland, recognising that additional factors can be considered when specialists seek suitable consultant posts and departments and hospitals seek suitable specialists.

What IC Services are being provided in Irish Hospitals?

Table 13. Number of Admissions 2023 NOCA Data

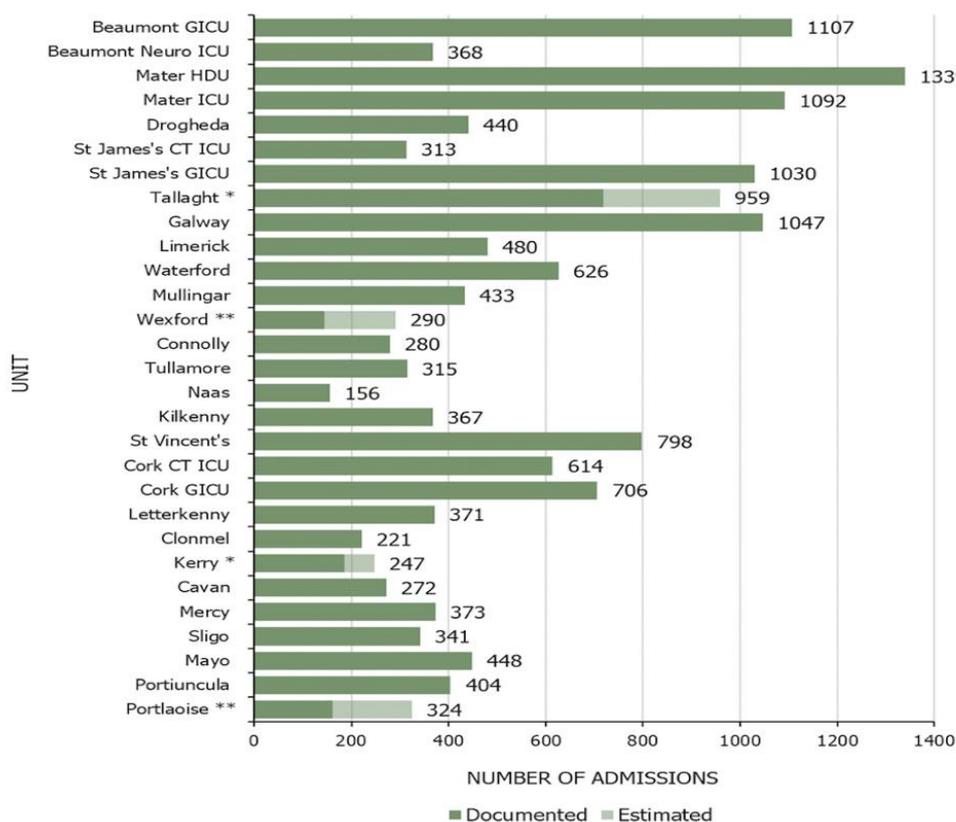


Table 14. ICU Activity
Survey Data Model 3 and Model 4 Hospitals
PA per annum, M Medical, S Surgical

	Hospital	Level 3 beds	Admissions PA	Ventilated PA	Consult/ Resuscitation	Trauma Admissions	Paediatric Admissions PA
1	Model	7	287	186		25	
2	3	5	180	90		-	
3	3	5	342	170	5 per day	-	
4	3	12	400	200	-	-	
5	3	6	436	106			22
6	3	6	326	187	-	0	0
7	3	10	-	-	-	-	-
8	3	8	-	-	-	-	-
9	3	-	-	-	-	-	-
10	4 (P)	0	NA	NA	300 per year	NA	NA
11	3	0	NA	NA	-	NA	NA
12	3	20	904 634 M, 261 S	534	-	-	NA
13	4	30	1963 1263 M, 700 S	786	-	-	NA
14	4	5	324	144	-	-	0
15	3	4	469	104			

Table 15. ICU Procedures
Survey Data Model 3 and Model 4 Hospitals

	Hospital	RRT PA	CD	Percutaneous Tracheostomy	Abdominal Paracentesis	TPM	Pericardiocentesis	Thoracocentesis
1	Model 3	✓	✓	✓	-	-	-	-
2	Model 3	✓	o	✓	o	✓	o	o
3	Model 3	✓	✓	✓	✓	o	o	✓
4	Model 3	✓	✓	✓	✓	o	o	✓
5	Model 3	✓	✓	✓	✓	o	o	✓
6	Model 3	✓	✓	✓	✓	o	✓	✓
7	Model 3	-	-	-	-	-	-	-
8	Model 3	✓	o	✓	✓	o	o	o
9	Model 4	-	-	-	-	-	-	-
10	Model 3	NA	NA	NA	NA	NA	NA	NA
11	Model 3	NA	NA	NA	NA	NA	NA	NA
12	Model 4	200	✓	✓	✓	✓	o	✓
13	Model 4	624 DD	✓	✓	✓	✓	✓	✓
14	Model 3	27	✓	✓	o	✓	o	o
15	Model 3	41	✓	✓	✓	✓	✓	o

RRT PA renal replacement therapy cases per year, DD dialysis days, CD chest drain insertion, TPM transvenous pacemaker

Anaesthesiologists Providing ICM Services in Model 3 Hospitals

A model 3 hospital may require a consultant anaesthesiologist to provide regular sessional commitments in ICM or/and support the ICM roster requirements (*Intensive Care Workforce Plan 2020*). It is important that the job description for such posts clearly states these requirements.

Table 16. Consultant Scheduling
Survey Data Model 3 and Model 4 Hospitals
 IC/CC unit (sessional) and (out of hours) Anaesthesiology
 IC/CC unit and Labour Ward
 in Irish Hospitals

Hospital	WTE	ICU Day	ICU O/C	Anaesthesiology	LW	Combined O/C
	Consultants					
Model 3	11.5	1	-	-	NA	1 A+IC
Model 3	7+1	1	-	-	1	1 A+IC
Model 3	13	1	-	1	-	1 LW+IC
Model 3	26(30)	2	1	1	1	-
Model 3	12	1	-	-	1	1 A+IC
Model 3	9.5	1	-	-	NA	1 A+IC
Model 3	24	1	-	-	1	1 A+IC
Model 3	19	1	1	-	-	1 A+LW
Model 4	12.8	-	-	1	NA	-
Model 3	7.6	NA	NA	-	-	1 A+LW
Model 3	6.2	NA	NA	-	-	1 A+LW
Model 4	15+4	2	1	1	NA	-
Model 4	31.66	2	1	1	NA	-
Model 3	8	1	-	1	-	1 IC+LW
Model 3	14	1	1			1 A+LW

Anaesthesiologists Providing ICM Services In Model 4 Hospitals

Consultant anaesthesiologists are entitled to work in model 4 hospital ICUs, and this practice currently exists in several model 4 hospitals in major metropolitan centres. However, most of these ICUs recruiting new consultant staff, will seek candidates with a higher level of ICM training and experience which may make it difficult for a consultant anaesthesiologist without a higher level of ICM training and experience to effectively compete for these posts.

This is not a flaw in the anaesthesiology CSCST, rather a reflection of prevailing market forces for doctors who wish to work in intensive care medicine in model 4 ICUs in Ireland.

Anaesthesiologists in Ireland – Role Profile

Model 4 hospitals will therefore draft job descriptions that reflect their requirements (e.g., experienced ICM consultants) and that will attract the type of specialist they want in their ICUs and/or anaesthesiology departments.

In the past, intensive care sessions covered by anaesthesiologists in many hospitals were not included in job descriptions and the work done by these clinicians was therefore not factored into the overall planning for ICU cover.

This has meant that ICU cover has fallen on a few individuals and that ICU cover has not been mandated and planned for by individual Departments of Anaesthesiology. A functioning intensive care unit with level 2 and level 3 beds is critical for the safe running of all model 3 and model 4 hospitals. This also allows for the development of sessional commitment to ICU, with the provision of training modules and adherence to JFICMI standards for ICM.

The Future

The interrelationship between anaesthesiology and intensive care medicine practice in Ireland is clearly visible in the data provided in this document showing the number of clinicians involved in anaesthesiology and in day to day management and out-of-hours cover in ICUs.

This is further proven by the planned increase in numbers required for staffing in *Anaesthesiology Medical Workforce in Ireland 2023-2038*, having particular relevance to model 3 hospitals in which the majority of intensive care is provided by anaesthesiologists with sessions in ICU or undertaking dual cover. Based on our current healthcare capacity and workforce data a relationship between training in ICM and anaesthesiology will always exist in the Irish healthcare environment.

Out of hours emergency anaesthesiology services will always comprise a significant percentage of clinical time, even with extended working hours (Public Only Consultant Contract). In most institutions across Ireland, that require these clinical services, the intensive care element will be delivered by trained general anaesthesiologists.

It seems unlikely that sufficient numbers of consultants in ICM, will, in the short to medium term be available to deliver intensive care medicine services even if the ICU working day is extended e.g., 10-12hours, indicating that dependence on anaesthesiologists for this service is likely to persist indefinitely.

The MCI decision to change the CSCST to Anaesthesiology has resulted in CAI and JFICMI examining the overall scope of practice, training and assessment of intensive care medicine in Ireland.

Anaesthesiologists in Ireland – Role Profile

It has also meant that CAI examine its interface with intensive care and initiated development of a *White Paper on The Future of Anaesthesiology and Intensive Care Medicine* to guide CAI and JFICMI. The White Paper Group will set out recommendations for future training in both areas and will guide clinicians in their roles in anaesthesiology and/or intensive care medicine. It will allow for expansion of training opportunities for ICM modular training to model 3 hospitals which achieve JFICMI standards. This document (*Anaesthesiologists in Ireland: Role Profile*) will it is hoped help contribute to the workstream of the White Paper Group.

We acknowledge the challenges that arise in model 3 hospitals concerning departmental rosters and public perception, especially between consultants with and without SI ICM. This was highlighted to MCI before the finalised decision on CSCST nomenclature. The RP group has endeavoured to address these distinctions by developing a role profile aligning with the *Model of Care for Anaesthesiology*, with the objective that patients receive care from professionals in our specialty whose qualifications and competencies are well-communicated.

Clinicians with varying backgrounds will continue to work collaboratively in all ICUs: consultants in intensive care medicine with base specialty training in medicine, emergency medicine and surgery, anaesthesiologists with a special interest in ICM, anaesthesiologists who are dual certified and anaesthesiologists with rostered commitments to ICM.

Management of emergency admissions from older populations with complex medical issues by ICU based clinicians reliably ensures early detection of deterioration and early treatment escalation. These clinicians will be involved in all acute hospital care pathways, including surgical pathways. CAI and JFICMI training by supporting self-knowledge, leadership training and skill development opportunities for trainees will ensure that these are embedded across the ICM workforce.

MDT in ICU

Intensivists and anaesthesiologists in ICUs will continue to collaborate within wider multidisciplinary teams, including critical care nurses, pharmacists, physiotherapists and rehabilitation experts

Greater separation of elective and emergency pathways

Expanded training in peri-operative medicine during the CAI training programme may allow surgical patients to be managed by anaesthesiologists in collaboration with the surgical team throughout the entire elective pathway, including enhanced post operative care.

Anaesthesiologists in Ireland – Role Profile

Complex decision making

Intensive Care Medicine Specialists and Anaesthesiologists have developed skills in complex decision making, i.e., addressing problems that overlap multiple specialties. Training will necessarily therefore include decision-making ethics as well as scientific and data knowledge skills

Research

Anaesthesiologists and Intensivists will continue their involvement in research programmes, collection and review of data generated in the ICU and application of research findings to ensure correct resource use and optimal patient outcomes.

Paediatric anaesthesia and paediatric intensive care medicine

The Model of Care for Paediatric Anaesthesia

43,207 children per annum have general anaesthesia administered for surgical or medical procedures carried out in public hospitals in the Republic of Ireland. A total of 21,127 anaesthetics are administered within CHI, and a further 22,080 anaesthetics are administered to children in adult (model 3 and model 4) hospitals across the country.

Anaesthesiology Medical Workforce in Ireland 2023-2038: Paediatric Anaesthesiology

Table 17. Current and Future Demand for Paediatric Anaesthesiologists in CHI

	Current Consultant Workforce WTE	Current Deficit to Meet CHI Requirements	Future Consultant Workforce Requirement
Total	31.5	25.5	57

Currently 31.5 WTE consultants in Paediatric Anaesthesia work across CHI Crumlin, CHI Temple Street (HSE DIME, 2023). To ensure appropriate consultant staffing at the new Children’s Hospital, a further 25.5 WTE consultants are required (sub-total 57 WTE). To allow for a 6-day working week (POCC2023) an additional 11.4 WTE’s would be required.

Table 18. Demand for Consultants in Anaesthesiology contributing to the Paediatric Anaesthesia Roster in Model 3 Hospitals (*Anaesthesiology Medical Workforce in Ireland 2023-2038*)

Consultant Anaesthesiologists with an SI in Paediatric Anaesthesia	Current Consultant Workforce WTE	Current Deficit to Meet MoC Requirements WTE	Future Consultant Workforce Requirement WTE
Total	4	14	18

Anaesthesiologists in Ireland – Role Profile

Future Consultant Workforce Requirement for Anaesthesiologists with a SI in Paediatric Anaesthesiology M4 Hospitals

The Model of Care for Paediatric Surgery advocates funding and developing paediatric surgical hubs in model 4 hospitals in Limerick, Cork and Galway, requiring a minimum of 6 anaesthesiology consultants with SI paediatrics to fill the 24/7 duties and on-call rosters. Therefore, to sufficiently run paediatric anaesthesia services in regional centres, at least 18 consultants will be needed across the three hospitals, i.e., 14 additional WTEs to join the current estimated 4 WTE consultant paediatric anaesthesiologist group.

Future Consultant Workforce Requirement for Anaesthesiologists with a SI in Paediatric Anaesthesiology M3 Hospitals

It is anticipated that model 3 hospitals currently providing paediatric anaesthesia services continue to do so, albeit caring for cases of lesser complexity than those attending the newer regional centres. Currently, these (model 3 hospital) consultants dedicate approximately 34% of their working week to paediatric care. Expert stakeholders informing this report anticipate that this time commitment (to paediatric anaesthesiology care) will remain unchanged unless some of these hospitals are redesignated to model 2 status.

Care and Transfer of The Critically Ill Infant and Child between Model 3 and Model 4 Hospitals

Arrangements for the immediate care of critically ill children should be in place in any hospital that manages children. This need can arise suddenly and unpredictably in an emergency department, operating theatre or in-patient ward. In-house arrangements are therefore required for providing emergency treatment, for stabilising critically ill infants and children and for initiating intensive care prior to the transfer of the critically ill infant/child to a paediatric or neonatal intensive care unit

Transfer of critically ill children to specialist centres is usually undertaken by paediatric emergency retrieval teams (see transport page 48.). In certain circumstances, e.g., a child presenting to a non-specialist centre with an acute neurosurgical emergency, it may be necessary for an appropriate senior anaesthesiologist from the referring hospital to accompany an intubated, ventilated child.

A survey of Clinical Chairs in Departments of Anaesthesiology across model 3 hospitals carried out by NCPA in 2022 to determine whether these hospitals are adequately staffed to deliver anaesthesiology services (short term and future), and, to consider compliance with the 2 plus 2 model of care, indicated a necessary increase in WTE consultant numbers.

Demand for Consultants in Paediatric Critical Care Medicine (PCCM)

The Model of Care for Paediatric Critical Care (NCPCC, 2019), estimated a demand for 20 WTE consultants in PCCM: WTE PCCM, split posts or SI posts between paediatric

Anaesthesiologists in Ireland – Role Profile

anaesthesiology and PCCM. The recommendation for development of PCCM services is that a core group of 16 WTE consultants is assigned to PCCM and a further 4 WTE provide paediatric critical care transport services.

Regional High dependency Units (RHUs)

Children awaiting a PICU retrieval team or children requiring short duration intensive care and not necessitating transfer to a PICU may require admission to a general critical care facility, which can be provided by a RHDU (Paediatric Critical Care MoC 2019)

The Future

Strong consensus among stakeholders involved in the safe delivery of paediatric anaesthesia in Ireland indicates that a national steering group with oversight of paediatric services throughout the country is needed. This national steering group should include leaders from anaesthesiology, critical care medicine, paediatric surgery, paediatrics, neonatology, transport medicine, as well as nursing and management representatives.

Non-clinical skills and roles

Specialist training at a senior level in anaesthesiology, intensive care medicine and in pain medicine, provides an understanding of clinical governance, risk management and quality improvement principles, emphasises leadership, collaborative working and communication, in addition to highlighting the concepts of accountable personal development planning, evidence based practice, patient safety standards and patient centred care, all of which are fundamental to an anaesthesiologist's clinical and nonclinical roles.

The anaesthesiology role frequently includes development and/or expansion of a clinical service (including pain services and intensive care) that encompasses assessment of demographics, resource (human and financial) issues, identifies optimum outcomes, business case planning and project execution.

The anaesthesiologist is usually further involved in a clinical governance oversight role in operational and clinical management of these services e.g., perioperative care pathways, pain services, overseeing multidisciplinary team performance, leading quality improvements and supporting achievement of national clinical programmes' key performance indicators and quality outcomes to ensure alignment with national standards

Anaesthesiologists endeavour to ensure clinical effectiveness (including audit and guidelines), a key component of patient safety that integrates best evidence with delivery of care ensuring consistently high standards while linking resource allocation to efficiency, acknowledging the health expenditure impact and the wider political landscape.

Anaesthesiologists in Ireland – Role Profile

- **research and innovation:** to encourage and facilitate research within operative services framework, contributing to the development of new and innovative approaches to perioperative care via liaisons with clinical research facilities and equivalents.
- **patient advocacy:** care is coordinated, compassionate, and respectful of preferences
- expertise in management of **complex patient care pathways**

Global Health

Seigne, P

Many anaesthesiologists in Ireland have developed a voluntary role in the increasingly important area of global health. These roles highlight anaesthesiologists' responsibility for promoting safe and equitable perioperative care worldwide. In low and middle income countries, anaesthesiologists help address critical gaps in training and safety standards. By participating in education, advocacy and capacity-building initiatives, they contribute to reducing global disparities in perioperative care. The anaesthesiologist's expertise is also vital during health emergencies that demand airway management, resuscitation and critical care skills. Engaging in global health strengthens both patient outcomes and professional development, reinforcing the anaesthesiologist's role as a leader in advancing global surgical safety.

The College of Anaesthesiologists of Ireland

Many anaesthesiologists, ICM and PM specialists undertake additional voluntary roles within CAI in e.g., education, credentialling, training, including simulation training, and examinations or, as (elected, ex officio or co-opted) CAI council members and committee chairs.

CERTIFICATE OF SATISFACTORY COMPLETION OF SPECIALIST TRAINING and REGISTRATION

A CSCST or specialist registration defines the status a clinician has achieved through clinical experience, completion of mandatory training courses, training assessments and success in examinations. It recognises a level of competency consistent with that of a specialist. It is therefore a statement of past performance and not an indication of possible future clinical practice.

Specialist Registration

The CSCST awarded by CAI to doctors who complete the CAI training programme allows doctors entry to the MCI Specialist Division in Anaesthesiology i.e., these doctors are not (and never were) eligible for the ICM Specialist Division based on the wording of the CSCST.

The MCI has deemed that the current (CAI SAT) curriculum does not provide sufficient level of ICM to allow for a dual registration (SR Anaesthesiology and SR ICM). Significant changes

Anaesthesiologists in Ireland – Role Profile

to the curriculum would need to be undertaken if a dual qualification was pursued. Currently this is not the intention of CAI (pending White Paper Group's recommendations).

The substantive CAI training programme curriculum includes ICM competencies and training time and this remains a requirement of the training programme accredited by MCI. CAI Specialist Anaesthesiology Trainees (SATs) will continue to work in ICM during training years. Substantive changes to the curriculum would require MCI accreditation. CAI may offer graduates of its training programme recognition of ICM training in a separate certificate/letter confirming the training that has been undertaken.

Employment, contracts, job descriptions

(see Appendix III. Job Description Consultant Anaesthesiologist, M3 Hospital)

Job Description Anaesthesiology

A (recent/new) job description in anaesthesiology may specify sessional commitments to surgical lists requiring regional anaesthesia, to anaesthesia for cardiothoracic surgery, pre-assessment clinics, obstetric analgesia/anaesthesia or to anaesthesia services in a co-located hospital. In addition, an anaesthesiology job description could require that potential applicants commit to sessions in ICU, most apposite for model 3 hospital recruitment (Appendix III).

However, for some in-post consultant anaesthesiologists who contribute to ICU services, ICM sessions/on call may not have been specified in the original contract or job description and changing a job specification once in contract or appointed within the HSE is likely to present a challenge. A job plan/work plan supported by a clinical director may present a solution.

Job Description ICM

The individual doctor's contract with the employer, including the job description defines that doctor's clinical practice. An ICU director is required to write a job description for any new post and may alter the description of existing posts that have become vacant.

Model 4 hospitals recruiting ICM consultants will generally seek either consultants with ICM SI or consultants in ICM.

Training and Experience

The requirements of a specific consultant role and job plan are developed by the recruiting hospital. HSE recognises the experience and training of graduates of the CAI anaesthesiology training programme in intensive care medicine and this expertise will continue to be reflected in job plans.

The Legal Nature of a Job Description

The Terms of Employment (Information) Acts 1994–2014 states employers must give employees certain information (a written statement of particulars) about their employment, such as a contract of employment, a job description, rate of pay and hours of work.

A job description outlines the anaesthesiologist's main duties and responsibilities within the role.

This forms part of a written statement of particulars

<https://www.irishstatutebook.ie/eli/1994/act/5/section/3/enacted/en/html#sec3> that an employer gives to a consultant anaesthesiologist on or before the first day of her/his work, containing the job title and a description of duties and tasks.

A written statement of particulars is a legal document in which basic terms and conditions of employment are set out. To comply with the law, the consultant anaesthesiologist must receive this within eight weeks of starting her/his job. Although not a legal requirement, it is good practice for employers to give a consultant a lengthier detailed job description.

In general, unlike a contract of employment, a job description is not legally binding. The consultant anaesthesiologist might be asked to take on other tasks as long as they are reasonable and legal.

Within some contracts of employment, there might be a 'variation clause' which allows the employer make changes to the contract. However, if a change to the contract is without notice or is unreasonable it may be a breach of implied 'trust and confidence'. A consultant anaesthesiologist must be given 'fair warning' if the employer is using a variation clause to make changes to a contract that could include working hours, and/or rates of pay.

A head of department can only define what an individual doctor does, in agreement with HR at local level. This feeds into the written statement of particulars, the job plan.

Compliance with a Job Description

The performance and accountability framework in the HSE

<https://www.hse.ie/eng/about/who/acute-hospitals-division/about/hse-accountability-framework.pdf> clearly states that the performance management of all employees in a clinical site is the responsibility of the CEO. The CEO may delegate that responsibility to the clinical director.

If the CEO has empowered the clinical director in a hospital, it would be appropriate for a clinical director to deal with underperformance, including performance that places patients at risk, fails to meet the required standards for that service, or departs from what is considered normal practice.

Anaesthesiologists in Ireland – Role Profile

HSE Position

Anaesthesiology CSCST awarded by CAI allows doctors entry to the specialist division of the MCI register in Anaesthesiology. These doctors are not (and never were) eligible for the ICM division based on the wording of the CSCST.

MCI has deemed that the current curriculum does not provide sufficient level of ICM to allow for a dual qualification. Significant changes would need to be undertaken if a dual qualification was pursued and currently this is not the intention of CAI.

There are currently no plans to alter the TP curriculum which will continue to include intensive care competencies and ICM training time. Any substantive changes would require accreditation approval by MCI. Therefore, trainees on the CAI TP will continue to spend training time in ICUs as modular ICM remains a requirement of the MCI accredited TP.

HSE does not require or seek a CSCST from candidates for any consultant job. (Appendix III)

HSE does require registration on the Specialist Division i.e., applicants for anaesthesiology consultant posts must be registered on the MCI Anaesthesiology Specialist Register. This requirement also pertains to candidates who have trained outside Ireland or who apply from outside the Irish TP and who wish to apply for a consultant anaesthesiology position, i.e., doctors who do not hold a CAI CSCST.

The requirements of the individual consultant role and job plan are developed at hospital level. HSE, as it always has, recognises the experience and training of graduates of the CAI TP in intensive care and this is reflected in anaesthesiology job plans.

CAI may offer its graduates recognition of ICM training through separate certification document(s) confirming the training undertaken.

SCA supports consultant anaesthesiologists that work in intensive care units and has confirmed this position to CAI, MCI and HSE.

HSE is aware that consultant anaesthesiologists look after critically ill patients in all hospitals and will ensure no impact on consultant recruitment.

The Medical Council of Ireland: Anaesthesiologists working in ICUs

A doctor's area/breadth/scope of clinical practice is defined by her/his contract of employment and job description. The work is not defined by the category of that doctor's specialist registration (*Dr Suzanne Crowe, President MCI*).

Anaesthesiologists in Ireland – Role Profile

MCI considers all practitioners on the Anaesthesiology Specialist division of the Register to be competent to practice ICM in all situations. This includes daytime ICU scheduling and on call duties either with or without contemporaneous on call anaesthesia responsibilities.

This is the view also held by the College of Anaesthesiologists of Ireland (CAI), and the Joint Faculty of Intensive Care Medicine of Ireland (JFICMI), the HSE and the State Claims Agency based on the extensive ICM training component of the CAI training program.

The Model of Care for Anaesthesiology recommends that consultant posts are structured to allow incumbents use their (general and sub-specialty) skills/training appropriately, to offer a reasonable work-life balance (1:8 rostering recommended) as well as adequate time for administration, education, teaching, research and career development opportunities.

CAI continues to collaborate on alignment of training programmes and professional standards with national requirements. Ultimately the original objectives prevail recognition of anaesthesiologists' expertise and the integrity of the profession.

This is the view also held by CAI, JFICMI, the HSE and SCA on the basis of the extensive ICM training component of the CAI training programme.

There are approximately 436 consultants providing ICM care in Ireland. Of these 118 are on the ICM register, a small number are dually certified and the remainder (solely) on the anaesthesiology register. A large majority of these anaesthesiology consultants have a contractual obligation to provide care in ICU and are not eligible for entry to the ICM register. This number is likely to grow given expected increases in consultant numbers at model 3 hospitals. A similar situation exists in private ICM practice.

Advanced Career Development In ICM

JFICMI sets standards for ICU governance and ICM training. For training recognition, an ICU director (in particular in model 4 ICUs) should be at least at the grade of SI consultant (Fellow JFICMI). Candidates for election to the JFICMI board must be SI consultant or above.

Consultant anaesthesiologists (without JFICMI) can be included on the board as co-opted members.

Indemnification

The stated Medical Protection Society position is *“The Medical Protection Society will indemnify a specialist registered anaesthesiologist to work in ICU without the need for specialist registration in intensive care medicine”* (Úna Buckley Weir, MPS, personal communication to Mr Martin McCormack, CEO October 3rd 2024)

Anaesthesiologists in Ireland – Role Profile

The State Claims Agency will support consultant anaesthesiologists working in ICM who hold a CSCST Anaesthesiology or/and who are registered on the MCI Specialist Register in Anaesthesiology. (CAI, MCI, HSE, SCA confirmation discussions)

HSE and State Claims Agency (SCA) statements on ICM

1. In 2017, the HSE CCO and Director of Acute Hospital Services supported CAI's proposal for ICM and acknowledged that anaesthesiologists, on the MCI anaesthesiology register, maintain their entitlement to practice ICM
2. In 2018, Dr Cathal O'Keefe (SCA) stated *"ICM practitioners with CSCST in Anaesthesiology, continue to have clinical indemnity for the practice(s) outlined in their job plan(s)"*
3. In 2021 a HSE NDTP ICM workforce planning document stated *"the opening of an ICM specialist register does not affect anaesthesiologists' on the MCI specialist anaesthesiology register entitlement to practise ICM"*

PROFESSIONALISM (MCI)

Anaesthesiologists demonstrate professionalism according to the values underpinning good practice (Eight Domains MCI), applying their knowledge and skills while adhering to high standard and ethical conduct. These include prompt actions to mitigate compromised patient safety, open disclosure and pursuit of care quality based on incident report data, in addition to providing leadership and directing efforts towards supportive and inclusive healthcare provision while acknowledging the fundamental principles of confidentiality, effective and empathic communication and collaborative decision making.

Summary and recommendations

1. The doctor who completes the CAI SAT programme and is eligible for CSCST, is a well-trained anaesthesiologist capable of delivering clinical services in intensive care medicine, anaesthesiology and pain medicine, aligning with Irish health service requirements for comprehensively trained anaesthesiologists. The extent of this role and the breadth of experience gained during CAI training should be recognised appropriately in CSCST nomenclature and in MCI registration.
2. Recognition of outcomes of training is a key issue emerging from the RP SLWG. A large group of doctors finishing the CAI SAT programme have completed 6-12 months recognised ICM and have not undertaken the JFICMI examination. If as indicated the CSCST Anaesthesiology will not from 2030, include ICM, some alternative recognition should be offered to these doctors
3. According to the CAI curriculum, a SAT who completes the minimum ICM requirements (6 months and on-call) has satisfied the curricular competencies (above) and is eligible to work independently as a consultant in intensive care practice. It must be also recognised however that more time in ICM training can offer greater opportunities to achieve even broader competency outcomes.
4. The modest divergence in competency based training outcomes between the CAI SAT and JFICMI programmes includes recognition of model 3 hospital ICM modular experience. JFICMI acknowledging the volume and complexity of ICU activity and the variety of procedural ICU experience available in these hospitals plans to address this in the near future realising its importance as a capacity training issue
5. Regarding competency in ICM in a broader sense for existing consultant anaesthesiologists, the professional competency scheme, a life-long professional process, could be used at intervals to endorse the evolved clinical practice of anaesthesiologists that although lacking the current requisite credentials for dual certification have very significant breadth and depth of experience that can be appraised.
6. Changing a job description once an incumbent is in contract seems to be difficult if not impossible. However individualised job plans agreed with the relevant clinical director should be emphasised as a way to support colleagues in the job that they actually do. In general, clinical directors are not anaesthesiologists, many are surgeons. These work plans might be easier to agree and might have greater influence were clinical directors' backgrounds within our family of disciplines. Our group of clinicians in anaesthesiology, ICM and PM is large enough to make this suggestion worthy of consideration.

Anaesthesiologists in Ireland – Role Profile

7. The complex relationship between anaesthesiology and intensive care medicine is likely to be poorly understood among non-anaesthesiology medical colleagues and in the wider community and may be influenced by MCI's separate categorisation of intensive care medicine and anaesthesiology.
8. Although anaesthesiologists undertaking clinical work in ICUs are indemnified by SCA there remains concern about potential for reputational damage to individuals or to the CAI training programme should an anaesthesiologist be questioned on the appropriateness of the CSCST to intensive care medicine or accused of practising outside her/his area of competence.
9. Recruitment of additional doctors for NASCCRS adult and paediatric retrieval is recommended (see Appendix IV). In addition, the anaesthesiology training curriculum should include a focus on inter-ICU and inter-ED transfer.
10. The SLWG recognises the "two plus two" model as fundamentally important to patient care and to skill maintenance among consultant anaesthesiologists and encourages its ongoing implementation. This demands a critical mass of surgical, intensive care medicine and obstetric services to justify roster number expansion and therefore may be linked to a need for consolidation of services and hospital reconfiguration.

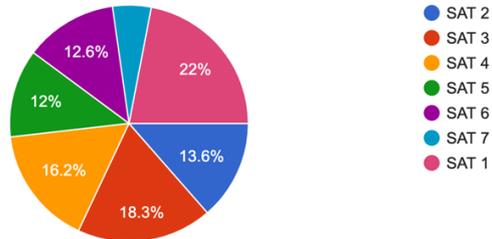
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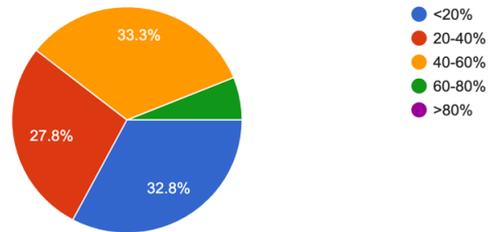
Anaesthesiologists in Ireland – Role Profile

Appendix I Trainee Survey

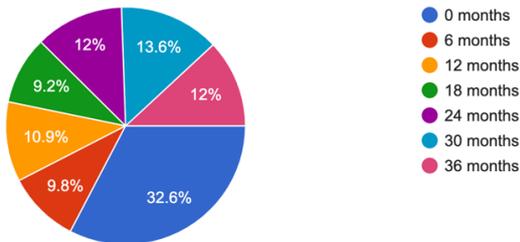
Stage of Training (n=191)



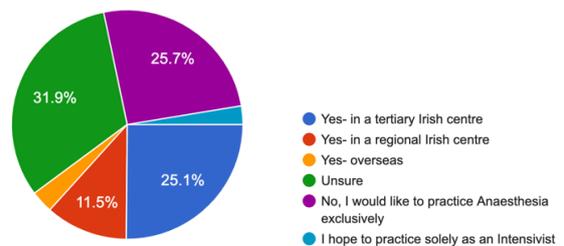
Percentage of Training Time in ICU (n=181)



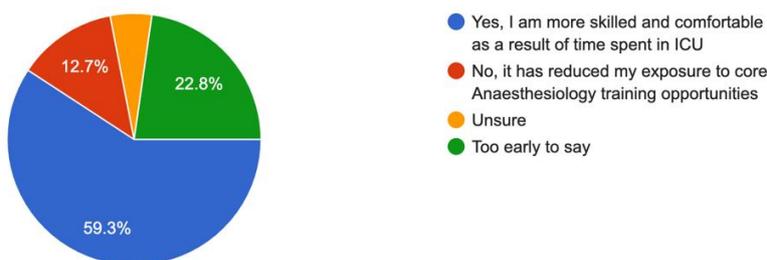
Months of ICU Call (n=184)



Intention to Practise ICM as a Consultant (n=191)



Enhanced Skills due to ICM training (n=189)



Appendix II CSCST Negotiation/Nomenclature Change Timeline

Anaesthesiologists in Ireland – Role Profile

The Medical Council of Ireland (MCI) directed, June 2024, that the wording on the certificate of successful completion of specialist training (CSCST) awarded to graduates of College of Anaesthesiologists of Ireland Specialist Anaesthesiology Training Programme, change to *Anaesthesiology*. Previously the certificate read *CSCST in Anaesthesiology, Intensive Care Medicine and Pain Medicine*.

Timeline CSCST Negotiations:

- 2020 Autumn: directive (first) from MCI following a training programme accreditation review in 2019, that CSCST should change to “*Anaesthesiology*”
- CAI in partnership with JFICMI strongly disagreed with and vigorously resisted change to nomenclature over 4+ years, corresponded with and held many meetings with MCI 2020-2024 in efforts to dissuade the regulator from this course of action while highlighting potential implications
- MCI insisted on confidentiality during this time, thereby limiting CAI’s ability to consult with its fellows and blocking discussion
- CAI recommended to MCI that the breadth of clinical practice of anaesthesiologists in Ireland be defined in advance of implementing a CSCST nomenclature change
- March 1st, 2024: MCI demanded implementation; with HSE support CAI requested and was granted a stay
- June 27th 2024: MCI demanded immediate implementation of the change to CSCST nomenclature, specifically that the CSCST *Anaesthesiology* be conferred on SATs who complete the training programme in 2029; CAI’s request that new SAT1s (commencing July 2024) be included in the derogation, was rejected
- Communication with anaesthesiology fellows and trainees predictably precipitated widespread concern/anxiety



Anaesthesiology at X Hospital

The clinical anaesthesia service is currently provided for the hospital by 8 consultant anaesthesiologists. These services include provision of anaesthesia, provision of intensive care medicine, provision of acute pain medicine, pre-operative assessment clinics, transport of the critically ill and the various administrative roles taken on by anaesthesiologists.

The department provides anaesthesia for general surgery, orthopaedic surgery, obstetric and gynaecological surgery, a 24/7 labour epidural service, psychiatry, dental/maxillofacial surgery and day case ENT surgery.

The Intensive Care Unit admits, on a 24-hour basis, critically ill patients from all disciplines within the hospital and takes responsibility for rapid response to emergencies. The service has an integral role in the Trauma Team for the Accident and Emergency Department and in the Cardiac Arrest Team for the hospital. A Pre-operative Assessment Unit has been established for all surgical patients, and the department runs a High Risk Antenatal Obstetric Anaesthesia Clinic.

The Department of Anaesthesiology

1. There is a need to maintain the present capacity for the provision of anaesthesiology services in an environment of increased volume and complexity of surgical, obstetric and critical care activity at the hospital.
2. The hospital role in providing general surgical service within region is expected to develop in line with policy.
3. A comprehensive high volume orthopaedic service providing elective (including joint replacement), emergency and trauma care is increasing.
4. The oncology service requires increasing critical care support in a patient population with diverse cancer types.
5. The Anaesthesiology Department aims to comply with a 2+2 rota (2 consultants with 2 NCHDs on call) based on

The Model of Care for Anaesthesiology in Ireland

The National Maternity Strategy 2016-2026 Anaesthetic Cover in Hospitals with co located maternity units.

NCPA: Providing Quality, Safe and Comprehensive Anaesthesia Services in Ireland- A

Anaesthesiologists in Ireland – Role Profile

Review of Manpower Challenges

The Role

The post holder will join the existing consultant team, delivering a 24 hour 7 day emergency and elective service with an on-call commitment of 1:12 first on, 1:12 second on call giving an overall call frequency of 1:6.

The post functions within the governance structure of the HSE X Region as part of the Peri-Operative Directorate and through the directorate reports to the executive team with established targets and KPIs

This post holder will undertake full consultant responsibility to provide care for patients in the ICU, on the labour ward and in the operating theatres.

The key responsibilities are

- anaesthesiology and intensive care services and participation in the on call roster
- administrative, planning and strategic development of the clinical service

Reporting Relationships

The consultant's reporting relationship and accountability for the discharge of his/her contract is

- through the Clinical Director to the Chief Executive Officer of the hospital
- occasionally to the Hospital Group Chief Executive Officer
- to the Associate Clinical Director of the Peri Operative Directorate for clinical issues
- to the COO for non-clinical issues.

Key Working Relationships

Staff resources specific to this post including secretarial support are in place and shared equally among all consultant anaesthesiologists. 16 NCHDs are in place (6 CAI training posts)

Location

This is an appointment to the HSE X Region by the Health Service Executive on a Public Only Consultant Contract 2023. The initial commitment for this post will be to X Hospital for 37 hours per week. This post may be subject to future restructuring to facilitate reorganisation of acute services in line with new clinical models of acute and community services. The post must facilitate implementation of national health policy, the HSE National Clinical Programmes including commitment to deliver the relevant performance outcomes.

Due to the establishment of the HSE regions and the geographic realignments of CHO Areas/Hospital Groups within these regions, the appointing service may differ from that outlined in the Letter of Approval for this post

Operational, strategic, developmental, clinical, administrative and other duties

This is a Consultant Anaesthesiologist post with key responsibilities to

- provide anaesthesiology services and participate in the emergency on call roster

Anaesthesiologists in Ireland – Role Profile

- participate in administration, planning and strategic development of the Anaesthesiology Service

Clinical

- attend at X Hospital for 37 hours a week
- attend emergencies as required during working hours (above) and outside working hours while participating in the on call rota, and remain in attendance if his/her services are required
- attend a clinic or HSE site within the group and provide treatment or consultation services as appropriate
- attend as consultant anaesthesiologist when required in any hospital or institution managed by the HSE X
- be responsible for the service quality of the Anaesthesiology Department

Management and Administration

- maintain appropriate liaison arrangements between his/her department and the patient's primary medical team
- collaborate with the Clinical Director, Director of Nursing, medical and surgical staff in matters pertaining to general efficiency
- ensure that adequate supplies of necessary drugs, medical and surgical devices and equipment are available in the department and to report (to HSE) unsatisfactory arrangements for the dangerous drug storage
- provide clinical details on request to a Registered Medical Practitioner authorised by the HSE or by the Minister for Health and Children, of a person under his/her care in the hospital with that person's written consent (or that of the person's representative or next-of-kin)
Note whenever the Minister for Health and Children is of the opinion, that it would not be in the interests of the common good to seek such consent and he/she certifies accordingly, the consultant shall provide the required information to a Registered Medical Practitioner authorised by the Minister for Health and Children. When the consultant is of the opinion that he/she should inform the patient of the requirement of the Minister for Health and Children, he/she is at liberty to do so.
- issue to a patient under his/her care and without payment, certificates required for his/her normal employment or his/her entitlement to benefit under Social Insurance or Assistance Schemes
- keep records and provide reports and other information that may be required by the HSE
- co-operate in relevant matters with other consultant anaesthesiologists, senior medical personnel and officials of the HSE X Region

Human Resources

- participate in selection processes for NCHDs and other staff as appropriate, the employer will provide training and ensure that an anaesthesiology consultant representative is involved in the relevant selection process
- share responsibility with the other anaesthesiologists for training of NCHD staff in the Department of Anaesthesiology, ICM and PM

Risk Management, Health and Safety

Anaesthesiologists in Ireland – Role Profile

- notify the appropriate infection control officer of cases of infectious or suspected infectious disease in the hospital and provide details required to carry out preventative measures
- ensure satisfactory arrangements for storage and safe administration of dangerous drugs in his/her department

Financial

- assist in the preparation of annual estimates/budgets for which he/she is responsible

General

- reside convenient to X hospital
- perform other duties appropriate to the office assigned to him/her by the HSE
- assist in expansion of the anaesthesiology service in X hospital

Note the person appointed will hold office under the terms and conditions of the POCC23 contract for consultants employed in the public service which will determine that he/she participate actively in the management of the hospital, recognise resource constraints and retain clinical autonomy while practicing.

Standard Duties and Responsibilities

- a) undertake duties and functions within a consultant anaesthesiologist's area of competence, set out in the Clinical Directorate Service Plan and in line with policies specified by the employer
- b) ensure that duties and functions are undertaken to minimise delays for patients or disruption of services
- c) work within the framework of the hospital's service plan and level of service determined by the employer. Planning for individual clinical services is progressed through the Clinical Directorate
- d) co-operate with expeditious implementation of disciplinary procedures
- e) participate in the operation of the Clinical Directorate, a consultant shall receive training and support to enable participation
- f) periodically formally review execution of the Clinical Directorate Service Plan with the Clinical Director (a consultant may seek an internal review of the plan with the Clinical Director)
- g) provide expert opinion on consultation to other consultants' patients on request
- h) ensure, with the Clinical Director, that appropriate medical cover is always in place with due regard to the European Working Time Directive for doctors in training
- i) share responsibility with the other anaesthesiologists for teaching and training of NCHD staff in the Department of Anaesthesiology, ICM and PM
- j) supervise and be responsible for diagnosis, treatment and care provided by NCHDs
- k) participate in selection processes for NCHDs and other staff as appropriate, the employer will provide training and ensure that an anaesthesiology consultant representative is involved in the relevant selection process
- l) participate in clinical audit and proactive risk management and facilitate use of data and information required in accordance with regulatory, statutory and corporate policies and procedures

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- m) facilitate collection of data required to validate delivery of duties and inform planning and management of service delivery
- n) be familiar with relevant Health Information and Quality Authority (HIQA) Standards e.g., *Medication Safety Standards, National Standards for the Prevention and Control of Healthcare Associated Infections*, and comply with associated HSE protocols for maintaining these standards
- o) support, promote and participate in energy, water and waste initiatives to create a more sustainable, low carbon health service
- p) act as spokesperson for the hospital if required

Note This job description is not intended to be a comprehensive list of all duties involved and consequently, the post holder may be required to perform other duties assigned to him/her from time to time and to contribute to the development of the post.

Professional Qualifications

Registration on the Specialist Division of the Register of Medical Practitioners maintained by the Medical Council of Ireland in the specialty of Anaesthesiology.

Continuation in posts that require statutory registration depends on the post holder maintaining annual registration on the Anaesthesiology Specialist Division of the register maintained by The Medical Council of Ireland.

COMPETENCY FRAMEWORK IMPLEMENTATION 2022

A review of the competency framework for medical consultants, including anaesthesiologists, has been conducted by PAS in collaboration with the HSE. A job analysis was conducted by a team of chartered occupational psychologists on the role of a medical consultant. A range of stakeholder groups was involved and extensive international benchmarking was carried out. A comprehensive competency framework was outlined comprising 4 areas of competence; clinical, organisational and interpersonal requirements as well as the future focussed direction of the role, and this framework is used for candidate assessment

1. Clinical Competence: Skills, and Knowledge – Delivering Clinical Expertise

(incorporating clinical experience, and continuous practitioner development)

- detailed knowledge and understanding of the anaesthesiology domain
- clear understanding of the clinical challenges facing relevant population groups
- applies knowledge effectively to make clear and proactive decisions
- maintains knowledge of current research and practice
- engages in further education to develop clinical practice
- recognises the complexity, uncertainty and ambiguity inherent in medical practice
- meticulous management of challenging cases and complex referrals
- anticipates rather than reacts
- a patient-centred approach to understanding patient needs and delivering care
- leadership skills to enhance patient care and safety
- makes clear and decisive contributions within multi-disciplinary teams

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2. Organisational Competence – Leading and Governance

(incorporating clinical leadership and accountability, clinical service planning)

- accountable for clinical outcomes, patient safety, risk, quality, stewardship of resources, change management
- directs, reviews performance, motivates, promotes equality and diversity
- recognises accountability of the CEO, COO, CD
- efficient, organised, employs effective processes to manage and prioritise workload
- open and honest, learns from experiences
- manages available resources appropriately to ensure delivery of a safe, efficient service
- contributes to business and service planning
- reviews and monitors service provision
- identifies, assesses, monitors and manages risk within the anaesthesiology service

3. Interpersonal Competence - Engaging Staff, Patients and Families

(incorporating communication skills, teamwork and collaboration)

- attentively and accurately listening, tailors' communication (oral and written) to the individual and to the situation
- encourages collaboration towards a common goal
- helps to identify and develop strengths in others, supports others when things go wrong
- self-aware, understands personal limitations
- manages emotions, resilient, remains calm under pressure
- inclusive, collaborative approach, respects other roles within a multi-disciplinary team
- acts as a team member, takes or gives direction
- effectively influences and persuades others

4. Future Focused Competence – Improving Future Care

(healthcare quality improvement, teaching and research)

- identifies contexts for change, demonstrates awareness of the political, social, technical, economic, organisational and professional environment
- encourages continuous service improvement and innovation using evidence based knowledge
- evidence based decision making
- evaluates outcomes and takes corrective action if necessary
- shares learning with colleagues formally and informally i.e., thinking aloud
- shows empathy for learners, promotes a safe learning environment

Health and Character

The consultant anaesthesiologist must be fully competent and capable of undertaking the duties of the post and be in a state of health to offer regular and efficient service, and must be of good character.

Terms and Conditions

public jobs refers to Public Appointments Service established under the *Public Service Management (Recruitment and Appointments) Acts 2004-2013*

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Tenure

The appointment is whole-time, permanent and pensionable as an employee of the Health Service Executive governed by the *Health Act 2004* and the *Public Service Management (Recruitment and Appointment) Act 2004*.

Taking up Appointment

Within 3 months of being interviewed by PAS

Working Week

37 hours per week (standard)

Annual Leave

30 working days per annum *Organisation of Working Time Act 1997*

Superannuation

The candidate will be notified of the pension scheme within the contract of employment *Section 60 of the Health Act 2004*

Age

*The Public Service Superannuation (Age of Retirement) Act, 2018** determined that public servants recruited since 1 January 2013 are members of the Single Pension Scheme and have a compulsory retirement age of 70ys

* Public servants recruited between 1 April 2004 and 31 December 2012 have no compulsory retirement age.

Probation

Permanent appointment to this post depends on the satisfactory completion of a 6 month probationary period, which may be extended at the discretion of the employer for a further period of up to 6 months. The reasons for the extension will be sent in writing to the employee.

A probationary period will not apply if:

- the employee currently holds a permanent consultant appointment and the employer is satisfied that the employee has satisfactorily completed probation
- the employee previously held a permanent consultant appointment the employer is satisfied that the employee (a) satisfactorily completed probation and (b) there is not more than 26weeks between termination of the previous appointment and commencement of this appointment
- the employee has, for a period of more than 12 months, held this post on a temporary basis

Protection of Children Guidance and Legislation

The consultant anaesthesiologist must understand specific responsibilities under the *Children First Act 2015*, *Protections for Persons Reporting Child Abuse Act 1998, Section 2*, *Children First National Guidance*

Infection Control

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The consultant anaesthesiologist must have a working knowledge of HIQA Standards (above)

Ethics in Public Office

The consultant anaesthesiologist must comply with the requirements of the *Ethics in Public Office Acts 1995 (Section 18) and 2001* i.e.,

- required to prepare and furnish an annual statement of interests that could materially influence the performance of the official functions of the post, that is submitted to the CEO not later than 31st January in the following year
- required, whenever they function as an HSE employee and have material interest in a related matter, provide at the time a statement of the facts of that interest to the CEO
- the function cannot be performed unless there are compelling reasons to do so stated in writing to the CEO
- acts in accordance with guidelines or advice published by the *Standards in Public Office Commission* which oversees compliance with tax clearance provisions

Details of a consultant anaesthesiologist appointment and the post holder's contact details are shared with the commission.

Non-compliance will be investigated by the Commission. A report will be furnished to the HSE and laid before each House of the Oireachtas, at which point it will be made public. Continuing non-compliance will be noted in the *Commission's Annual Report Under the Standards in Public Office Act 2001*.

The consultant anaesthesiologist must within nine months of appointment provide to the Standards in Public Office Commission, 18 Lower Lesson Street, Dublin 2:

- a statutory declaration, attesting to compliance with the tax obligations in *Section 25(1) of the Standards in Public Office Act*, declaring that nothing in *Section 25(2)* prevents issuing of a tax clearance certificate
- and
- either a *Tax Clearance Certificate* issued by the Collector-General or an *Application Statement* issued by the Collector-General

The Public Appointments Service has full responsibility for the recruitment and selection process. Following a successful clearance process, a letter of recommendation will issue to the National Recruitment Service (NRS) in the HSE. All candidate documentation collected as part of the clearance process will also issue to the NRS.

Following recommendation by PAS

- I. the NRS contacts the successful candidate
- II. NRS agrees with the candidate and the employer a start date, work schedule and salary
- III. NRS issues a contract of employment

Appendix IV Inter-hospital transfer of Critically Ill Adults and Children

Challenges and Areas for Development

- recruitment of additional doctors for NASCCRS adult and paediatric retrieval as currently specialised transfer teams are not always available and there are difficulties servicing certain areas of the country
- the anaesthesiology training curriculum requires continuing focus on inter-ICU and inter-ED transfer
 - specialised training for aeromedical retrieval may be required
 - modular training for all SATs is not possible currently
 - modular training is delivered for ICM trainees and paediatric JFICMI trainees
 - retrieval training is recommended for anaesthesiologists, intensivists and emergency medicine physicians in preparation for careers which include transport and retrieval medicine.
- standardisation of policy and process

Future Directions in Transport and Retrieval

Enhanced Training Programmes for anaesthesiologists including

- standardised certification
- retrieval fellowships
- continuous education
- pre-hospital critical care training

Appendix V Helsinki Declaration on Patient Safety in Anaesthesiology

Anaesthesiology shares responsibility for quality and safety in Anaesthesia, Intensive Care, Emergency Medicine and Pain Medicine, including the whole perioperative process and in many other situations inside and outside the hospital where patients are vulnerable.

Although there has been more than a 10-fold decrease in anaesthesia/surgery related mortality since 1970, approximately 3% of patients undergoing anaesthesia for major surgery every year develop severe complications of which one third die.

Anaesthesiology is the key specialty promoting perioperative safe patient care by mitigating preventable harm and advocating achievement of patient safety goals. These include provision of appropriate resources (equipment and drugs), delivery of patient safety training including simulation and human factors training and patient safety research and innovation.

Anaesthesiologists and Departments of Anaesthesiology promote adherence to internationally recommended standards of monitoring in operating theatres and in recovery areas as well as compliance with anaesthesiology recognised sedation standards for safe practice and guidance on infection control and post operative pain relief. In addition, protocolisation of preoperative assessment and optimisation, safety checks (drugs and equipment), medication safety beyond syringe labelling, support for the WHO Safe Surgery Saves Lives Checklist, handover and cognitive aids to management of emergency situations e.g., difficult and failed airway intubation, malignant hyperpyrexia, anaphylaxis, local anaesthetic toxicity and massive haemorrhage, significantly improve outcomes.

Departments of Anaesthesiology are encouraged to collect data on patient morbidity and mortality, to contribute to major (national or international) audits of safe practice and critical incident reporting and to produce annual reports on patient safety improvements.

In addition, CAI, JFICMI and FPM Patient Safety and Wellness initiatives in collaboration with Departments of Anaesthesiology recognising the importance to safety of supporting individuals and teams after an adverse patient outcome, encourage peer to peer early debriefing, crisis intervention and an opportunity to discuss ethical concerns, as well as an opportunity to contribute insights into how similar events could be prevented in future.

Mellin-Olsen, Jannicke; Staender, Sven; Whitaker, David K; Smith, Andrew F. *The Helsinki Declaration on Patient Safety in Anaesthesiology*. European Journal of Anaesthesiology 27(7):p 592-597, July 2010

Mellin-Olsen, Jannicke et al. *Ten years of the Helsinki Declaration on patient safety in anaesthesiology: An expert opinion on peri-operative safety aspects*. European Journal of Anaesthesiology 37(7):p 521-610, July 2020x

Appendix VI HSE Statement on CSCST

The HSE is aware of the of the MCI decision which requires the College of Anaesthesiologists of Ireland to change the nomenclature on the CSCST currently issued. We have been informed that the certificate has traditionally included *Anaesthesiology and Intensive Care Medicine and Pain Medicine* and that the wording on the CSCST for trainees entering the training programme from July 2024 will state only *Anaesthesiology*. It is our understanding that the first set of certificates with this updated wording will be issued in 2030.

We confirm that the HSE considers this change as a registration issue rather than an employment issue. The MCI has confirmed that holders of CSCST with the updated wording will continue in line with their predecessors to be registered on the Specialist Division in Anaesthesiology.

The change in CSCST wording does not impact the published HSE employment qualifications for a consultant anaesthesiologist which requires registration as a specialist in the Specialist Division of the Register of Medical Practitioners maintained by the MCI in the specialty of anaesthesiology.

The HSE does not require or seek a CSCST from candidates applying to consultant roles as the HSE's requirement is for a successful interviewee to be registered as a specialist in the relevant specialty i.e., on the Specialist Division in Anaesthesiology maintained by MCI, before taking up appointment.

The HSE has received confirmation from CAI and from MCI that the anaesthesiology training programme will continue to incorporate intensive care medicine and pain medicine in line with the requirements of the HSE model of care.

The HSE continues to support the SAT curriculum learning outcomes including intensive care medicine and pain medicine. The HSE has no plans to change the HSE Model of Care for Anaesthesiology or the HSE Model of Care for Critical Care both of which require anaesthesiologists' practice to include intensive care medicine and pain medicine.

Requirements of the individual consultant role and the job plan are developed at clinical site level. The HSE, as it always has, will continue to recognise and utilise the experience and training of the graduates of the CAI anaesthesiology training programme and this will continue to be reflected in job plans. We trust this outlines the position of the HSE in relation to the updated nomenclature on the CSCST Anaesthesiology.

Dr Colm Henry Chief Clinical Officer, Ms Anne Marie Hoey, Chief People Officer, 7th August 2024

Appendix VII

MEDICAL COUNCIL of IRELAND BRIEFING NOTE – ANAESTHESIOLOGY CSCST TITLE

13th August 2024

A Certificate of Successful Completion of Specialty Training (CSCST) is an important document which is issued to doctors upon successful completion of a programme of specialty training that has been accredited by the Medical Council (MCI). The CSCST is used as evidence by MCI when entering a doctor on the specialist division of the register of medical practitioners in the speciality named on the CSCST. It can also be used by doctors as evidence of a specific qualification, when submitted to international regulators outside the European Union (EU). A CSD (Certificate of Specialist Doctor) is used within the EU.

The designated approved title for anaesthesiology is ‘Anaesthesiology’. The College of Anaesthesiologists of Ireland (CAI) has been issuing CSCSTs with the title ‘Anaesthesiology to include Intensive Care Medicine and Pain Medicine’ to doctors who successfully complete training in anaesthesiology.

The only title that can be used (on CAI CSCST) following MCI’s accreditation process, subsequently approved by MCI Education and Training Committee and followed by ministerial approval, is the already designated title ‘Anaesthesiology.’

The issue is ongoing since 17th August 2021, when the draft accreditation report was issued to CAI stating that a CSCST should state ‘Anaesthesiology’ only. In its role as a regulator, MCI asked CAI to use the correct title when issuing Anaesthesiology CSCSTs.

The correct CSCST title is required to maintain full compliance with the Medical Practitioners’ Act 2007 and to convey information in a manner that is clear, equitable and transparent. There is precedent, similar requests have been given to other Postgraduate Training Bodies (PGTBs) and MCI’s approach in this instance is in line with the approach taken with other PGTBs.

Following a request from MCI, several PGTBs updated CSCST titles to maintain full compliance with the Medical Practitioners’ Act (2007), the EU Directive and MCI’s regulatory authority.

ROLE of THE MEDICAL COUNCIL of IRELAND

MCI is the regulatory body for doctors in Ireland. It has a statutory role in protecting the public by promoting the highest professional standards amongst doctors practising in the Republic of Ireland. MCI is responsible for quality assuring medical education and training in Ireland across a continuum which spans the undergraduate, intern and specialist training

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stages of professional development. The Medical Practitioners Act 2007 (as amended) sets out the MCI's responsibility for accrediting specialist training programmes and the postgraduate training bodies that deliver the programmes. MCI is responsible for designating the CSCST title for all accredited programmes of specialist training. All titles and designations of qualifications granted by MCI in the state, to enable a doctor to be registered in the specialist division of the register, must comply with the terms of Section 89(2) of the Medical Practitioners Act 2007 and the EU Directive on mutual recognition of professional qualifications (EU Directive 2005/36/EC as amended).

In summary MCI has a statutory responsibility for

- a) approving the specialties that are recognised in Ireland,
- b) the bodies approved to deliver specialist training programmes in each of those specialties,
- and
- c) accrediting each specific specialist training programme in line with the standards set out by MCI, including the title to be used in the CSCST that is awarded.

ROLE OF THE POSTGRADUATE TRAINING BODY

A PGTB is approved by MCI under section 89(3)(a)(ii) of the Medical Practitioners Act as the body which may grant evidence of satisfactory completion of specialist training. CAI is the body approved by MCI for the speciality of Anaesthesiology.

The specialist training programme accreditation report states the designated title and designation of qualification of the CSCST to enable a medical practitioner to secure registration on the Specialist Division of the Register under the terms of Section 89(2) of the Medical Practitioners Act 2007. The designated title to be used on the CAI CSCST is Anaesthesiology.

Following the accreditation approval process (MCI ETC and ministerial approval) CAI is furnished with the finalised approved accreditation report that lists conditions and recommendations needed for CAI to be fully compliant with MCI standards. An action and implementation plan is developed and a subsequent meeting between CAI and MCI is held to discuss implementation.

On a yearly basis, progress is monitored via MCI's Annual Returns. CAI is required to update MCI on progress and to notify MCI on significant changes and/or updates that may impact programme education and training quality.

APPROVED CAI-RELATED SPECIALTIES (FOR SPECIALIST REGISTRATION)

There are three approved specialties related to Anaesthesiology. Each one has a separate, accredited specialist training programme leading to the award of a CSCST in that speciality.

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1) Anaesthesiology – the approved training body is CAI, the accredited training programme is Anaesthesiology. The holder of a CSCST in Anaesthesiology is entitled to be on the MCI specialist division register of medical practitioners in the speciality of Anaesthesiology.

2) Intensive Care Medicine – the approved training body is the Joint Faculty of Intensive Care Medicine of Ireland, the accredited training programme is Intensive Care Medicine. The holder of a CSCST in Intensive Care Medicine is entitled to on the MCI specialist division register of medical practitioners in the speciality of Intensive Care Medicine.

3) Pain Medicine - the approved training body is the Faculty of Pain Medicine - the accredited training programme is Pain Medicine. The holder of a CSCST in Pain Medicine is entitled to be on the MCI specialist division register of medical practitioners in the speciality of Pain Medicine.

EU LAW DIMENSION

MCI is obliged to comply with the EU Directive on mutual recognition of professional qualifications (2005/36/EC as amended). The title listed for Ireland under point 5.1.3 of Annex V of the Directive is Anaesthesiology. Titles listed in Annex V must correlate with the CSCST being issued in Ireland.

THE CAI CSCST PROBLEM

The title being used by CAI on CSCSTs for the accredited anaesthesiology training programme is incorrect, is not, and never has been, approved by MCI. The title includes references to two other accredited specialties: Pain Medicine (PM) and Intensive Care Medicine (ICM). However, this CSCST does not entitle the bearer to be registered in the specialist division in either of these two specialties.

All CSCST titles must comply with relevant EU Directives, and MCI is statutorily responsible for ensuring this.

The CSCST title being used by CAI is not approved and could be misleading. MCI must be trusted by fellow regulators in other countries to provide accurate information upon which they can make decisions with assurance. In addition, the risk exists of doctors being placed on the incorrect register or on multiple registers outside the EU if CSCST is the main certification used for registration in those countries.

CONCERNS RAISED BY CAI

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- 1) **Clinical Practice:** changes to the title could lead to concerns that anaesthesiologists are working beyond their scope of practice, perhaps resulting in anaesthesiologists withdrawing from ICM and/or PM services and/or may impact negatively on recruitment
- 2) **Indemnity:** a change to CSCST could raise indemnity risks if an anaesthesiologist was deemed to have acted outside their scope of practice and held liable for a negative outcome.

MCI sought advice from the HSE and the National Treasury Management Agency on these concerns

Clinical Practice: the HSE confirmed that a doctor's role and workplan should include provision of services in ICM and PM. The title on a CSCST does not impact this role.

Indemnity: a representative from the NTMA confirmed that this is not an issue. Doctors working in hospitals covered by the state's clinical indemnity scheme fall under enterprise indemnity provided to the clinical site i.e., not indemnified on an individual basis.

TIMELINE DISCUSSIONS

August 2021: The issue was raised with CAI following accreditation. Multiple engagements August 2021 to December 2023 (5 stakeholder meetings, 6 letters and emails).

February 2024: Meeting between MCI and CAI representatives; letter from MCI to CAI stating "title on CSCST must state only Anaesthesiology"; letter to MCI from CAI requesting "additional time for clarification and transitional arrangements"; letter from MCI approving this request.

June 2024: meeting between MCI and CAI; multiple engagements regarding implementation of the decision across different cohorts of trainees.

MCI DECISION

In line with the approach MCI has taken with other PGTBs who deviated from the designated approved CSCST title, MCI requested following an accreditation process that CAI change its CSCST title to 'Anaesthesiology', the title designated and approved by MCI Education and Training Committee with ministerial approval.

FREQUENTLY ASKED QUESTIONS

1. Will this affect recruitment by HSE?

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No.

HSE confirmed that reverting to the approved title of ‘Anaesthesiology’ will not affect the recruitment strategy. HSE confirmed that a doctor’s job description and workplan should specify requirements for the provision of ICM and PM services.

2. Does this affect indemnity?

No.

NTMA confirmed that indemnity is not an issue, as the state’s clinical indemnity scheme indemnifies doctors based on professional roles in a hospital, irrespective of the CSCST title held.

3. Does this restrict scope of practice?

No.

Anaesthesiology training covers the full spectrum of anaesthesiology practice including modules in intensive care medicine and pain medicine. The programme will not change as a result of reverting to the approved title Anaesthesiology.

Scope of Practice is not fixed throughout the working life of a specialist. While it remains (under maintenance of professional competence rules) the responsibility of each individual to ensure that she/he maintain competence relevant to the scope of practise, it is understood that

practice may evolve within the job and based on research interests

4. When does this decision come into effect?

Discussions on this issue have been ongoing since 2021. CAI was formally notified on the 9th of February 2024 about MCI’s decision. The decision was due to become effective from the 1st of March 2024 and to apply to all doctors who complete anaesthesiology training after this date. Trainees commencing anaesthesiology training after February 2024 will have the approved title ‘Anaesthesiology’ on the CSCST after successfully completing the programme.

Does this affect those who already have an Anaesthesiology CSCST?

No.

The decision will not be applied retrospectively.

6. How does this affect trainees enrolled on the anaesthesiology training programme in the last 6 years (i.e., before February 2024)?

The current cohort of trainees, on successful completion of the programme will receive a CSCST with the title of *Anaesthesiology to include Intensive Care Medicine and Pain Medicine*, subject to inclusion of the following: *This CSCST entitles the holder to Specialist Division Registration in Anaesthesiology only*. This sentence will be underneath the title of CSCST and will be issued to all trainees currently on the anaesthesiology training programme.

7. How does this affect trainees who commence anaesthesiology training in July 2024?

Trainees commencing the programme in July 2024 will receive a CSCST stating the approved designated title of 'Anaesthesiology'.

8. Does this change impact the quality of the anaesthesiology qualification in terms of curriculum content and modules covered?

No.

The anaesthesiology training programme will remain the same in terms of the design, content, delivery and final outcome/quality.

9. Does this change the way the anaesthesiology training programme is delivered? Will it impact the experiences of trainees on the programme?

No.

The format, duration and the delivery of the programme remains the same.

10. What is the change to the anaesthesiology training programme resulting from the change to CSCST stating Anaesthesiology (only).

There will be no change to the training programme. The words 'to include Intensive Care Medicine and Pain Medicine' will be removed from the CSCST. The modules on Pain Medicine and Intensive Care Medicine will still be delivered on the programme.

11. Why did MCI not bring this to CAI's attention before now?

Since August 2021, MCI has engaged with CAI on this matter. In the process of making this decision, MCI also consulted with HSE, NTMA and has sought legal advice

Appendix VIII Patient Information

WHAT IS AN ANAESTHESIOLOGIST?

Anaesthesiologists form a very large group of doctors in Irish hospitals, specialising in anaesthesia care, pain management and critical care medicine.

Anaesthesiologists in Ireland are specialist doctors responsible for providing anaesthesia to patients for operations and procedures. Anaesthesiologists evaluate, monitor and deliver patient care before, during and after surgery, ensuring optimal patient safety. In addition, anaesthesiologists have a range of practice extending beyond anaesthesia for surgery to include pain management and intensive care medicine.

Anaesthesiologists have had 12–14 years of medical education including medical school, and at least 7 years of postgraduate clinical training. The standards of training in Ireland are high and exacting.

Most consultant anaesthesiologists have developed subspecialist interests in a particular area of surgical practice, or in pain management or in critical care medicine.

ANAESTHESIA FOR SURGERY

An anaesthesiologist's role includes meeting the patient to assess health and fitness for surgery, answering questions and meeting with the surgical team to plan appropriate and safe anaesthesia care. This may happen on the day of surgery for straightforward operations, or in an anaesthesia pre-assessment clinic for more complex surgery.

In the operating theatre, the anaesthesiologist administers anaesthesia tailored to the individual patient and the anaesthesiologist remains with the patient throughout the operation, monitoring the patient and managing the anaesthetic, medical problems that may occur during surgery, as well as managing chronic conditions such as heart problems, asthma, diabetes. This involves monitoring the heart, blood pressure and oxygen levels, and in more complex cases providing advanced organ support. The anaesthesiologist will also plan and implement a pain relief strategy to ensure patient comfort after the operation.

The anaesthesiologist remains responsible and is immediately available to the patient in the recovery area until the patient is ready to return to the surgical ward. Where complex types of pain relief are used on the ward the anaesthesiologists in the pain service will continue to review and care for the patients.

TYPES OF ANAESTHESIA PROVIDED BY ANAESTHESIOLOGISTS.

General anaesthesia. The patient loses consciousness. The drugs are administered through an anaesthesia mask or breathing tube or through a drip. It is used for major operations.

Monitored anaesthesia or IV sedation. IV sedation can result in various levels of consciousness, ranging from minimal (drowsy but able to talk) to deep (no memory for the

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procedure). This anaesthesia is often used for minimally invasive procedures such as colonoscopies. IV sedation is sometimes combined with local or regional anaesthesia.

Regional anaesthesia. Pain medication to numb part of the body, given through an injection or through a small tube – the patient is awake but unable to feel the area. This type of anaesthesia which includes spinal block and epidurals, is used during labour and for surgery of the arm, leg, or lower abdomen.

Local anaesthetic. An injection that numbs a small area where the procedure is being done (the patient is awake and alert but pain free) is used for removing a skin lesion or stitching a deep cut.

OTHER ROLES OF THE ANAESTHESIOLOGIST

During training, all anaesthesiologists complete specialist training in intensive care medicine. Most of the doctors therefore in intensive care medicine are anaesthesiologists and are involved in resuscitation teams.

Some anaesthesiologists also choose to specialise in caring for specific sorts of pain including pain during labour. Some anaesthesiologists focus their practices on treating patients with long term (chronic) pain problems e.g., pain after an injury, migraine or back pain.

Anaesthesiologists also play a key role in taking care of patients who are having minor surgery and who may or may not require general anaesthesia. In addition, patients are likely to come across anaesthesiologists in areas outside the operating theatres, e.g., imaging, scanning, endoscopy, interventional radiological and endovascular procedures, cardiology procedures and dental treatments often require an anaesthesiologist to administer anaesthesia and to monitor the patient.