Dr. Rhona Mahony, Master at the National Maternity Hospital, delivered this year’s Doolin Lecture. In her professional role, Mahony has been a strong and highly visible advocate for women’s healthcare.

She began her delivery with a brief history of women through the ages. She referred to De Valera’s 1943 Irish country idyll, happy maidens whose firesides would be forums for the wisdom of serene old age. The woman’s position had been placed firmly in the home. In 1922 the first laws of the Free State excluded women from certain jobs. The marriage ban which prevented women from working after marriage was not abolished until 1973. The Juries Bill precluded women from sitting on juries. In the early decades the role of women in politics was minimal, and it wasn’t until 1981 that the number of female TDs exceeded 10 representatives. This was a source of disappointment because women had played a major part in the 1916 Rebellion, such as the heroics of Elizabeth O’Farrell.

The conservative moral structures of Church and State came down heavily on women. Pregnancy outside marriage was a moral outrage. Redeemable women were sent to Mother and Baby homes, the irredeemable ones were incarcerated in the Magdalene laundries. The Criminal Law Amendment Act 1935 criminalised the use of contraception. This had a profound adverse effect on women’s ability to plan their families and their reproductive choices. This regressive law remained in place for over 50 years culminating the successful prosecution of Virgin megastore in 1991 for selling condoms.

The idealistic Mother and Child Scheme 1951 was undermined and abandoned on the premise that it would lead to socialism and interference with family privacy. Liam Kirwan in his book ‘The Unholy Trinity’ states ‘there is little doubt that the future development of the Irish Health service was, in its direction and ideology, determined by the outcome of the Mother and Child conspiracy of 1950. The proposed scheme for mothers during pregnancy and their children up to 16 years would have been entitled to free service regardless of income. Many years later watered down, means tested version of the scheme was introduced’.

The introduction of free secondary education, the lifting of the marriage ban, and the wide availability of third-level education has greatly benefitted women. 58% of Irish women have completed third level education compared with 44% of men. Women constitute 46% of all those in employment, but many are in part-time jobs. At the top table just 14% of companies are led by women.

Mahony pointed out the obvious challenges facing the working mother. Female participation in the
Women frequently defer having children in order to secure their careers. The average age of a first-time mother being 32 years. This has potential reproductive consequences, with higher rates of infertility problems.

Mahony went on to explore the role of women in medicine. She looked at it from the medical student, through postgraduate training, and on to a career as a consultant. At medical school level, women are performing well. Currently 65% of medical school entrants are female. Irish universities first admitted women to medical schools in the 1880s, well before many other European countries.

The experiences women in postgraduate training programmes are more challenging. This busy period of their professional lives coincides with their optimal reproductive years. Little allowance has been made to accommodate for the increased feminization of the workforce. Female graduates try to balance work/life balance by targeting certain specialties such as GP, Dermatology, Paediatrics, Palliative Care, and Obstetrics. On the other hand men are more likely to enter Surgery, Anaesthesia, and Emergency Medicine.

The ritual annual circulation of trainees to hospitals all over Ireland creates considerable stress in terms of separation from their families or the alternative of costly relocation.

Mahony explored how women fare when they become qualified GPs or consultants. 42% of GPs are women. The number of female consultants is steadily increasing. Women predominate in the under 44’s and men in the over 44’s.

The challenge of recruitment and retention was discussed in some length. There are 200 permanent consultant posts vacant, and there are 300 non-permanent constant positions. In 2015, 22% of consultant posts had one or no applicant. The struggle to get specialists into posts is compounded by the protracted bureaucracy of the appointments process. A new post application has got to get through 3 different bodies before it comes before the CAU. These difficulties are an obstacle to the creation of much needed additional consultants. The lack of consultant throughput makes working abroad more attractive. The exit interviews that have been undertaken report that the top 5 reasons for emigration are working conditions, training, career progression, and financial reasons. These issues must be resolved if our health service is to attract more consultants and move away from its current dependence on NCHDs.

Mahony outlined her blueprint for the Irish health service:

- The first is that the prevention services should include health education programmes in our
The second aspiration is timely access to care in an appropriate setting. Current problems are elective surgery and outpatient waiting lists. The number of elective surgery cases have decreased by 54%, 187,000 to 86,000, since 2012. The outpatient waiting lists have increased by 15%, and patients on trolleys by 58%. One of the solutions is to expand community services and reduce pressure on acute hospital care. Care of the elderly must be a focus as they account for 50% of total hospital beds and 25% of ED attendances.

The third aspiration is that patients should increasingly be seen by trained doctors rather than doctors in training.

The fourth step is to monitor population trends, disease trends, and outcome trends. A uniform IT structure is required nationally.

The fifth issue is the rising costs of medical negligence. Last year the SCA reported that the liability for clinical claims was 1.6 billion euro in 2016, a 23% increase on the previous year. Obstetrics is costing up to 80 million euro annually. While the SCA have reduced its legal costs, the plaintiff’s legal costs are significantly higher. The current trends are unsustainable.

Mahony concluded with the following statement: ‘We might be dancing away from the crossroads but it feels as though we might be dancing to the edge of the cliff’

JFA Murphy
Editor