Comhairle na nDochtúirí Leighis
Medical Council

Medical Workforce Intelligence Report 2024

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Acknowledgments

This report was prepared by the Research and Regulatory Data Insights Team at the Medical Council. This research report could not have been produced without the support of doctors who retained their registration with the Medical Council and completed the workforce questions on the Annual Retention Form in 2024. We hope that through their contributions, this report can help further strengthen and develop a supported and resourced medical workforce that provides quality and safe healthcare in Ireland.

Executive Summary

Maintaining the Register of Medical Practitioners ('the Register') is fundamental to the Medical Council's remit of protecting the public, and data held on the Register provides valid and robust insight into the medical workforce in Ireland. This workforce intelligence report contains data that can be used to inform recruitment and retention strategies, medical education and training development and health policy in Ireland. This robust data, combined with employment data, can support effective planning for a strong and sustainable medical workforce into the future.

This workforce data reinforces issues highlighted in previous iterations of this report and other workforce research reports (Brugha et al., 2021; Hanlon et al., 2024; Humphries et al., 2021; McLoughlin et al., 2021). These relate to, for example, the need for increased supports and training opportunities for non-consultant hospital doctors (NCHDs), excessive working hours in contravention of the European Working Times Directive (EWTD) and various workforce challenges due to retirement, changing work patterns and heavy reliance on doctors with international qualifications.

Our medical workforce is facing immense challenges in relation to recruitment efforts and supporting retention of doctors upon completion of training. Our workforce challenges have implications for the wider health system, particularly Ireland's ability to effectively implement Sláintecare healthcare reforms, which aim to increase access to public healthcare in Ireland, and to expand primary and community healthcare. Ireland's population expansion, increasing health inequalities, social deprivation and demographic ageing present unique challenges and are further increasing demand on our medical workforce.

Improving the quality, consistency and timeliness of medical workforce data is essential to facilitate informed and effective decision-making on key workforce issues now and into the future. The Medical Council is striving to improve and refine the quality and scope of our data collection, and this report contains data from new questions included in the annual retention process for doctors. We are committed to collaboratively sharing workforce data with our stakeholders including policymakers, educators, regulators, employers, Department of Health (DOH), Health Service Executive (HSE), Forum of Irish Postgraduate Medical Training Bodies and Medical Schools.

Workforce Intelligence Report 2024 in Numbers

Comhairle na nDochtúirí Leighis
Medical Council

Doctors per Division

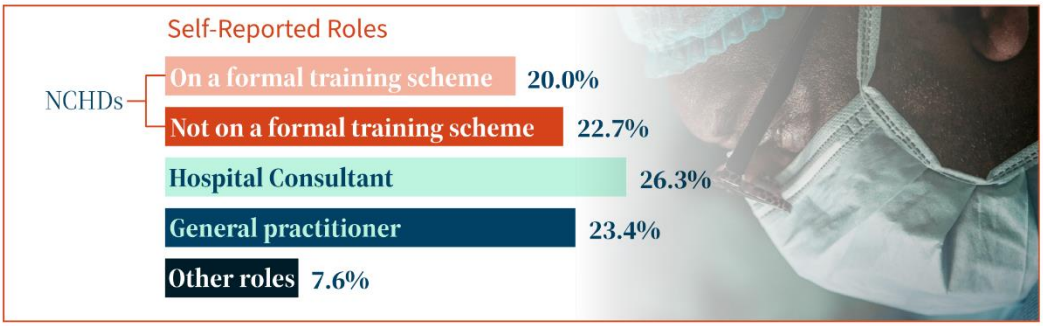
Age

43.7 mean age
20.6% aged **55 and above**

Gender

52.8% Males
47.2% Females

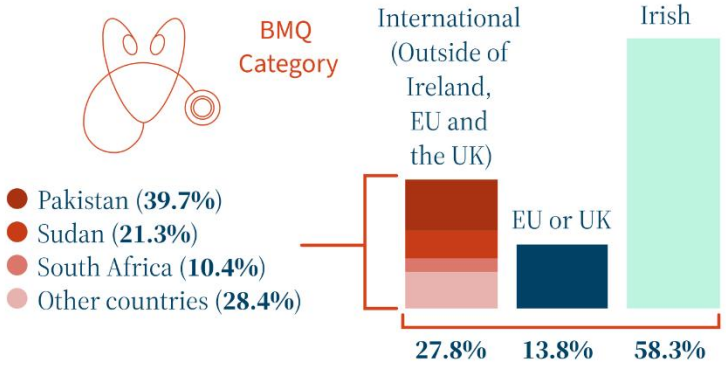
Self-Reported Roles



On an average week…

23.1% of doctors reported working more than 48 hours and
10.7% spending more than 48 hours in direct patient care

BMQ Category



Main barriers to providing good patient care (% of doctors selecting option)

73.0% Pressure on workloads
55.1% Time spent on bureaucracy/administration
46.1% Delays to providing care, treatment and screening

Key Observations

This Workforce Intelligence Report analyses and presents data provided by doctors who completed the Medical Council's annual retention process in 2024. It contains an overview and analysis of the clinically active medical workforce in Ireland including quantitative analysis of demographics and divisional status, details on employment and practice, medical disciplines and specialities, and for the first time, hours spent working in direct patient care, patient safety barriers and future career plans.

In 2024, there were 20,962 clinically active doctors ('clinically active workforce') working in the Republic of Ireland. This represents 78.8% of the doctors who retained their place on the Register and demonstrates that the overall number of doctors on the Register does not translate directly to the number of doctors working on the ground who form part of the clinically active workforce in Ireland.

A number of demographic characteristics of clinically active doctors in Ireland in 2024 are particularly noteworthy:

- The proportion of clinically active female doctors was 47.2% and continues to show a slight but steady increase (47.0% in 2023 and 46.8% in 2022).
- The mean age of doctors was 43.7 and approximately 1 in 5 (20.6%) were 55 and older, thus approaching the typical retirement age.
- Just over half of clinically active doctors (50.3%) were registered on the Specialist Division, while 30.8% were on the General Division.
- The highest number of clinically active doctors were concentrated in disciplines of General Practice (25.9%) and Medicine (23.4%), followed by Surgery (11.9%).
- The proportion of clinically active doctors with an international basic medical qualification (from outside Ireland, the EU and the UK) was 27.8% and continues to rise (25.7% in 2023 and 23.3% in 2022).
    - The most common country of qualification for international graduates was Pakistan, with 2,314 doctors (39.7% of the international graduate cohort). This was followed by Sudan, with 1,240 doctors (21.3% of the international graduate cohort).

Working in Direct Patient Care

The Medical Council gathers data on doctors' average working hours per week. Almost a quarter of doctors self-reported working more than 48 hours on average per week, in contravention of the European Working Time Directive (EWTD). This varied depending on the division on which doctors were registered, with doctors on the Trainee Specialist Division showing the highest proportion of those working in excess of 48 hours on average per week (37.1%). Just over one in five doctors on the General Division (22.5%), and just under one in five doctors on the Specialist Division (18.3%)

were working in excess of 48 hours per week. While these proportions are high, it is encouraging to report that they reflect a decrease across all divisions from the proportions reported 2023.

For the first time in 2024 doctors were asked how many hours they spent in direct patient care, which in some cases when compared to overall hours worked, can provide insight into time spent on administrative and non-core tasks. Among doctors who reported working in excess of 48 hours per week, 2,147 (45.6%) also reported that they were working in direct patient care in excess of 48 hours per week. Of this doctor cohort, the vast majority were registered either on the General Division (*n* = 864, 40.2%) or the Trainee Specialist Division (*n* = 810, 37.7%). This raises concerns in relation to doctor wellbeing and patient safety, as excessive work hours are demonstrably associated with attrition, stress, burnout and are predictive of adverse event involvement.

Doctor Views of Patient Safety

For the first time, doctors were asked about their views of patient care and safety. A closed, single-choice question was employed to ask how frequently, if at all, they found it difficult to provide a patient with sufficient care. Slightly more than a quarter of doctors (26.1%) reported experiencing difficulty providing a patient with sufficient care at least once a week or more frequently. The majority of these doctors were registered on the Specialist Division, had Irish qualifications and worked in General Practice, followed by Psychiatry.

Doctors were subsequently asked to identify the main barriers to patient care from a pre-defined list. Barriers selected by most doctors included 'pressure on workloads', 'time spent on bureaucracy/administration', followed by 'delays to providing care, treatment and screening'. Doctors' views of barriers to patient safety provides an opportunity to identify and examine critical factors that can detract particular cohorts of doctors from providing and enabling safe patient care and factors that hinder good practice and effective team working in the clinical environment.

Non-Consultant Hospital Doctors (NCHDs)

NCHDs play a critical role in the safe and timely delivery of healthcare and need to be supported with appropriate education and training. NCHDs work under the supervision of a consultant doctor, however, there is a significant shortage in the number of approved training posts, and career training pathways for NCHDs can be precarious for those not on a formal training scheme. The majority of these NCHDs are doctors who have trained overseas, and many have not been able to access specialist training in Ireland.

In 2024 over half of clinically active NCHDs were not on a formal training scheme (*n* = 4,767, 53.3%). This represents an increase of 12.6% from 2023 (*n* = 4,233). Furthermore, the difference in the number of NCHDs who were on a formal training scheme and those who were not grew in the last 3 years, reaching a 13.9% difference in 2024. Many are employed in Model 2 and Model 3 hospitals (NDTP, 2023), which have high proportions of NCHDs overall and are heavily reliant on NCHDs not on a formal training scheme.

Our data indicate that 73.0% (*n* = 3,057) of NCHDs on a formal training scheme had obtained their qualifications in Ireland, whereas in the case of NCHDs not on a formal training scheme two thirds (*n* = 3,174, 66.6%) had international qualifications from outside Ireland, the EU and UK. Furthermore, NCHDs on a formal training scheme had a higher proportion of doctors working more than 48 hours on an average week than NCHDs not on a formal training scheme, and the same is observed for weekly hours spent in direct patient care.

General Practice

General practice is considered the cornerstone of the Irish health service, often the first point of contact for patients, providing comprehensive care and continuity of care. The general practice workforce is undergoing a significant change internationally. Increasing numbers of General Practitioners (GPs) are changing their working life and career path by reducing the number of clinical working sessions, developing portfolio careers whereby GPs take the opportunity to explore variation or different avenues of work, and/or considering emigration (Keenan et al., 2024).

Our data show that female doctors now constitute 52.4% of the GP workforce. When looking at gender breakdown within specific GP categories, GP principals or partners are evenly split while the majority of GPs working in sessional or assistant positions are female, and the majority working in single handed practices, out of hours and locum positions are male. Furthermore, the proportion of female doctors will most likely continue to increase as older male doctors retire. Therefore, understanding and examining the female GP workforce and their career choices is crucial to planning a sustainable future medical workforce.

Our workforce data indicate that in 2024 the mean age of GPs was 49.2 and 31.1% (*n* =1,483) were 55 years of age or older, bringing them closer to the typical retirement age and posing a challenge for the healthcare system. The ICGP reported in 2022 that 24% of Ireland's GPs were due to retire in the coming decade (ICGP, 2022) and some research has demonstrated that this cohort of GPs aged 55+ are more likely to work longer sessions and finish later which highlights a further challenge to replacing this cohort (Crosbie et al., 2020). The GP workforce crisis is particularly severe in rural Ireland, where retiring GPs are struggling to recruit replacements, and practising GPs are unable to find locum cover to enable them to take annual leave or sick leave. It is difficult to recruit GPs to work in areas of socioeconomic deprivation. There is no recognition of differential levels of need of patients attending practices in socioeconomically deprived areas compared to affluent areas. This means that GP practices in areas of deprivation receive similar funding per patient to those in more affluent areas (Shea et al., 2024).

Several reports have pointed to an increased demand for the GP workforce in Ireland, stating that the provision of a sufficient response to patients' demands requires an increase of 42% in the number of GPs (NDTP, 2015, 2020). Current GP demographics, work practices and patterns must be recognised and utilised to inform training and education needs and ensure delivery of timely and high-quality patient care.

Just over one in ten GPs reported working in excess of 48 hours on an average week, however over half of this cohort spent 40 hours or less in direct patient care. This suggests that this cohort of doctors could be spending at least 8 hours per week on administrative work or other non-core tasks. This aligns with research demonstrating that a significant proportion of GP workload does not involve face-to-face consultations, but comprises a variation of clinical paper work, administrative work and other work types (Crosbie et al., 2020). There is therefore a significant workload burden outside of the direct patient consultation that can impact GP retention and patient safety.

Compared to other medical disciplines, doctors working in General Practice tended to show the highest percentage of doctors reporting on most barriers to good patient care. Moreover, it should be noted that 56.8% of all doctors reporting "inadequate access to specialist opinion", and 37.9% of all doctors reporting "inadequate communication between healthcare professionals" as a barrier were working in the area of General Practice.

Background

The Medical Council 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.

The Register of Medical Practitioners is a valid and complete list of doctors who are permitted under Irish law to practise medicine in the State. The cornerstone of the Medical Council's work in protecting the public is establishing and maintaining a Register of doctors. Under Irish law, no one can practise medicine in the Republic of Ireland unless they are registered as a doctor with the Medical Council. Data held on the Register provides valid and robust insight into the medical workforce in Ireland.

Doctors register in one of six divisions of the Register, depending on the training they have completed, or are currently undertaking. Division is therefore not static, and doctors can transfer depending on their current circumstances. The six divisions of the Register are:

- **Specialist Registration:** Doctors may practise independently, without supervision and may represent themselves as specialists.
- **Trainee Specialist Registration:** Doctors are on recognised training programmes and practise solely within the confines of posts allocated by the HSE in conjunction with the postgraduate training bodies (PGTBs).
- **General Registration:** Doctors may practise independently, without supervision but may not represent themselves as specialists.
- **Supervised Registration:** Doctors who have been offered a post that has been approved by the HSE, which has specific supervisory arrangements.
- **Internship Registration:** Allows a doctor to carry out internship training in a hospital recognised by the Medical Council. These posts are allocated by the HSE.
- **Visiting EEA Practitioners Registration:** Doctors are European Union citizens who are fully established to practise medicine in another European Union member state. These doctors may practise medicine in Ireland on a temporary basis without having to take out General or Specialist Registration.

Methods

Data Sources

The data presented in this report was obtained through the annual retention process doctors completed in 2024. All doctors practising medicine in Ireland must renew their registration with the Medical Council every year. Failure to complete this process can ultimately result in a doctor's name being removed from the Register, after a warning and a notification of potential removal.

All doctors who are active on the Register as of the 30 April each year are invited to participate in retention. The annual retention application form (ARAF) is available through each doctor's personal online registration account (and in a small number of cases a paper version of the ARAF is sent to doctors by post if preferred).

The ARAF has several compulsory questions where doctors must make declarations about their current position. Since 2012, the Medical Council has included a set of questions to collect and analyse data on registered doctors' work practices to inform strategic workforce planning, regulatory operations and development. These questions are optional but have a high response rate. Notably, in 2024 questions on practice of medicine, place of practice and self-reported role became mandatory. Furthermore, in 2024, new questions were added to the form about hours worked in direct patient care, views of patient care and safety, barriers in providing patients with sufficient levels of care, and possible future career changes. More information about changes and updates to the ARAF 2024 can be found in the appendix.

These data have been analysed against basic information about doctors' age, gender, registration division and country of qualification that are housed on the Medical Council database. It should be noted that this is a living database and doctors can transfer divisions. The data in this report was extracted in October 2024 after the retention period had ended. A small proportion of doctors may have been registered in a different division while completing their ARAF form or by year end 2024.

Clinically Active Workforce Data

The process of selecting the clinically active workforce cohort for analysis consists of a three-step filtering process: retention status, practice of medicine, and place of practice (Figure 1).

In 2024, 26,591 doctors chose to retain their registration. This cohort of doctors was asked whether they were currently practising medicine, and if they answered yes to this question, a follow up question was asked about their place of practice (these two questions were updated and became mandatory in 2024). Place of practice offered the options:

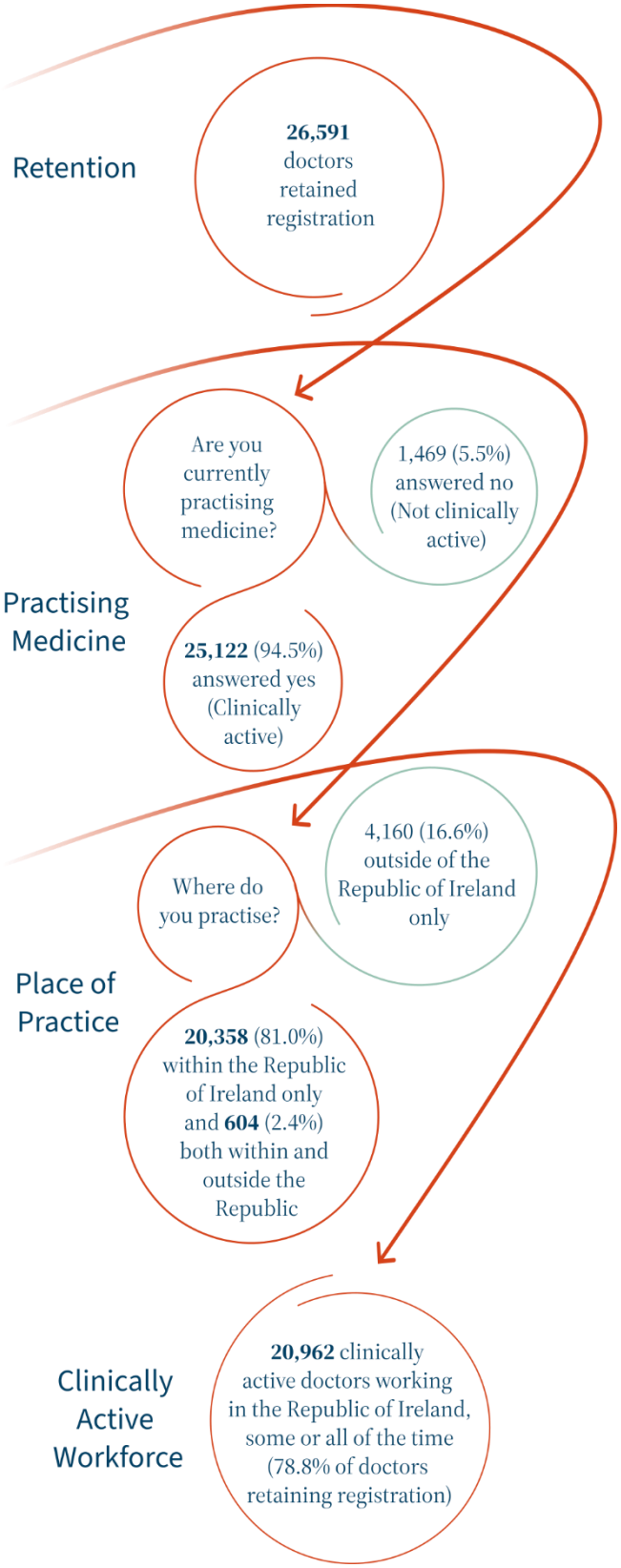
- Within the Republic of Ireland only
- Outside the Republic of Ireland only

- Both within and outside the Republic of Ireland.

The clinically active workforce consists of those **clinically active** doctors who work in the Republic of Ireland only (all of the time) and those working both within and outside the Republic of Ireland (some of the time). In 2024, the clinically active medical workforce consisted of 20,962 doctors, which represents 78.8% of those retaining registration. There are certain cohorts of doctors, however, that are not captured in this figure given the way the retention process works:

- Doctors undertaking their internship.
- Doctors who have just completed their internship year. These doctors are not required to complete the annual retention process but rather they apply to the Medical Council to transfer registration if they wish to continue practising.
- Doctors who were registered for the first time or who restored registration after 30 April 2024. These are not captured in the retention data as they are not required to renew their registration during this period.
- Doctors who hold Visiting EEA registration are similarly not required to apply to retain registration with the Medical Council as this is time limited.

Figure 1. Filtering Clinically Active Workforce Data



Clinically Active Doctors in Ireland

Demographics and Registration Division

Information on demographics and registration division for clinically active doctors in Ireland is provided in Table 1. The mean age of doctors was 43.7 (SD = 12.0) and approximately 1 in 5 (20.6%) were 55 and older, thus approaching the typical retirement age. The proportion of females was 47.2%, and continues to show a slight but steady increase from 46.8% in 2022, and 47.0% in 2023 (Figure 2). Furthermore, when age groups are divided by gender, a close to 50/50 split can be observed in all but the older group (55 and older), with just over two thirds (67.4%) of doctors being male (Figure 3). Slightly over half of the doctors (*n* = 10,539, 50.3%) were registered on the Specialist Division, while 30.8% (*n* = 6,453) were on the General Division.

There were 12,230 (58.3%) doctors who obtained their Basic Medical Qualifications (BMQs) in Ireland, 2,902 (13.8%) in the EU/UK, and 5,830 (27.8%) who graduated from medical schools outside of Ireland, the EU and the UK (this group is referred to as 'international'). It should be noted that this classification of international BMQ differs from that used in previous reports, where international BMQ was simply *any* BMQ outside of Ireland. Adopting this new definition of international BMQ allows for a more focused analysis on a specific cohort of doctors who are more likely to have graduated in developing countries. This can provide valuable information given the commitments set in the WHO Global Code of Practice on the International Recruitment of Health Personnel.

As shown in Figure 4 the proportion of international graduates continues to rise (from 23.3% in 2022 and 25.7% in 2023). The most common country of primary medical degree for international graduates was Pakistan, with 2,314 doctors (39.7% of the international graduate cohort), an increase of 25.0% from the figure of 1,851 in 2023. In second place was Sudan, with 1,240 doctors (21.3% of the international graduate cohort).

Table 1. Clinically Active Doctors in Ireland

Clinically Active Doctors (n = 20,962)		
Age	**Mean**	**SD**
	43.7	12.0
Age group	**n**	**%**
34 and younger	5,833	27.8
35 to 44	6,446	30.8
45 to 54	4,358	20.8
55 and older	4,325	20.6
Gender	**n**	**%**
Male	11,058	52.8
Female	9,904	47.2
Division	**n**	**%**
Trainee Specialist	3,825	18.2
Supervised	145	0.7
General	6,453	30.8
Specialist	10,539	50.3
BMQ	**n**	**%**
Irish	12,230	58.3
EU or UK	2,902	13.8
International	5,830	27.8
Top 5 Countries of International Graduates	**n**	**%**
Pakistan	2,314	39.7
Sudan	1,240	21.3
South Africa	605	10.4
India	310	5.3
Egypt	243	4.2

Figure 2. Proportion of Males and Females 2022-2024

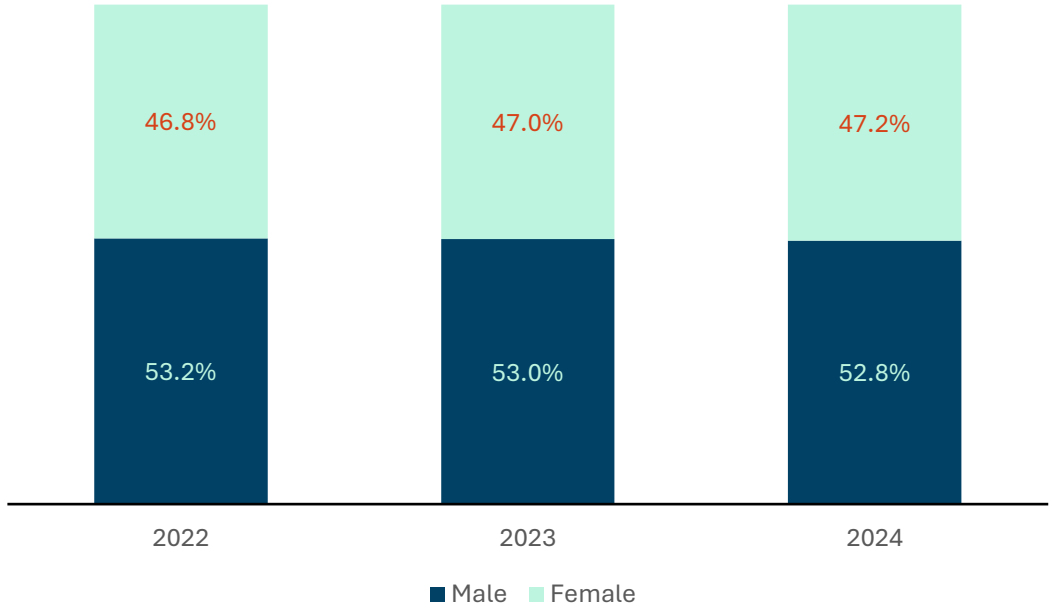


Figure 3. Age Group by Gender

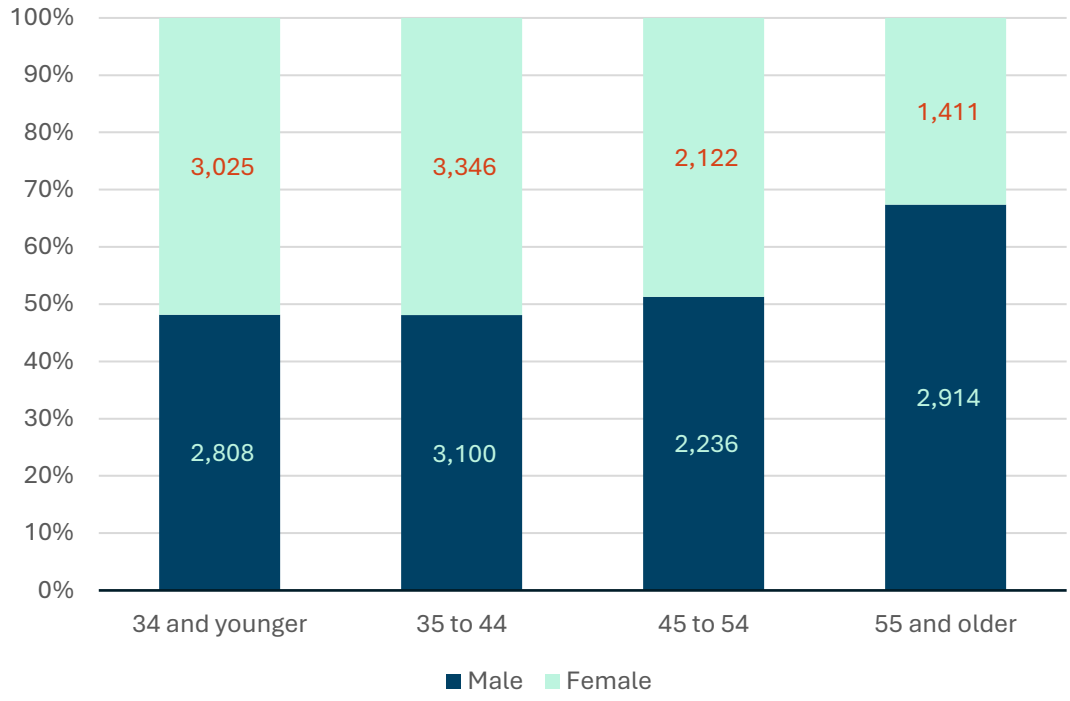
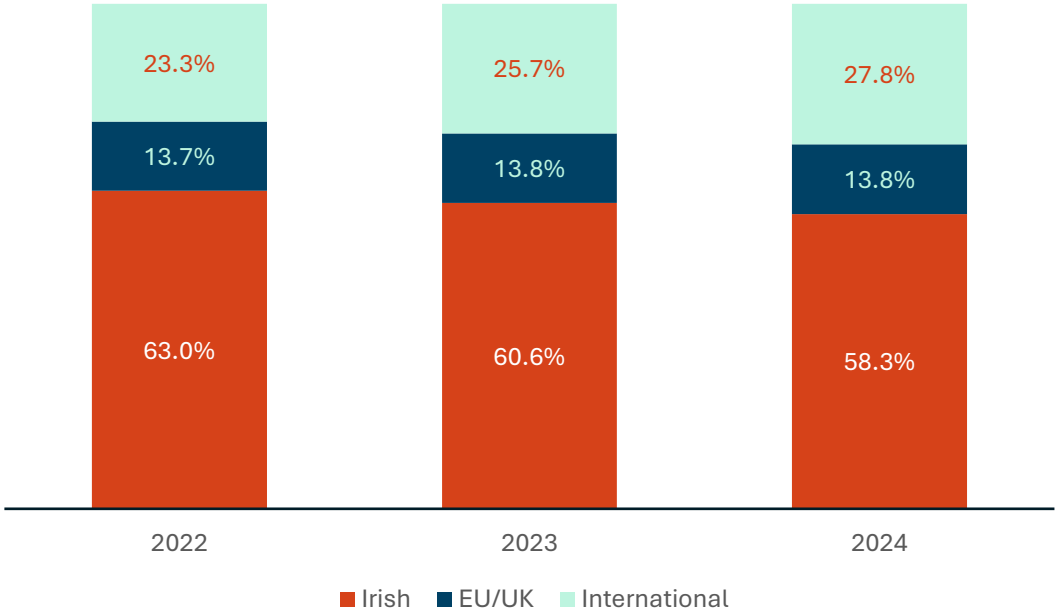
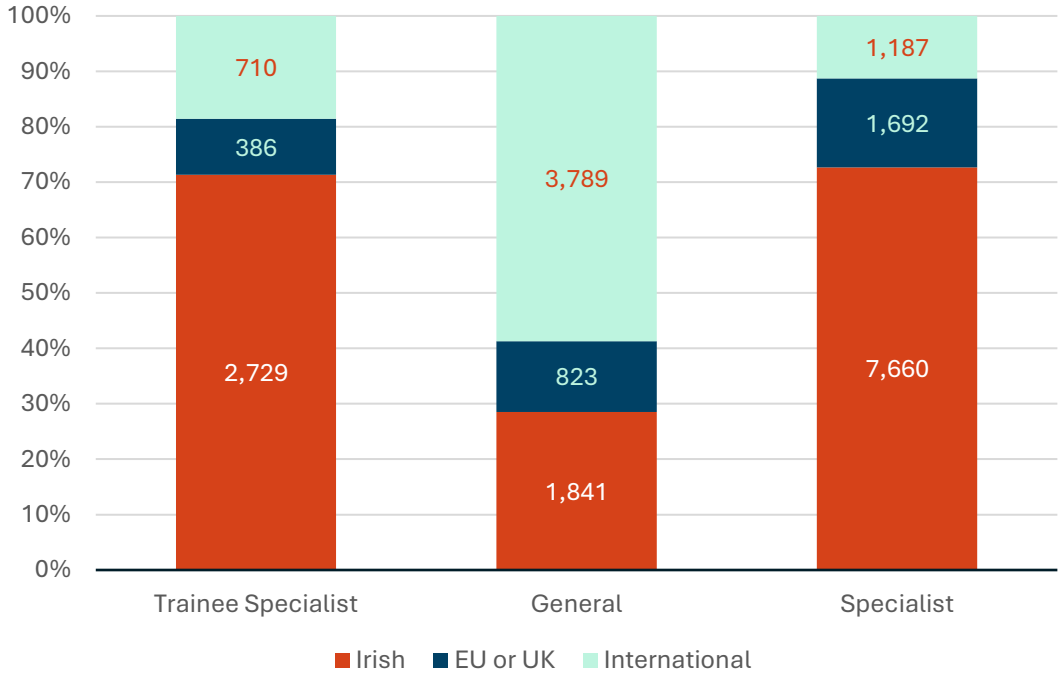


Figure 4. Proportion of BMQ Categories 2022-2024



In terms of Division by qualification category (Irish, EU or UK, International), just over 70.0% of doctors in the Specialist and Trainee Specialist Divisions had Irish Qualifications (72.7% and 71.3% respectively), whereas in the General Division, the majority of doctors (58.7%) had international qualifications from outside Ireland, the EU and the UK (Figure 5).

Figure 5. Division by Qualification Category



Employment and Practice

(a) County of Practice

The majority of doctors reported practising in county Dublin (*n* = 8,988, 42.9%), followed by county Cork (*n* = 2,382, 11.4%) and county Galway (*n* = 1,575, 7.5%) (Table 2).

Table 2. Doctors' County of Practice

County	n	%	County	n	%
Dublin	8,988	42.9	Wexford	340	1.6
Cork	2,382	11.4	Offaly	310	1.5
Galway	1,575	7.5	Meath	289	1.4
Limerick	1,197	5.7	Cavan	265	1.3
Waterford	708	3.4	Laois	263	1.3
Louth	585	2.8	Wicklow	186	0.9
Donegal	520	2.5	Clare	159	0.8
Kerry	503	2.4	Carlow	111	0.5
Sligo	472	2.3	Roscommon	99	0.5
Kildare	388	1.9	Monaghan	75	0.4
Mayo	388	1.9	Longford	43	0.2
Kilkenny	376	1.8	Leitrim	34	0.2
Westmeath	356	1.7	**Total**	**20,948**	**100.0**
Tipperary	336	1.6			

Note. Data on county of practice was not available for 14 doctors.

(b) Medical Disciplines

Doctors reported the specialty that best described their current or most recent practice of medicine. These specialties are grouped in the 14 medical disciplines shown in Table 3. The highest number of doctors were concentrated on the disciplines of General Practice (*n* = 5,342, 25.9%) and Medicine (*n* = 4,820, 23.4%). Among doctors registered on the Specialist Division only, the same pattern can be observed, with more than half of doctors on this division practising in either the General Practice or Medicine disciplines.

Table 3. Doctors by Discipline (Totals and Specialist Division Only)

Medical Discipline	Total		Specialist Division Only	
	n	%	n	%
Anaesthesiology	1,392	6.7	699	6.7
Emergency Medicine	1,055	5.1	226	2.2
General Practice	5,342	25.9	3,889	37.3
Medicine	4,820	23.4	1,712	16.4
Obstetrics and Gynaecology	765	3.7	282	2.7
Occupational Medicine	164	0.8	113	1.1
Ophthalmology	167	0.8	101	1.0
Paediatrics	1,153	5.6	452	4.3
Pathology	684	3.3	437	4.2
Psychiatry	1,624	7.9	782	7.5
Public Health Medicine	286	1.4	168	1.6
Radiology	696	3.4	492	4.7
Sports and Exercise Medicine	27	0.1	25	0.2
Surgery	2,461	11.9	1,051	10.1
Total	**20,636**	**100.0**	**10,429**	**100.0**

Note. 326 doctors declared a scope of practice that was limited to urgent care only, aesthetics only, gynaecology only or medicolegal only. These doctors have not been included in this table.

Table 4 describes doctors by medical discipline in terms of gender, age, and BMQ. The disciplines of Public Health Medicine and Obstetrics and Gynaecology had the highest percentages of female doctors, with 76.2% and 70.8% respectively. The two disciplines with the lowest percentages of females were Sports and Exercise Medicine (11.1%) and Surgery (23.4%). In relation to doctors 55 years of age and older, Ophthalmology had the greatest proportion (37.7%), followed by Public Health Medicine (36.4%). Public Health Medicine features also as the discipline with most doctors holding an Irish BMQ, with a striking 92.0%. In contrast, only 32.1% of doctors working in Emergency Medicine had an Irish BMQ.

Table 4. Doctors Descriptives by Discipline

Medical Discipline	n	% Female	% 55 and older	% Irish BMQ
Anaesthesiology	1392	36.5	21.0	47.9
Emergency Medicine	1055	36.0	9.1	32.1
General Practice	5342	53.0	28.4	71.5
Medicine	4820	46.2	13.0	57.1
Obstetrics and Gynaecology	765	70.8	19.1	43.3
Occupational Medicine	164	59.8	35.4	73.2
Ophthalmology	167	60.5	37.7	59.3
Paediatrics	1153	63.7	15.0	48.9
Pathology	684	60.4	21.2	72.4
Psychiatry	1624	51.5	22.0	52.1
Public Health Medicine	286	76.2	36.4	92.0
Radiology	696	37.9	22.7	78.2
Sports and Exercise Medicine	27	11.1	33.3	77.8
Surgery	2461	23.4	19.7	49.4

Note. 326 doctors declared a scope of practice that was limited to urgent care only, aesthetics only, gynaecology only or medicolegal only. These doctors have not been included in this table. Columns are shaded with gradations: the darker the tone, the higher the value within the column.

(c) Self-Reported Role, Service Provision and Training

Just over a quarter of doctors reported working as hospital consultants (*n* = 5,511, 26.3%) followed by General Practitioners (*n* = 4,899, 23.4%) (Table 5).

Table 5. Doctors' Self-Reported Role

Self-reported Role	n	%
Non-consultant hospital doctor, on a formal training scheme	4,185	20.0
Non-consultant hospital doctor, not on a formal training scheme	4,767	22.7
Hospital Consultant	5,511	26.3
Other Consultant or Specialist	794	3.8
General Practitioner	4,899	23.4
Community Health Doctor	233	1.1
In-house doctor/ Medical officer	147	0.7
Industry, e.g., Pharmaceuticals	25	0.1
Others	397	1.9
Total	**20,958**	**100.0**

Note. Data on self-reported role was not available for 4 doctors.

Doctors were asked which category best described their service provision arrangements and over half of doctors answering this question were providing publicly funded services only (*n* = 10,480, 51.3%), and only 7.4% (*n* = 1,521) were providing privately funded services only (Table 6).

Table 6. Service Provision Arrangements

Service Provision	n	%
Provision of publicly funded services only	10,480	51.3
Provision of privately funded services only	1,521	7.4
Provision of publicly and privately funded services	8,419	41.2
Total	**20,420**	**100.0**

Note. 542 doctors did not provide information on this question.

Doctors were asked if they trained other doctors and one third (*n* = 6,917, 33.7%) reported that this was part of their role (Table 7). Almost 30% (*n* = 6,030, 29.4%) reported also training other doctors, but this was not a formal part of their role. Furthermore, doctors were asked if they had protected time for training, and among those who provided training as a formal part of their role, more than half (*n* = 3,231, 51.9%) answered no (Table 8).

Table 7. Doctors Training Others

Do you train other doctors?	n	%
Yes, it's part of my role to train other doctors	6,917	33.7
Yes, but it's not a formal part of my role to train other doctors	6,030	29.4
No, I do not train other doctors	7,556	36.9
Total	**20,503**	**100.0**

Note. Data on training doctors was not available for 459 doctors.

Table 8. Doctors Training Duties and Protected Time

	Doctors Training Other Doctors (n = 11,611)*			
	Part of doctor's role		Not a formal part	
Protected time for training doctors	n	%	n	%
No	3,231	51.9	4,174	77.4
Yes	2,989	48.1	1,217	22.6
Total	**6,220**	**100.0**	**5,391**	**100.0**

Note. Data on protected time for training was not available for 1,336 doctors who provided training.

The majority of doctors who reported training other doctors as a formal part of their role were Hospital Consultants (*n* = 4,007, 57.9%), followed by General Practitioners (*n* = 918, 13.3%) (Table 9). The majority of doctors providing training that reported it was not a formal part of their role were NCHDs, either on a formal training scheme (*n* = 1,870, 31.0%) or not on a formal training scheme (*n* = 1,856, 30.8%).

Table 9. Self-Reported Role of Doctors who Provided Training

	Providing Training is Formal Part of Role			
	Yes		No	
Self-Reported Role	**n**	**%**	**n**	**%**
Non-consultant hospital doctor, on a formal training scheme	902	13.0	1,870	31.0
Non-consultant hospital doctor, not on a formal training scheme	684	9.9	1,856	30.8
Hospital Consultant	4,007	57.9	956	15.9
Other Consultant or Specialist	315	4.6	149	2.5
General Practitioner	918	13.3	1,004	16.7
Community Health Doctor	15	0.2	76	1.3
In-house doctor/ Medical officer	12	0.2	46	0.8
Industry, e.g., Pharmaceuticals	6	0.1	4	0.1
Others	58	0.8	69	1.1
Total	**6,917**	**100.0**	**6,030**	**100.0**

(d) Working Hours

In relation to average hours worked per week, doctors were asked to select which option best described their current practice of medicine. Answers are shown by Division in Table 10. A total of 4,733 doctors from those who responded to the question (23.1%) reported working more than 48 hours on average per week, in contravention of the European Working Time Directive (EWTD). This reflects a decrease from 26.6% in 2023 and 28.6% in 2022.

As can be observed when Divisions are compared, more doctors appear to be overworking (41 hours on average per week or more) in the Trainee Specialist and Supervised Divisions than in the General and Specialist Divisions. For example, 37.1% (*n* = 1,401) of Trainee Specialists worked more than 48 hours on average per week, compared to 18.3% (*n* = 1,885) of those on the Specialist Division.

Table 10. Doctors' Average Weekly Working Hours by Division

		Count and % Within Division				Total
Weekly hours		Trainee Specialist	Supervised	General	Specialist	
< 10hs	n	14	0	172	382	568
	%	0.4	0.0	2.7	3.7	2.8
10 to 20hs	n	24	0	242	702	968
	%	0.6	0.0	3.8	6.8	4.7
21 to 30hs	n	42	0	346	1,069	1,457
	%	1.1	0.0	5.5	10.4	7.1
31 to 40hs	n	662	43	2,138	3,502	6,345
	%	17.5	31.6	34.0	34.0	31.0
41 to 48hs	n	1,632	61	1,976	2,747	6,416
	%	43.2	44.9	31.4	26.7	31.3
> 48hs	n	1,401	32	1,415	1,885	4,733
	%	37.1	23.5	22.5	18.3	23.1
Total	**n**	**3,775**	**136**	**6,289**	**10,287**	**20,487**
	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Note. Data on weekly hours was not available for 475 doctors.

While the proportion of doctors on the Trainee Specialist Division working in excess of 48 hours per week remains high it is encouraging to note that this reflects a decrease from 45.5% in 2023 and 50.1% in 2022. The proportion of doctors on the General Division working in excess of 48 hours (26.7% in 2023, 28.4% in 2022) and Specialist Division working in excess of 48 hours (20.5% in 2023 and 22.0% in 2022) also decreased. The proportion of doctors on the Supervised Division has decreased in relation to 2023 and was slightly higher than the 2022 proportion (27.9% in 2023, 22.4% in 2022).

Doctors were also asked, on an average week, the average number of hours they spent in direct patient care. From those who responded (584 doctors did not answer) 18.3% (*n* = 3,726) reported working directly in patient care 41 to 48 hours a week, while 10.7% (*n* = 2,187) worked more than 48 hours weekly in direct patient care. When average weekly hours were cross tabulated with hours spent in direct patient care, it was found that 45.6% (*n* = 2,147) of doctors working more than 48 hours on average per week were spending more than 48 hours in direct patient care. Therefore, this particular cohort reported not only working excessive hours, but also intensely working with patients in their care.

Further information on this group of doctors is presented in Table 11. Half of these doctors (*n* = 1,078, 50.2%) were in the youngest age group of 34 and younger, and just over 60% (*n* = 1,347, 62.7%) were male. The vast majority were registered either on the General Division (*n* = 864, 40.2%) or the Trainee Specialist Division (*n* = 810, 37.7%). Over half of doctors had an Irish BMQ (*n* = 1,191, 55.5%) and one third an international BMQ (*n* = 714, 33.3%). From that third of doctors with an international BMQ, almost 4 in 10 (*n* = 281, 39.4%) had obtained their qualifications in Pakistan, and a quarter had done so in Sudan (*n* = 177, 24.8%). The main specialties where doctors practised medicine were Anaesthesiology (*n* = 276, 12.9%) and General Surgery (*n* = 236, 11.0%).

Table 11. Doctors Working More Than 48hs a Week in Direct Patient Care

Doctors Working More Than 48Hs a Week in Direct Patient Care (n = 2,147)		
Age	**Mean**	**SD**
	38.2	10.4
Age group	**n**	**%**
34 and younger	1,078	50.2
35 to 44	569	26.5
45 to 54	268	12.5
55 and older	232	10.8
Gender	**n**	**%**
Male	1,347	62.7
Female	800	37.3
Division	**n**	**%**
Trainee Specialist	810	37.7
Supervised	22	1.0
General	864	40.2
Specialist	451	21.0
BMQ	**n**	**%**
Irish	1,191	55.5
EU or UK	242	11.3
International	714	33.3
Top 5 Countries of International Graduates	**n**	**%**
Pakistan	281	39.4
Sudan	177	24.8
South Africa	79	11.1
Egypt	33	4.6
India	28	3.9
Main Specialties Within Cohort	**n**	**%**
Anaesthesiology	276	12.9
General Surgery	236	11.0
General (Internal) Medicine	220	10.2
Trauma and Orthopaedic Surgery	177	8.2
Obstetrics and Gynaecology	159	7.4
General Practice	135	6.3
Paediatrics	113	5.3

Table 12 shows the percentage of doctors by medical discipline working more than 48 hours a week on average and spending more than 48 hours a week on average in direct patient care. The disciplines most likely to indicate working more than 48 hours a week were Surgery (*n* = 2,410, 50.9%) and Obstetrics and Gynaecology (*n* = 754, 34.9%). The same two disciplines also had the highest percentage of doctors working the most hours in direct patient care.

Table 12. Doctors' Medical Discipline by Average Weekly Working Hours and Hours in Direct Patient Care

	Average Weekly Working Hours*		Weekly Direct Patient Care**	
Medical Discipline	**n**	**% Working > 48hs**	**n**	**% Working > 48hs**
Anaesthesiology	1,366	31.7	1,364	20.7
Emergency Medicine	1,035	12.4	1,033	8.5
General Practice	5,181	10.7	5,165	2.7
Medicine	4,725	27.4	4,701	11.6
Obstetrics and Gynaecology	754	34.9	751	21.7
Occupational Medicine	155	2.6	153	0.7
Ophthalmology	165	12.7	164	8.5
Paediatrics	1,137	23.7	1,128	10.1
Pathology	662	21.6	654	6.1
Psychiatry	1,592	10.3	1,577	2.1
Public Health Medicine	273	4.8	270	0.0
Radiology	684	27.0	680	8.5
Sports and Exercise Medicine	27	7.4	27	0.0
Surgery	2,410	50.9	2,394	29.0

**Note.* Data was not available for 796 doctors.
***Note.* Data was not available for 901 doctors.
Columns are shaded with gradations: the darker the tone, the higher the value within the column.

(e) Difficulties to Providing Sufficient Patient Care

Doctors were asked how frequently, if at all, they have found it difficult to provide a patient with the sufficient level of care needed over the last 12 months (Table 13). From the doctors who answered this question, one third (*n* = 6,797, 33.6%) said never, while almost 1 in 10 (*n* = 1,853, 9.2%) reported experiencing difficulties at least once a day, and 16.9% (*n* = 3,429) at least once a week.

Table 13. How Frequently You find It Difficult to Provide a Patient with Sufficient Care?

Difficulties providing care	n	%
At least once a day	1,853	9.2
At least once a week	3,429	16.9
At least once a month	1,652	8.2
Occasionally	6,515	32.2
Never	6,797	33.6
Total	**20,246**	**100.0**

Note. 716 doctors did not provide information on this question.

This means that slightly more than a quarter of doctors (26.1%) experienced barriers at least once a week, or more. Table 14 offers more detailed information on this cohort. From this group of 5,282 doctors, 31.4% (*n* = 1,660) were in the 35 to 44 age group and over half (*n* = 2,782, 52.7%) were female. The majority were registered on the Specialist Division (*n* = 3,196, 60.5%), had an Irish BMQ (*n* = 4,270, 80.8%), and worked in General Practice (*n* = 1,637, 31.0%).

Table 14. Doctors Experiencing Difficulties to Providing Sufficient Care at Least on a Weekly Basis

Doctors Reporting Barriers to Providing Patient Care at Least Once a Week (n = 5,282)		
Age	**Mean**	**SD**
	42.5	10.8
Age group	**n**	**%**
34 and younger	1,541	29.2
35 to 44	1,660	31.4
45 to 54	1,209	22.9
55 and older	872	16.5
Gender	**n**	**%**
Male	2,500	47.3
Female	2,782	52.7
Division	**n**	**%**
Trainee Specialist	1,250	23.7
Supervised	4	0.1
General	832	15.8
Specialist	3,196	60.5
BMQ	**n**	**%**
Irish	4,270	80.8
EU or UK	517	9.8
International	495	9.4
Top 3 Countries of International Graduates	**n**	**%**
South Africa	135	27.3
Pakistan	110	22.2
Sudan	83	16.8
Main Specialties Within Cohort	**n**	**%**
General Practice	1,637	31.0
Psychiatry	421	8.0
General (Internal) Medicine	349	6.6
Emergency Medicine	343	6.5
Paediatrics	264	5.0

Doctors were asked to consider what would be the main barriers, if any, to providing good patient care that they have observed or experienced in the last year. There were 14 different barriers, covering issues related to work pressure, healthcare quality, support, training, supervision, and communication. Doctors could select any of the options, or as many as they considered necessary, or none.

Table 15 shows the results from this question and are based on the 18,861 doctors who selected at least one barrier (90.0% of the total of 20,962 clinically active doctors in Ireland). The barrier that was selected most by doctors (73.0%) was “pressure on workloads”, representing 19.2% of all total responses. The second and third most selected barriers were “time spent on bureaucracy/administration” (55.1% of doctors chose this option) and “delays to providing care, treatment and screening” (46.1% of doctors chose this option).

Table 15. Barriers to Good Patient Care

Barriers to Good Patient Care*	% of Doctors**	Responses	
		n	%
Pressure on workloads	73.0	13,769	19.2
Time spent on bureaucracy/administration	55.1	10,400	14.5
Delays to providing care, treatment and screening	46.1	8,694	12.1
Lack of access to necessary equipment or services	37.7	7,115	9.9
Rota gaps	32.3	6,099	8.5
Inadequate access to specialist opinion	29.6	5,578	7.8
Lack of appropriately qualified staff	26.4	4,988	6.9
Inadequate communication between healthcare professionals	25.6	4,836	6.7
Unsafe systems	20.3	3,838	5.3
Insufficient support from senior colleagues, peers and non-clinical management	11.7	2,214	3.1
Inadequate communication with patients	7.1	1,337	1.9
Inadequate training or preparation	6.3	1,187	1.7
Providing patient care remotely	4.8	900	1.3
Insufficient supervision carrying out tasks	4.4	825	1.1
Total* **		**71,780**	**100.0**

**Note*. 2,101 did not answer this question.

***Note*. The "% of doctors" column represents the proportion of doctors selecting each barrier as part of their answer.

****Note*. The Total at the bottom of the "Responses" column is a sum all responses. This number surpasses the total number of doctors answering the question because each doctor may have selected multiple barriers.

Furthermore, results were cross-tabulated with specialties (Table 16), to assess which areas of practice had the highest percentages of doctors choosing from the different barriers (as some doctors did not provide information on specialty the number of responses analysed is slightly lower than in Table 15).

As can be observed from Table 16, the specialty of General Practice had the highest percentage of doctors reporting on 10 of the 14 barriers, with the exception of General (Internal) Medicine, on 3 barriers, and Psychiatry on 1. Of note, the highest percentage across the table can be observed for the item "Inadequate access to specialist opinion", where 56.8% of those working in General Practice consider it a barrier. The data also reveals that the difference between the first and second highest proportion of doctors choosing barriers in many specialties tended to be at least 10%.

Table 16. Barriers to Good Patient Care and Specialties

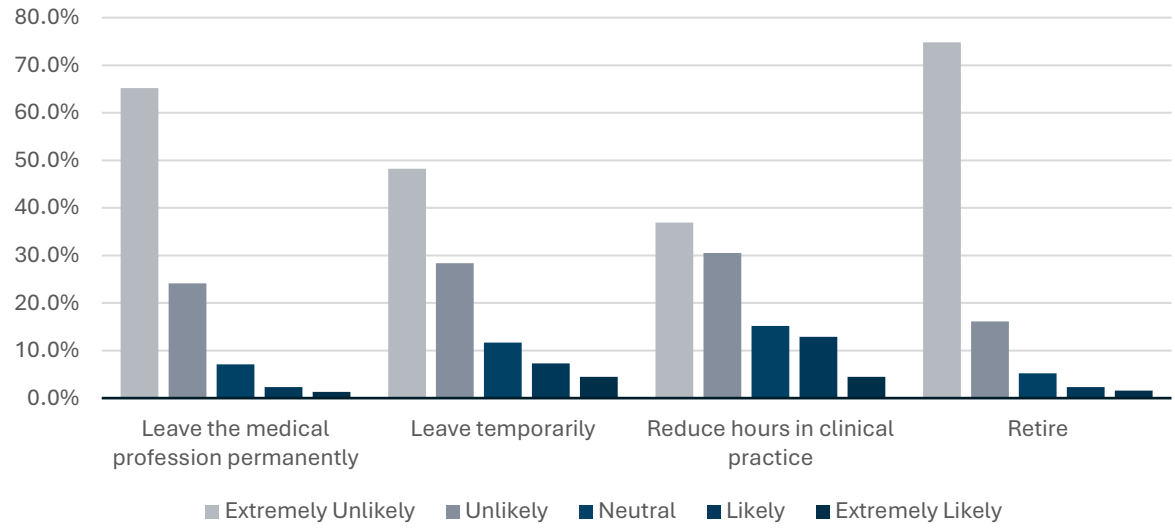
Barriers to Good Patient Care (n = 18,612)*				
	Specialty with highest %		Specialty with second highest %	
	Specialty	%**	Specialty	%
Pressure on workloads	*General Practice*	26.2	*General (Internal) Medicine*	9.7
Time spent on bureaucracy/administration	*General Practice*	30.9	*Psychiatry*	9.4
Delays to providing care, treatment and screening	*General Practice*	27.8	*General (Internal) Medicine*	8.1
Rota gaps	*General Practice*	14.8	*General (Internal) Medicine*	12.4
Lack of access to necessary equipment or services	*General Practice*	26.6	*Psychiatry*	8.0
Lack of appropriately qualified staff	*Psychiatry*	13.5	*General Practice*	12.3
Providing patient care remotely	*General Practice*	31.7	*Psychiatry*	7.3
Inadequate communication between healthcare professionals	*General Practice*	37.9	*Anaesthesiology*	7.6
Inadequate communication with patients	*General Practice*	21.5	*General (Internal) Medicine*	10.0
Insufficient supervision carrying out tasks	*General (Internal) Medicine*	19.5	*Emergency Medicine*	10.4
Inadequate training or preparation	*General (Internal) Medicine*	17.4	*General Practice*	10.8
Insufficient support from senior colleagues, peers and non-clinical management	*General (Internal) Medicine*	13.8	*General Practice*	12.1
Unsafe systems	*General Practice*	17.1	*General (Internal) Medicine*	9.1
Inadequate access to specialist opinion	*General Practice*	56.8	*General (Internal) Medicine*	7.5

**Note*. 2,350 doctors did not provide information to at least one of the questions (barriers or specialty).
**Column is shaded with gradations: the darker the tone, the higher the value within the column.

(f) Career Changes

Doctors were asked how likely they were to make a number of career changes in the next year, namely: leaving the medical profession permanently, leaving temporarily, reducing hours in clinical practice, and retiring. Figure 6 below shows that the vast majority of doctors were extremely unlikely or unlikely to make any of the mentioned career changes. However, 12.9% and 4.5% of doctors were likely or extremely likely to reduce hours in clinical practice, making this the most likely career change among doctors.

Figure 6. Career Changes



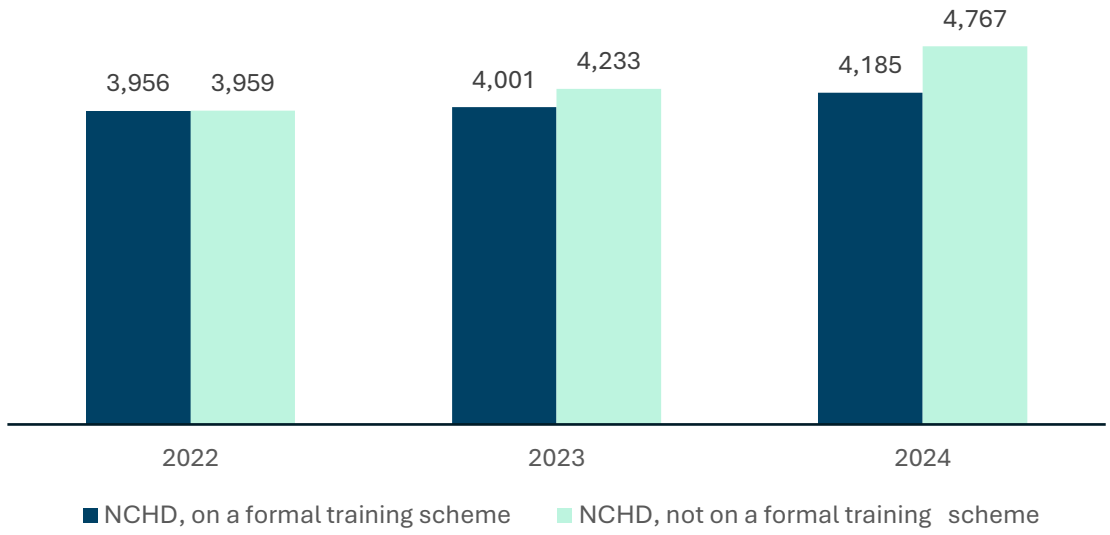
NCHDs

In 2024, there were 8,952 NCHDs in the medical workforce. This group is divided here by training status: those who were on a formal training scheme, and those who were not. Over half of the NCHDs were not on a formal training scheme (*n* = 4,767, 53.3%). This represents an increase of 12.6% of the 2023 figure of 4,233. Furthermore, and as can be observed in Table 17 and Figure 7, the difference in the number of NCHDs on a formal training scheme and not on a formal training scheme grew in the last 3 years, reaching a 13.9% difference in 2024.

Table 17. NCHDs Figures in the Last Three Years

	Year				
Role	**2022**	**2023**	**% increase from previous year**	**2024**	**% increase from previous year**
NCHDs, on a formal training scheme	3,956	4,001	1.1	4,185	4.6
NCHDs, not on a formal training scheme	3,959	4,233	6.9	4,767	12.6
% difference between in training and not in training	0.1	5.8		13.9	

Figure 7. Differences in Numbers of NCHDs 2022-2024



Note. The categories were updated in the 2024 ARAF from 'NCHD, in training' and 'NCHD, not in training' to 'NCHD, on a formal training scheme' and 'NCHD, not on a formal training scheme' respectively (see Appendix).

Table 18 offers a comparison of NCHDs on a formal training scheme and not on a formal training scheme, in relation to demographic characteristics and other work-related aspects. NCHDs on a formal training scheme were younger (mean age 33.1, SD = 4.6) than those not on a formal training scheme (mean age 37.2, SD = 8.9). This was also reflected in the proportion of doctors aged 34 or younger, which was 68.8% in the training group, and 48.3% in the not training group. There was a female majority in the group in training (*n* = 2,317, 55.4%), and the opposite was true in the group not in training, with 58.8% males (*n* = 2,803).

In terms of BMQ, 73.0% (*n* = 3,057) of NCHDs on a formal training scheme had obtained their qualifications in Ireland, whereas in the case of NCHDs not on a formal training scheme, two thirds (*n* = 3,174, 66.6%) had international qualifications from outside of Ireland, the EU and UK.

When considering the country of qualification of international graduates from outside of Ireland, the EU and UK, the top three countries are the same, regardless of the training status. The difference, however, is that the proportion of NCHDs with qualifications from Pakistan is greater in the group not on a formal training scheme (*n* = 1,455, 45.9%) than in the group on a formal training scheme (36.9%, *n* = 264).

NCHDs on a formal training scheme had a higher proportion of doctors working more than 48 hours on an average week than NCHDs not on a formal training scheme, and the same is observed for weekly hours spent in direct patient care.

Table 18. NCHDs on a Formal Training Scheme and Not on a Formal Training Scheme

NCHDs (n = 8,952)	Training		Not Training	
Age	**Mean**	**SD**	**Mean**	**SD**
	33.1	4.6	37.2	8.9
Age group	**n**	**%**	**n**	**%**
34 and younger	2,878	68.8	2,303	48.3
35 to 44	1,206	28.8	1,643	34.5
45 to 54	90	2.2	525	11.0
55 and older	11	0.3	296	6.2
Gender	**n**	**%**	**n**	**%**
Male	1,868	44.6	2,803	58.8
Female	2,317	55.4	1,964	41.2
Division	**n**	**%**	**n**	**%**
Trainee Specialist	3,254	77.8	463	9.7
Supervised	113	2.7	29	0.6
General	593	14.2	4,099	86.0
Specialist	225	5.4	176	3.7
BMQ	**n**	**%**	**n**	**%**
Irish	3,057	73.0	951	19.9
EU or UK	412	9.8	642	13.5
International	716	17.1	3,174	66.6
Top 3 Countries of International Graduates	**n**	**%**	**n**	**%**
Pakistan	264	36.9	1,455	45.9
Sudan	194	27.1	827	26.1
South Africa	69	9.6	244	7.7
Working More Than 48hs on an Average Week	**n**	**%**	**n**	**%**
	1,573	38.2	1,235	26.5
Spent More Than 48hs on Direct Patient Care Weekly	**n**	**%**	**n**	**%**
	924	22.5	809	17.4

General Practitioners

This section focuses on General Practitioners (GPs) which were categorised as the cohort of doctors reporting working in the area of General Practice *and* reporting their role as General Practitioner. This encompasses two mandatory questions on the ARAF.[1] This cohort comprised of 4,764 doctors and a description of this cohort is offered in Table 19. The mean age of GPs was 49.2 (SD = 11.7) and 31.1% (*n* = 1,483) were 55 years of age or older, bringing them closer to the typical retirement age. The gender split overall was balanced, with slightly more females (52.4%) than males (47.6%). Almost 80% (78.8%, *n* = 3,753) were registered on the Specialist Division, however,1 in 5 were on the General Division (*n* = 955, 20.0%). There were 3,389 (71.1%) GPs who

[1] Some doctors working in the area of General Practice are excluded from this section if they did not select General Practitioner as their self-reported role. Some doctors, depending on their level of training and current practice, may have self-selected a different role such as 'NCHD, on a formal training scheme', 'Community Health Doctor' or 'Others'.

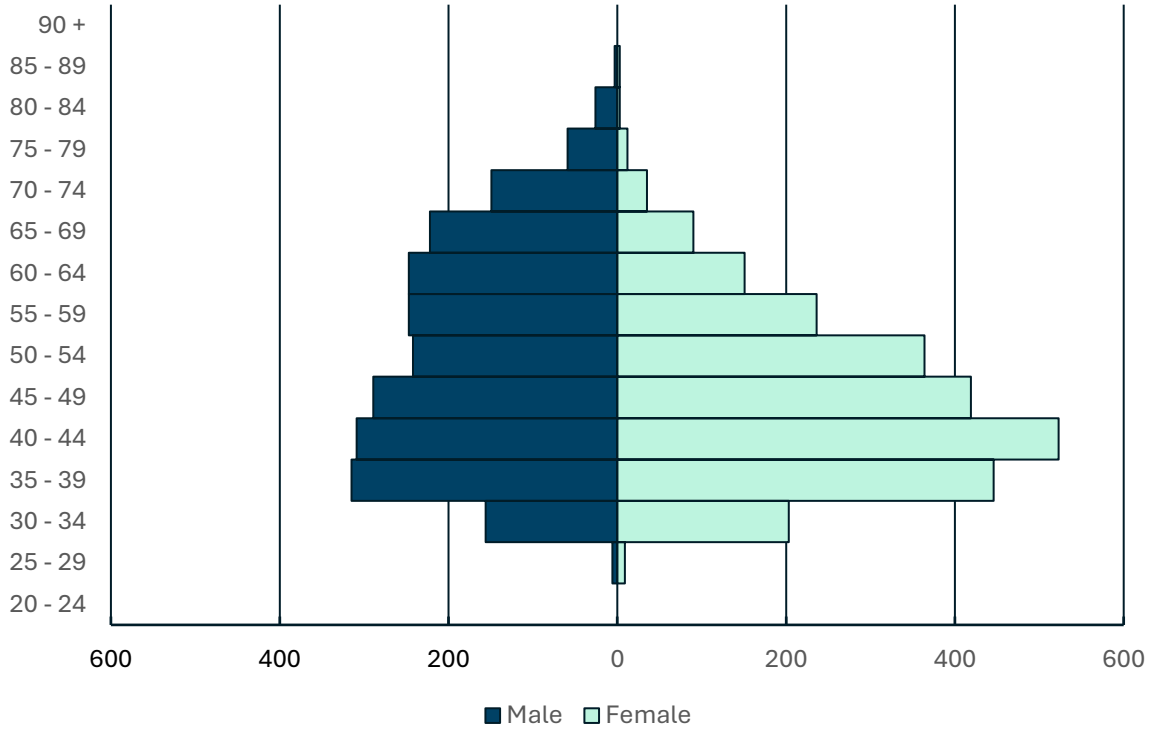
obtained their BMQ in Ireland. Among those with an International BMQ (*n* = 635, 13.3%), slightly over a quarter had graduated in South Africa (*n* = 168, 26.5%) and another quarter in Pakistan (*n* = 162, 25.6%). From all GPs, the proportion reporting working more than 48 hours on average week was 10.9% (*n* = 504), and the proportion of GPs spending more than 48 hours in direct patient care was 2.5% (*n* = 114).

Table 19. GP Demographic Details

GPs (n = 4,764)		
Age	**Mean**	**SD**
	49.2	11.7
Age group	**n**	**%**
34 and younger	374	7.9
35 to 44	1,593	33.4
45 to 54	1,314	27.6
55 and older	1,483	31.1
Gender	**n**	**%**
Male	2,270	47.6
Female	2,494	52.4
Division	**n**	**%**
Trainee Specialist	56	1.2
Supervised	0	0.0
General	955	20.0
Specialist	3,753	78.8
BMQ	**n**	**%**
Irish	3,389	71.1
EU or UK	740	15.5
International	635	13.3
Top 3 Countries of International Graduates	**n**	**%**
South Africa	168	26.5
Pakistan	162	25.6
Sudan	70	11.0
Working More Than 48hs on an Average Week	**n**	**%**
	504	10.9
Spent More Than 48hs on Direct Patient Care Weekly	**n**	**%**
	114	2.5

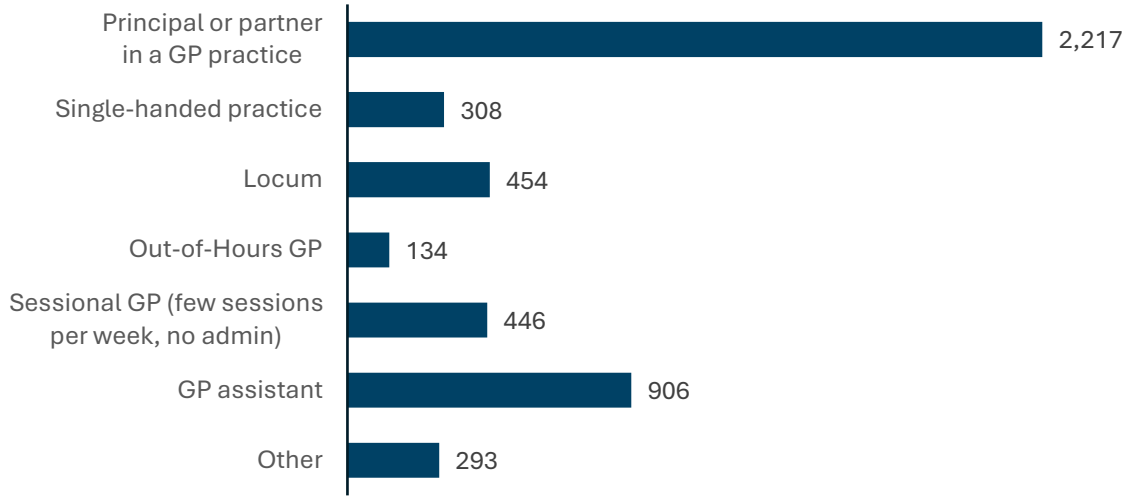
A detailed breakdown of gender by age is illustrated in the population pyramid from Figure 8. The bulk of the female portion of GPs concentrates between the ages 30 and 59, and older age brackets from there and above are dominated by males. Thus, this suggests that as older male doctors retire, the proportion of females will continue to grow.

Figure 8. GPs Population Pyramid



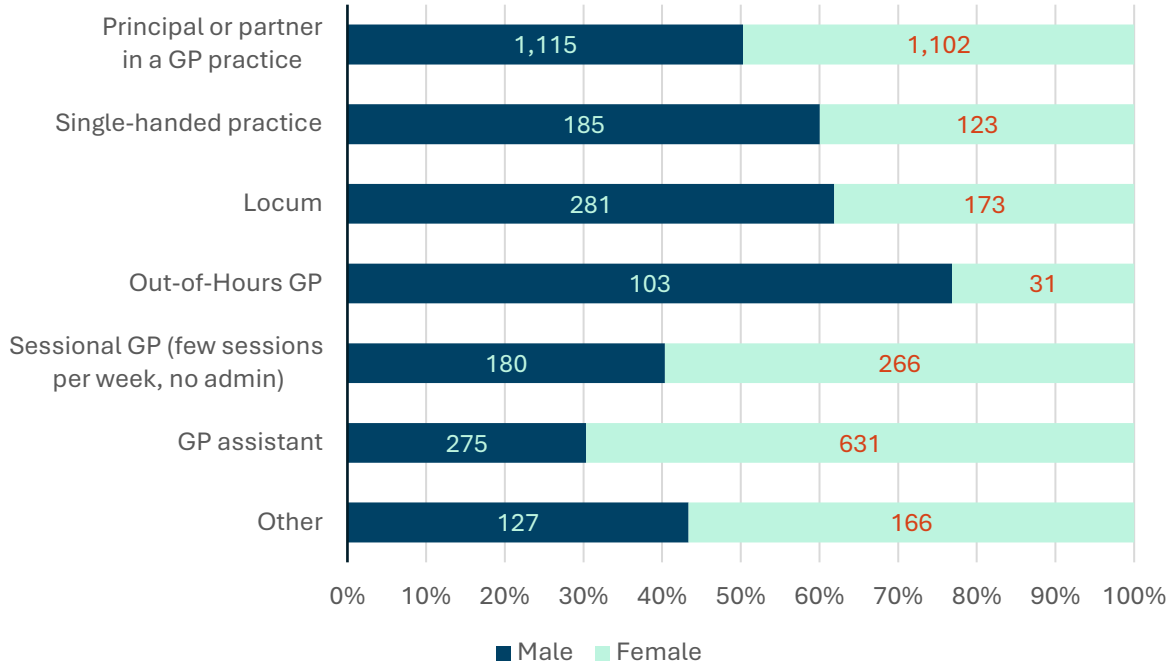
The breakdown of the different GP categories is shown in Figure 9, and a further breakdown of GP categories by gender is shown in Figure 10. The gender breakdown of principal or partners in a GP practice was evenly split, while most out-of-hours GPs were male (*n* = 103, 76.9%), as well as the majority of single-handed practice (*n* = 185, 60.1%) and locums (*n* = 281, 61.9%). On the contrary, the majority of sessional GPs (*n* = 266, 59.6%) and GP assistants (*n* = 631, 69.6%) were female.

Figure 9. GP Categories



Note. Data on GP category were not available for 6 doctors.

Figure 10. GP Categories by Gender



Note. Data on GP category were not available for 6 doctors.

Almost one third (31.9%, *n* = 1,518) of all GPs practised in county Dublin, followed by county Cork with 12.5% (*n* = 597) (Table 20).

Table 20. GPs by County

County	n	%	County	n	%
Dublin	1,518	31.9	Westmeath	109	2.3
Cork	597	12.5	Clare	99	2.1
Galway	273	5.7	Carlow	96	2.0
Limerick	234	4.9	Kilkenny	77	1.6
Kildare	173	3.6	Offaly	75	1.6
Kerry	154	3.2	Sligo	72	1.5
Donegal	149	3.1	Laois	67	1.4
Wicklow	136	2.9	Cavan	57	1.2
Waterford	132	2.8	Roscommon	45	0.9
Meath	128	2.7	Longford	42	0.9
Tipperary	125	2.6	Monaghan	38	0.8
Wexford	118	2.5	Leitrim	24	0.5
Louth	113	2.4	**Total**	**4,761**	**100.0**
Mayo	110	2.3			

Note. Data were not available for 3 doctors.

Table 21 shows the different categories of hours worked on an average week by the categories of average weekly hours spent in direct patient care. Closer inspection of the group of doctors working more than 48 hours a week (*n* = 501) reveals that over half of them (51.3%) spent 40 hours or less on average in direct patient care. This means that this cohort of doctors could be spending at least 8 hours per week on average in administrative work or other non-core tasks.

Table 21. GPs' Average Weekly Hours by Hours Spent in Direct Patient Care

Average Weekly Hours in Direct Patient Care		Average Weekly hours						
		< 10hs	10 to 20hs	21 to 30hs	31 to 40hs	41 to 48hs	> 48hs	Total
< 10hs	n	227	47	18	11	3	0	**306**
	%	95.4	10.3	2.3	0.6	0.3	0.0	**6.7**
10 to 20hs	n	9	403	206	48	8	3	**677**
	%	3.8	88.2	25.9	2.8	0.9	0.6	**14.8**
21 to 30hs	n	1	3	556	634	170	74	**1,438**
	%	0.4	0.7	69.9	36.6	19.6	14.8	**31.3**
31 to 40hs	n	1	3	15	1,026	449	180	**1,674**
	%	0.4	0.7	1.9	59.2	51.8	35.9	**36.5**
41 to 48hs	n	0	1	0	13	234	132	**380**
	%	0.0	0.2	0.0	0.8	27.0	26.3	**8.3**
> 48hs	n	0	0	0	0	2	112	**114**
	%	0.0	0.0	0.0	0.0	0.2	22.4	**2.5**
Total	**n**	**238**	**457**	**795**	**1,732**	**866**	**501**	**4,589**
	%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Note. 175 doctors did not provide information on at least one of these questions and are excluded from this table.

Medicine

The cohort of doctors working in the Discipline of Medicine (which comprises 22 different specialties) is analysed here. This group consisted of 4,820 doctors, which is described as a whole in Table 22. Of note, the largest proportion of doctors in this cohort were registered on the General Division (*n* = 1,878, 39.0%) followed by the Specialist Division (*n* = 1,712, 35.5%).

Table 22. Doctors in the Medicine Discipline

Doctors Working in the Medicine Discipline (n = 4,820)		
Age	**Mean**	**SD**
	39.9	11.0
Age group	**n**	**%**
34 and younger	2,004	41.6
35 to 44	1,413	29.3
45 to 54	774	16.1
55 and older	629	13.0
Gender	**n**	**%**
Male	2,595	53.8
Female	2,225	46.2
Division	**n**	**%**
Trainee Specialist	1,184	24.6
Supervised	46	1.0
General	1,878	39.0
Specialist	1,712	35.5
BMQ	**n**	**%**
Irish	2,751	57.1
EU or UK	555	11.5
International	1,514	31.4
Top 5 Countries of International Graduates	**n**	**%**
Pakistan	689	45.5
Sudan	435	28.8
South Africa	65	4.3
India	46	3.0
Egypt	33	2.2

Table 23 describes doctors by Medicine specialty, who were registered on the Specialist Division. The Medicine specialty with the highest percentage of females was Palliative Medicine, with 78.8%, and the one with the lowest percentage was Cardiology, with 17.5%. In terms of doctors aged 55 and above, the specialty of Clinical Neurophysiology had slightly over two thirds (68.8%) of doctors in this age bracket and therefore close to retirement. Clinical Pharmacology and Therapeutics, and Geriatric Medicine were the specialties with the highest proportion of doctors with an Irish BMQ (90.0% and 88.6% respectively), in contrast to doctors in the specialty of General (Internal) Medicine, with only 42.9% of Irish BMQ. In relation to the proportion of doctors working more than 48 hours in an average week, the highest percentage was seen among the specialty of Medical Oncology (42.1%), followed by Cardiology (36.6%).

Table 23. Doctors Working in the Medicine Discipline, Registered in the Specialist Division

Specialty Within Medicine* (n = 1,708)	Total	% Female	% 55 and older	% Irish BMQ	% Working More than 48hs**
Cardiology	206	17.5	32.0	66.0	36.6
Clinical Genetics	11	63.6	63.6	63.6	20.0
Clinical Neurophysiology	16	37.5	68.8	87.5	12.5
Clinical Pharmacology and Therapeutics	10	40.0	60.0	90.0	22.2
Dermatology	114	76.3	27.2	82.5	9.8
Endocrinology and Diabetes Mellitus	112	44.6	29.5	76.8	24.1
Gastroenterology	164	31.7	29.9	72.0	21.7
General (Internal) Medicine	156	33.3	45.5	42.9	10.5
Genito-Urinary Medicine	13	69.2	46.2	76.9	0.0
Geriatric Medicine	176	52.3	24.4	88.6	25.9
Infectious Diseases	56	58.9	14.3	78.6	16.1
Intensive Care Medicine	63	44.4	14.3	79.4	30.6
Medical Oncology	95	51.6	22.1	80.0	42.1
Nephrology	74	43.2	27.0	82.4	34.2
Neurology	91	39.6	25.3	71.4	24.7
Palliative Medicine	80	78.8	21.3	85.0	23.8
Pharmaceutical Medicine	9	44.4	44.4	66.7	11.1
Rehabilitation Medicine	20	60.0	30.0	80.0	15.0
Respiratory Medicine	150	30.0	27.3	76.0	30.4
Rheumatology	92	45.7	30.4	75.0	12.0

**Note.* Military medicine and Tropical medicine have been excluded due to counts lower than 5.
***Note*. 27 doctors in the Medicine specialty did not provide information on working hours.
Columns are shaded with gradations: the darker the tone, the higher the value within the column.

Surgery

Doctors working within the Discipline of Surgery, comprising 11 specialties, are analysed in this section. The group working within this discipline consisted of 2,461 doctors, described in Table 24. The majority of these doctors were registered on the Specialist Division (*n* = 1,051, 42.7%), although a sizable proportion were registered on the General Division (*n* = 956, 38.8%).

Table 24. Doctors in the Surgery Discipline

Doctors Working in the Surgery Discipline (n = 2,461)		
Age	**Mean**	**SD**
	42.8	11.8
Age group	**n**	**%**
34 and younger	785	31.9
35 to 44	672	27.3
45 to 54	520	21.1
55 and older	484	19.7
Gender	**n**	**%**
Male	1,885	76.6
Female	576	23.4
Division	**n**	**%**
Trainee Specialist	414	16.8
Supervised	40	1.6
General	956	38.8
Specialist	1,051	42.7
BMQ	**n**	**%**
Irish	1,216	49.4
EU or UK	343	13.9
International	902	36.7
Top 5 Countries of International Graduates	**n**	**%**
Pakistan	381	42.3
Sudan	230	25.5
Egypt	60	6.7
India	45	5.0
South Africa	36	4.0

Table 25 describes doctors by Surgery specialty, who were registered on the Specialist Division. The surgical specialty with the highest proportion of females was Ophthalmic surgery, with 33.6%, whereas there were only 4.8% females working in the Oral and Maxillo-Facial surgery specialty. Oral and Maxillo-Facial surgery and Paediatric surgery were the two specialties with the highest proportion of doctors aged 55 years and older (both 57.1%). Oral and Maxillo-Facial surgery was also the specialty with the highest percentage of doctors with an Irish BMQ (90.5%). In terms of percentage of doctors working more than 48 hours in an average week, 58.3% of surgeons in Cardiothoracic Surgery and 57.6% of Neurosurgeons fell into this category.

Table 25. Doctors Working in the Surgery Discipline, Registered in the Specialist Division

Specialty Within Surgery (n = 1,051)	Total	% Female	% 55 and older	% Irish BMQ	% Working More than 48hs*
Cardiothoracic Surgery	38	15.8	42.1	52.6	58.3
General Surgery	265	18.9	40.0	54.3	45.9
Neurosurgery	33	9.1	39.4	51.5	57.6
Ophthalmic Surgery	107	33.6	33.6	76.6	16.0
Oral and Maxillo-Facial Surgery	21	4.8	57.1	90.5	42.9
Otolaryngology	95	27.4	40.0	66.3	35.8
Paediatric Surgery	14	14.3	57.1	50.0	42.9
Plastic, Reconstructive and Aesthetic Surgery	85	29.4	32.9	68.2	31.8
Trauma and Orthopaedic Surgery	245	6.9	35.9	66.5	40.0
Urology	102	14.7	35.3	64.7	34.0
Vascular Surgery	46	23.9	26.1	58.7	47.7

**Note*. 20 doctors in the Surgery specialty did not provide information on working hours.
Columns are shaded with gradations: the darker the tone, the higher the value within the column.

Conclusion

Analysis of our workforce data provides a comprehensive understanding of Ireland's medical workforce. These data are crucial to informing recruitment and retention strategies, medical education and training development and health policy in Ireland.

Data in this report identify the rapid expansion of NCHDs, who are a valuable part of our medical workforce and whose wellbeing and retention is crucial to our health service. The working and training experiences of NCHDs on clinical sites needs to be prioritised and improved. The report by the National Taskforce on the NCHD Workforce observed that the rapid expansion of the NCHD workforce to meet health service delivery requirements has contributed to an already urgent need to increase and enhance supports and services for NCHDs (DOH, 2024). In 2025, the Medical Council will undertake a national survey of doctors on the General Division including NCHDs. This research will help identify patient safety risks and improve how we manage and support doctors to uphold the highest standards of patient care.

Many of the large number of internationally trained doctors from outside the EU and UK, who make up over one-quarter of the clinically active workforce in Ireland, are from countries which are themselves facing a shortage of doctors. Ireland, as a signatory to the WHO Global Code of Practice on the International Recruitment of Health Personnel, is required to apply ethical principles for international recruitment in a manner that will help to strengthen health systems of developing countries. There are ethical and global challenges associated with doctor migration and the Irish health service must focus on strengthening self-sufficiency and developing its domestic workforce.

Ireland is internationally recognised for its excellence in medical training, however retaining doctors who have trained in Ireland is challenging, and as the data in this report indicate, high proportions of doctors are working long hours that contravene the EWTD, which can lead to stress, burnout and absenteeism, and increased risk to patient safety. The NDTP's recent NCHD National Survey 2024 points to the complex and stressful daily work of an NCHD and difficulties experienced accessing basic working standards (NDTP, 2025). This is mirrored in the accompanying survey and qualitative feedback on doctors withdrawing from the Register who cite lack of training and career progression, long working hours and poor working conditions as reasons for leaving the Register.

Our data shows a higher proportion of female GPs, many of whom are concentrated in sessional and assistant roles. Doctors withdrawing from the Register often point to family and personal reasons that are not compatible with excessive working hours. These findings suggest the need for the development of support structures for flexible training schemes including Less Than Full Time (LTFT) training to balance doctors' work and personal lives. Potential benefits can include reduced stress, burnout and improved patient safety (Macqueen et al., 2019; Tomlinson et al., 2012). Recent research into LTFT in an Irish context suggests it is a viable strategy to reduce burn-out and attrition, and improve the training experience, without major reported adverse effects on service provision (Matthews et al., 2025). However, successful implementation requires

adequate planning and supports, as well as attitudinal change, and should be considered as part of our overall medical workforce strategy. Developing flexible training and practice options are essential as Ireland's increasing population demands an increase in GP numbers, as well as overall doctor numbers.

The Medical Council will continue to enhance and invest in our data quality and analytics capabilities, ensuring timeliness and consistency in developing and disseminating our workforce data. We are keen to support stakeholders across the HSE, the Department of Health, and training bodies with high-quality data to support development of strategic workforce planning initiatives at national and regional levels. A collaborative data-driven approach is key to support effective planning for a strong and sustainable medical workforce that can provide safe, high quality sustainable patient care into the future.

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Appendices

Appendix A – Changes to Existing Questions in ARAF 2024

A number of changes were made to existing questions on the ARAF in 2024, which should be considered when interpretating data in comparison to previous years. A summary of the key changes are summarised below.

Clinically Active Doctors

The question used to determine if doctors were clinically active was updated from "Have you practised medicine in the last 12 months" to **"Are you currently practising medicine?".** The response options were yes or no. This was to ensure more timely data capture of practising status. The follow up question remained the same and was "If yes, where do you practise?" With the response options of Within the Republic of Ireland only, Both within and outside the Republic of Ireland and Outside the Republic of Ireland only. Doctors selecting Republic or Ireland only or both within and outside the Republic of Ireland were used to determine clinically active doctors working in Ireland.

Doctors Area of Practice

Doctors are asked to provide their current or most recent area of practise by answering the following question:
"Which single category BEST describes your current or most recent practice of medicine (pick only one – if you are registered with a specialty interest but NOT working in that area, pick the one area which best describes your current practice)"

This question is used by the registration department at the Medical Council to verify that doctors are meeting their professional indemnity requirements. A proportion of doctors work in specific practice areas that are more limited in scope than the full specialty and as such have lower indemnity requirements. In 2024 the question remained the same and doctors were presented with the list of recognised specialties. However, for verification purposes, four new options which were more limited in terms of their scope of practice were added. A minority of doctors fall into these categories and differences in sample size are noted throughout the report. These were:

- Aesthetics only: I confirm I am engaged in non-surgical aesthetics/cosmetics practice.
- Urgent Care only: I confirm I am not carrying out surgeries and I am engaged in the primary care and treatment of patients presenting with minor injuries, but I am referring non-minor or complex cases to hospitals for treatment.
- Medicolegal only: I confirm my practice arrangements under medicolegal is non-clinical and there is no patient engagement.
- Gynaecology only: I confirm my practice includes gynaecology exams and/or fertility treatments. My practice does not include obstetrics, surgery or deliveries.

Doctors Current Role

All clinically active doctors are asked about their current role:
"Which single category describes your current role?"

This question remained the same in 2024 but there was a slight change in response options. 'Non-consultant hospital doctor, in training'/ 'Non-consultant hospital doctor, not in training' were updated to 'Non-consultant hospital doctor, on a formal training scheme'/ 'Non-consultant hospital doctor, not on a formal training scheme'. Two new options were added which were 'Industry e.g., Pharmaceuticals' and 'In-house doctor/ Medical officer' and two older categories 'Healthcare related management' and 'Public Health Doctor' were removed. The final response options are included below:

- Non-consultant hospital doctor, on a formal training scheme
- Non-consultant hospital doctor, not on a formal training scheme
- Hospital Consultant
- Other Consultant or Specialist
- General Practitioner
- Community Health Doctor
- Industry e.g., Pharmaceuticals
- In-house doctor/ Medical officer
- Others

Appendix B – New Questions for Clinically Active Doctors in Ireland ARAF 2024

For doctors reporting that they were clinically active in Ireland (all or some of the time) new questions on hours spent in direct patient care, protected time for training, frequency of issues providing a safe level of care, barriers to providing sufficient care and career intentions were added as optional questions.

Direct Patient Care

Question:
On an average week, please estimate the average number of hours spent in direct patient care:
Response Options:
Fewer than 10 hours per week; 10 to 20 hours per week; 21 to 30 hours per week; 31 to 40 hours per week; 41 to 48 hours per week; More than 48 hours per week.

Protected Time for Training

This was a follow up to existing question for doctors selecting "Yes" to the question "In your current role, do you train other doctors?".
Question:
If providing training, formally or informally, have you protected time for training?
Response Options:
Yes; No

Sufficient Level of Care

Question:
How frequently, if at all, over the last 12 months have you found it difficult to provide a patient with the sufficient level of care they need?
Response Options:
At least once a day; At least once a week; At least once a month; Occasionally; Never

Barriers

Question:
What would you consider to be the main barriers, if any, to providing good patient care that you have observed or experienced over the last year? (tick all that apply)
Response Options:

- ☐ Pressure on workloads
- ☐ Time spent on bureaucracy/administration
- ☐ Delays to providing care, treatment and screening
- ☐ Rota gaps
- ☐ Lack of access to necessary equipment or services
- ☐ Lack of appropriately qualified staff
- ☐ Providing patient care remotely
- ☐ Inadequate communication between healthcare professionals
- ☐ Inadequate communication with patients

- Insufficient supervision carrying out tasks
- Inadequate training or preparation
- Insufficient support from senior colleagues, peers and non-clinical management
- Unsafe systems
- Inadequate access to specialist opinion

Career Changes

Question:
How likely are you to make any of the following career changes in the next year?

- Leave the medical profession permanently
- Leave temporarily e.g., sabbatical, maternity or carer leave
- Reduce hours in clinical practice
- Retire

Response Options
Each statement was followed by a Likert scale response options of Extremely Unlikely; Unlikely; Neutral; Likely; Extremely likely.

Appendix C – New Questions for Clinically Active Doctors Abroad ARAF 2024

For doctors reporting that they were clinically active abroad (all or some of the time) a new question on where they were practising was added.

Country of Practice

Question:
If you practise outside the Republic of Ireland (all or some of the time), please provide the country outside or Ireland that you practise in:
Response Options:
Dropdown list of all possible countries.

Appendix D - Abbreviations

ARAF	Annual Retention Application Form
BMQ	Basic Medical Qualification
DOH	Department of Health
EEA	European Economic Area
EU	European Union
EWTD	European Working Time Directive
GP	General Practitioner
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
LTFT	Less than Full Time
NCHD	Non-Consultant Hospital Doctor
NDTP	National Doctors Training and Planning
PGTB	Post Graduate Training Body
SD	Standard Deviation
UK	United Kingdom

Appendix E - Glossary

B

Basic Medical Qualification: This determines a doctors eligibility to join the Register of Medical Practitioners in Ireland. This takes into account a doctors primary medical degree country and also their internship or equivalent experience. Doctors fall into one of five categories when they are initially approved on the Register. Category 1 doctors are graduates of Irish Medical Schools. For the purposes of this report these doctors have completed their primary medical degree in an Irish medical school and completed a recognised internship in Ireland. When discussing Irish Qualified doctors throughout the report this is cohort being referring to. Category 2 doctors are EU citizens who have graduated in an EU medical school and/or have their qualifications recognised under EU Directives. Prior to Brexit all doctors with a primary medical degree or internship equivalent experience from the United Kingdom would have been categorised as Category 2 doctors. Since Brexit a new category, Category 4 (UK) exists and doctors that have obtained their primary medical degree or internship/equivalent experience from the United Kingdom fall into this category. Category 3 doctors are non-EU citizens who graduated from an EU medical school and/or their qualifications would be recognised under EU Directives if EU citizens. For the purpose of our report these three groups (Category 2, Category 3 and Category 4 UK) are categorised as graduates from the EU or UK. Category 4 doctors are international medical graduates who have graduated from a medical school outside Ireland, the EU or UK, and do not come under any of the previous categories. For the purposes of this report these doctors are categorised as International Graduates.

C

Clinically Active: All doctors who retain their place on the Register are asked if they are currently practising medicine. If a doctor selects 'yes' to this question they are defined as being clinically active.

Clinically Active Abroad: All doctors reporting to be clinically active, are asked where they are practising medicine. If they reported practising outside the Republic of Ireland only they are defined as being clinically active abroad.

Clinically Active in Ireland: All doctors reporting to be clinically active, are asked where they are practising medicine. If they reported practising in the Republic of Ireland only, or both within and outside the Republic of Ireland they are defined as being clinically active in Ireland.

D

Division: Division of the Register that a doctor is registered on depending on their experience and training. A doctor can be registered on one of six divisions (Intern, Supervised, Trainee Specialist, General, Specialist, or Visiting EEA Practitioners Registration). This is not static, doctors may transfer between divisions. For example, a doctor will need to transfer from Intern to the General Division if they wish to continue practising after successful completion of training.

Doctors Retaining: All doctors who choose to renew their registration. Doctors retain their registration by completing the annual retention process and paying the required fee.

G

General Registration: Doctors may practise independently, without supervision but may not represent themselves as specialists.

H

Hours in Direct Patient Care: This is based on a question asking doctor how many hours in an average week they spend in direct patient care. This is a follow up to total hours worked.

I

International Graduates/ International Basic Medical Qualification: Doctors with a basic medical qualification from outside of Ireland, the EU and UK. It should be noted that this classification of international BMQ differs from that used in previous reports, where international BMQ was simply *any* BMQ outside of Ireland. Adopting this new definition of international BMQ allows for a more focused analysis on a specific cohort of doctors who are more likely to have graduated in developing countries. This can provide valuable information given the commitments set in the WHO Global Code of Practice on the International Recruitment of Health Personnel.

Internship Registration: Allows a doctor to carry out internship training in a hospital recognised by the Medical Council. These posts are allocated by the HSE.

Irish Graduates: Doctors with a basic medical qualification from Ireland. These are graduates from Irish Medical Schools.

N

Not Practising: All doctors who retain their place on the Register are asked if they are currently practising medicine. If doctors selects 'no' to this question they are not clinically active and defined as not practising.

O

Offered Retention: All doctors who are active on the Register must have their registration renewed, on expiry of a Certificate of Registration, which will occur at least once every twelve months. Offered retention therefore covers all doctors active on the Register who are invited to retain their place on the register.

P

Portfolio Careers: This involves doctors adding some variation to their work schedule and may involve taking fewer clinical sessions and adding an aspect of teaching, research or leadership for example to the typical working week. This has been suggested as a positive or potential avenue enhance wellbeing among doctors and needs to be considered for workforce planning purposes.

Primary Medical Degree Country: This is the country where a doctor obtained their medical degree. In many cases it will overlap with their basic medical qualification, however some doctors may complete their degree in one country and then move for internship or equivalent experience.

Q

Qualification Categories: This refers to a doctors' basic medical qualification, and is grouped as doctors with an Irish qualification, doctors with a qualification from either the EU or UK, or doctors with a qualification from outside of Ireland, the EU or the UK.

R

The Register: The Register of Medical Practitioners is a valid and complete list of doctors who are permitted under Irish law to practise medicine in the State. The cornerstone of the Medical

Council's work in protecting the public is establishing and maintaining a Register of doctors. Under Irish law, no one can practise medicine in the Republic of Ireland unless they are registered as a doctor with the Medical Council.

S

Specialist Registration: Doctors may practise independently, without supervision and may represent themselves as specialists.

Supervised Registration: Doctors who have been offered a post that has been approved by the HSE, which has specific supervisory arrangements.

T

Trainee Specialist Registration: Doctors are on recognised training programmes and practise solely within the confines of posts allocated by the HSE in conjunction with the postgraduate training bodies (PGTBs).

V

Visiting EEA Practitioners Registration: Doctors are European Union citizens who are fully established to practise medicine in another European Union member state. These doctors may practise medicine in Ireland on a temporary basis without having to take out General or Specialist Registration.

W

Working Hours: Doctors were asked from a number of options which one best described their current practice of medicine.

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