



Comhairle na
nDochtúirí Leighis
Medical Council

Medical Workforce Intelligence Report 2025

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Foreword

The Medical Council is the statutory regulator of doctors in Ireland. Its primary responsibility, as set out in the Medical Practitioners Act 2007, is the protection of the public, and central to that function is the maintenance of the Register of Medical Practitioners, the definitive record of all doctors legally entitled to practise medicine in Ireland. This workforce intelligence report draws on data held within the Register to present key findings on the demographics and employment practices of the clinically active medical workforce in Ireland. Ireland faces sustained and growing pressure on that workforce, with increasing demand for services, rising dependence on internationally qualified doctors, and persistent concerns around working hours, burnout and retention. Understanding the composition, distribution and wellbeing of our doctor workforce is not a reporting function but a strategic necessity. This report provides the evidence base that enables policymakers, health service planners and regulatory stakeholders to make informed decisions on workforce supply, service capacity and health equity, and to act on both current gaps and future demand.

Data used in the analysis, to determine the clinically active medical workforce in the Republic of Ireland, is drawn from doctors' completion of the annual retention application form between May and August 2025. This is matched to demographic and divisional data from our data management system and extracted at the end of retention. In 2025, 75.6% of doctors who retained their place on the Register were clinically active and working in the Republic of Ireland, reflecting 22,257 doctors. While this is an increase from 20,962 during the same period in 2024, the proportion of those retaining who are clinically active in the Republic of Ireland has decreased from 78.8% in 2024.

This report continues our previous years' expansive workforce reporting including General Practitioner practice arrangements, doctors' views of barriers to patient safety, time spent working in direct patient care and doctors' future career plans. The proportion of clinically active doctors with an international basic medical qualification (from outside Ireland, the EU and the UK) was 29.5% in 2025 and continues to rise (27.8% in 2024 and 25.7% in 2023).

The proportion of doctors self-reporting that they are working in excess of 48 hours on average per week in 2025 was 22.1%. More doctors appear to have worked excessive hours on the Trainee Specialist Division than other divisions. Excessive work hours are demonstrably associated with attrition, stress, burnout and are predictive of adverse event involvement, which can undermine patient safety. It is of concern that when doctors were asked about the likelihood of making career changes in the next year, the most likely career change reported was the planned reduction of hours in clinical practice.

The data in this report provide important insight into the barriers experienced by doctors in providing sufficient patient care, and for the first time this is explored in relation to age, gender, category of qualification and division of the Register.

We continue to develop a clearer view of General Practice, recognising that as the cornerstone of the Irish health service, it is often the first point of contact for patients, providing comprehensive care and continuity of care. In 2025, there were 5,017 doctors categorised as General Practitioners. The majority of these were on the Specialist Division however almost one in five were on the General Division of the Register (19.3%).

In addition to this key workforce intelligence report, the accompanying supplementary report presents data on doctors who have retained registration but are not clinically active either in Ireland or abroad and those clinically active outside of Ireland only. In 2025, 5.8% of doctors retaining their place were not practising medicine and 18.6% were practising medicine solely outside the Republic of Ireland. This additional data is important to comprehensively understanding the nuanced composition of our Register and informing measures to address retention and recruitment, ensuring workforce capacity is growing to meet service demands.

Robust data analysis enables us to effectively understand and respond to medical workforce challenges and provides important insight into the wellbeing of our doctor workforce and patient safety concerns. This report, along with our suite of supplementary workforce reports, are intended to support relevant stakeholders in facilitating strategic medical workforce decision-making and broader workforce planning.

Background and Context

A number of key workforce issues have been highlighted in recent reports and in previous iterations of our workforce intelligence reports. These include continued reliance on doctors with international qualifications, many of whom are on the General Division of the Register and are concentrated in Model 2 and Model 3 hospitals (Hynes, & O'Connor, 2024; NDTP, 2025; OECD/European Commission, 2024). These settings are also more reliant on Non-Consultant Hospital Doctors (NCHDs) who are not on a formal training scheme, and our data point to a need for increased supports and training opportunities for these NCHDs (Department of Health, 2024). Evidence highlights consistently high workload intensity across the workforce, reflected in doctors' self-reported working hours.

Ways of working among General Practitioners (GPs) are evolving as an increasing number are reducing the number of clinical working sessions, developing portfolio careers and job crafting (Hanlon et al., 2026; Humphries et al., 2026; Egan et al., 2025; Stringer et al., 2025, 2023; Keenan et al., 2024). This is a means of addressing workload intensity, long working hours and increased administrative workload. A reduction in the number of clinical sessions undertaken by GPs would require a further increase in the number of GPs across the country. The changing GP workforce also entails increased participation of women in the GP workforce and a move from single-handed to group practice (Humphries et al., 2026). The GP workforce challenge 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 (Shea et al., 2024).

Changing demographics and ways of working for the wider medical workforce, demand for flexible work and training options must be recognised and understood in order to ensure retention, support wellbeing and inform policy. The changing workforce reinforces the importance of improved data collection on the medical workforce, and the data contained in this report can play a part in informing accurate planning to ensure a strong workforce into the future.

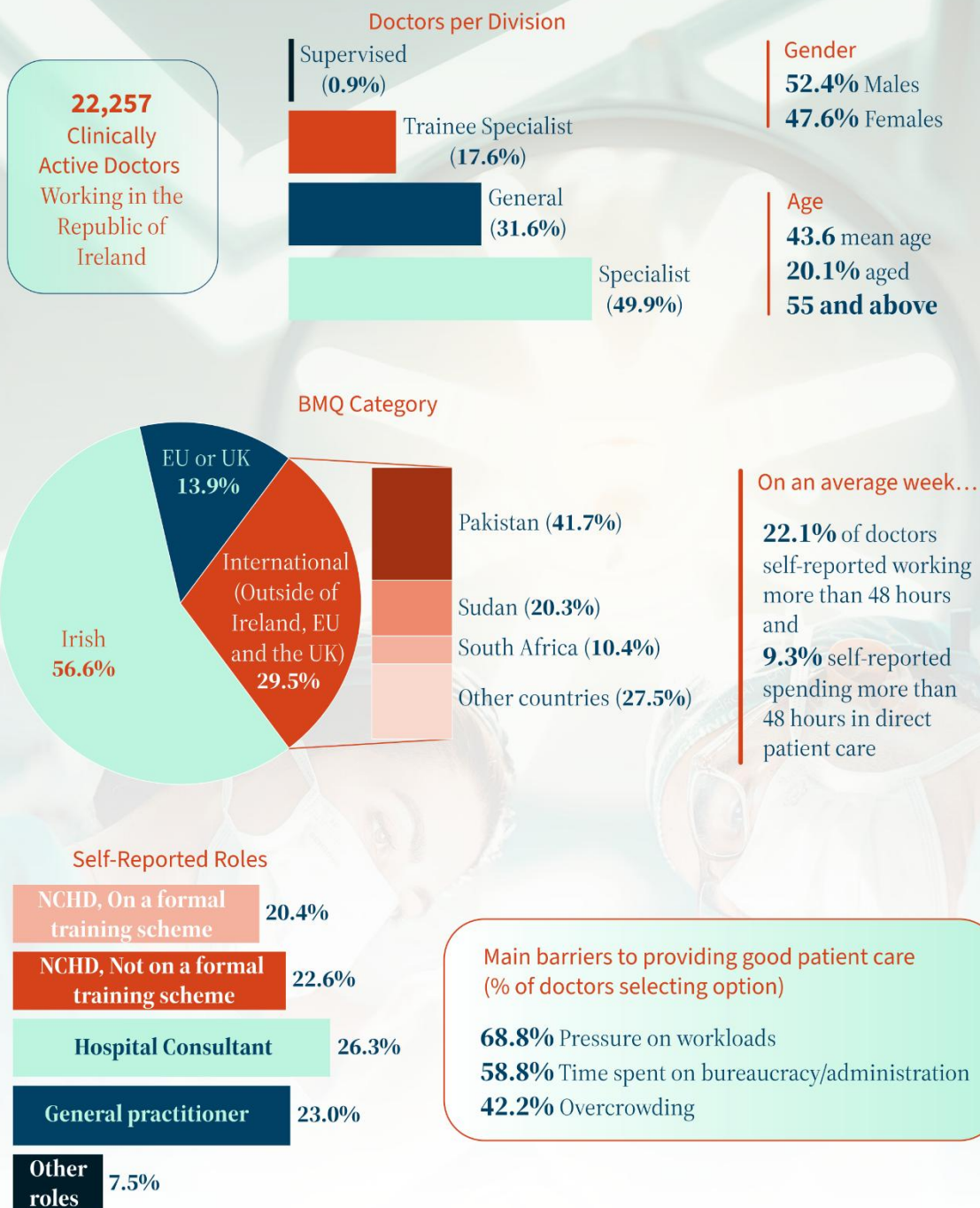
Our medical workforce is facing numerous immense and emerging challenges, including Ireland's population expansion, increasing health inequalities, social deprivation and demographic ageing. Epidemiological trends indicate rising multimorbidity, chronic disease, disability, and mental health need, increasing demand for integrated health and care services and community-based care. These challenges heighten the need to effectively implement Sláintecare 2025+ which aims to forge the way towards accessible, affordable, high-quality, healthcare for the people of Ireland when they need it, where they need it. Investing in a dynamic and agile workforce will help ensure we can meet the needs of a growing and aging population. Geographic distribution of the workforce across Ireland often indicates disparities, and can lead to challenges in attracting and retaining medical staff. Our workforce data can help identify supply needed across Ireland and identify regional and local level supply needs.

Ireland, along with the rest of Europe, is facing many novel security threats, which are having significant impact on our health systems. These include international security instability, global

foreign policy uncertainty, pressures on international energy supply, increasing cyber threats, risks related to infectious diseases and potential pandemics, and the impacts of climate change. These threats have affected European health systems, leaving the overall health and social care workforce insufficiently protected (Kuhlmann et al., 2026). Our medical workforce is already struggling with workforce shortages, recruitment and retention challenges, poor working conditions and burnout. Kuhlmann et al. (2026) recognise that security threats reinforce the need for a well prepared and protected medical workforce to ensure health system resilience and service provision. Ireland's workforce strategy should consider the capability to protect and retain our medical workforce, preparedness for cyberattacks, continuous climate change, and new infectious diseases.

The challenges facing our medical workforce are complex, and building capacity requires a long-term strategic evidence-based approach. The Medical Council is committed to improving the quality, consistency and timeliness of medical workforce data to facilitate informed and effective decision-making on key workforce issues now and into the future. Workforce planning should ensure all relevant stakeholders can contribute effectively to the planning process and engage in cross-sectoral cooperation and engagement. We are committed to collaboratively sharing workforce data with our stakeholders including the Strategic Workforce Planning Unit in the Department of Health (DOH), Health Service Executive (HSE), Forum of Irish Postgraduate Medical Training Bodies and Medical Schools, policymakers, educators, regulators and employers.

The Medical Council has engaged with the Department of Health in contributing to the recent report on workforce planning, *Ireland's Future Health and Social Care Workforce* (2025). This report along with the *Framework for Action On Health and Care Workforce in the WHO European Region 2023-2030* have shaped our understanding of and approach to workforce reporting. We are increasingly combining quantitative analyses of our workforce data with qualitative methods, and engaging with key stakeholders to understand how, as a regulator, we can support long-term sustainable workforce planning. Validating numerical trends with lived experience offers an in-depth multifaceted perspective of complex workforce systems.



Summary

This report presents data provided by doctors who completed the Medical Council's annual retention process in 2025. 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 an overview of hours spent working in direct patient care, patient safety barriers and future career plans. Our data describe a workforce that is nuanced, diverse and evolving.

In 2025, there were 22,257 clinically active doctors ('clinically active workforce') working in the Republic of Ireland. This represents 75.6% 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 2025 are particularly noteworthy:

- The proportion of clinically active female doctors was 47.6% and continues to show a slight but steady increase (47.2% in 2024, 47.0% in 2023 and 46.8% in 2022).
- The mean age of doctors was 43.6 years and approximately 1 in 5 (20.1%) were 55 and older, thus approaching the typical retirement age.
- Just under half of clinically active doctors (49.9%) were registered on the Specialist Division, while 31.6% were on the General Division.
- The most common country of qualification for international graduates was Pakistan, with 2,741 doctors (41.7% of the international graduate cohort). This was followed by Sudan, with 1,336 doctors (20.3% of the international graduate cohort) and South Africa with 686 doctors (10.4% of the international graduate cohort).

Key Observations

Working in Direct Patient Care

This workforce report presents data on key aspects of doctors' working hours. Over one-fifth of doctors (22.1%) self-reported working more than 48 hours on average per week, in contravention of the European Working Time Directive (EWTD). While this proportion is high, it represents a decrease from 23.1% reported in 2024. Self-reported working hours 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 ($n = 1,361$, 35.3%).

In addition to being asked to report their average working hours per week, doctors were asked how many hours they spent in direct patient care on an average week. In 2025, 9.3% ($n = 2,002$) reported working more than 48 hours directly in patient care, while a further 18.4% ($n = 3,949$) reported working 41 to 48 hours a week directly in patient care. It is noted that 41.5% ($n = 1,970$) of doctors working more than 48 hours on average per week were spending more than 48 hours in direct patient care. This represents a decrease from 2,147 doctors defined by the same criteria in 2024.

The highest percentage of doctors working more than 48 hours on an average week were in the disciplines of surgery (50.1%) and obstetrics and gynaecology (34.8%). This mirrored the percentage of doctors spending more than 48 hours on an average week in direct patient care.

Comparing hours worked in direct patient care to overall hours worked can potentially provide insight into time spent on administrative and non-core tasks. It raises concerns about doctor stress and burnout, patient safety and is associated with adverse event involvement.

Doctor Views of Patient Safety

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 over the last 12 months. From the doctors who answered this question, 27.6% ($n = 5,922$) of doctors experienced barriers at least once a week or more frequently (an increase from 26.1% in 2024). In terms of division, 60.5% ($n = 3,580$) were registered on the Specialist Division. The majority of doctors had an Irish qualification ($n = 4,639$, 78.3%). Only 11.2% ($n = 662$) had an international qualification from outside of Ireland, the EU or the UK. The majority worked in General Practice, followed by Psychiatry and Emergency Medicine.

Doctors were subsequently asked to identify the main barriers to patient care from a pre-defined list. The barrier most often selected was "pressure on workloads", representing 16.7% of total responses and being selected by 68.8% of doctors. In second place, "time spent on

bureaucracy/administration” was selected by 58.8% of doctors and in third place, “overcrowding” was chosen by 42.2% of doctors. Almost 30% of doctors selected two or three barriers ($n = 6,155$, 29.1%) in their answers, and 22.9% ($n = 4,855$) chose 4 or 5.

Regarding divisions across different barrier groups, doctors on the Trainee Specialist Division reported a higher number of barriers compared to other divisions. Interestingly, when age groups are compared across barrier categories it is clear that doctors aged 34 years and younger were more likely to report experiencing barriers, with the mean age of doctors decreasing as the number of barriers experienced increases. Almost 50% ($n = 254$, 49.1%) of those reporting 11 barriers or more were aged 34 and younger.

Exploring doctors’ views of barriers to patient safety provides an opportunity to develop a clear view of the type of doctor who is more likely to experience challenges to providing safe patient care. It helps identify and examine critical factors that can detract particular cohorts of doctors from providing and enabling safe patient care and that hinder good practice and effective team working in the clinical environment.

International Medical Graduates

Ireland’s dependency on international medical graduates (IMGs) is widely documented, having the fourth highest proportion of foreign educated doctors within OECD member states (Hynes & O’Connor, 2024). Our data indicate that the proportion of clinically active doctors with an international basic medical qualification (from outside Ireland, the EU and the UK) was 29.5% and continues to increase (27.8% in 2024, 25.7% in 2023 and 23.3% in 2022).

While the proportion of doctors with international qualifications continues to grow, the proportion of clinically active doctors with an Irish basic medical qualification continues to fall steadily (63% in 2022, 60.6% in 2023, 58.3% in 2024 and 56.6% in 2025). The proportion of doctors qualified in the EU or UK has remained stable around 14% in the timeframe 2022 to 2025.

There is stark variation in terms of division by qualification category with 71.4% ($n = 7,931$) of doctors on the Specialist Division having Irish qualifications and 59.2% ($n = 4,163$) of doctors on the General Division having international qualifications.

Research indicates that internationally trained doctors enter posts with the expectation of career progression or accessing specialist training. Many join the General Division of the Register, work as NCHDs and play a critical role in the safe and timely delivery of healthcare. Lack of progression opportunities, fear of deskilling, quality of training, excessive work hours and poor working conditions prompt many doctors to actively seek to migrate or return to their home country within a few years of arriving in Ireland. Our qualitative research on doctors who leave the Register points to the above issues and suggests that IMGs require appropriate education and training.

The Medical Council is currently undertaking research with doctors on the General Division, the majority of whom are IMGs, to comprehensively explore how, as a regulator, we can better support and manage these doctors. They represent a heterogeneous and diverse cohort and play a crucial role in the Irish healthcare service. The National Taskforce on the NCHD Workforce report (2024) recognises that newly arrived IMGs often do not receive specific induction and support. This is currently being addressed to ensure that IMGs new to the Irish health service receive enhanced and protected induction, bespoke to the Irish health service.

General Practice

General practice in Ireland is undergoing significant change, exemplified by the growing number of women in the GP workforce. This is reflected in our data, indicating that female doctors now constitute 52.8% of the total GP workforce of 5,017. The proportion of female doctors will most likely continue to increase as older male doctors retire. Therefore, exploring and understanding the female GP workforce and their career choices is crucial to planning a sustainable future medical workforce.

Our workforce data indicate that in 2025 the mean age of GPs was 49 and 29.7% ($n = 1,488$) were 55 years of age or older, bringing them closer to the typical retirement age and posing a challenge for the healthcare system.

It is noted that 19.3% of GPs were registered on the General Division. Research being undertaken by the Medical Council on the General Division in 2026 will pay particular attention to those 968 GPs to expand our knowledge of this cohort of doctors and understand how they can be better supported and managed.

Just over one in ten GPs reported working in excess of 48 hours on an average week, however only 1.7% spent more than 48 hours in direct patient care. This points to additional administrative work or other non-core tasks outside of clinical practice, as noted below. 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). Significant workload burden outside of the direct patient consultation 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 who reported experiencing barriers to providing sufficient patient care at least once a week (34.7%). The top barriers included “time spent on bureaucracy/administration”, “pressure on workloads” and “inadequate access to specialist opinion”.

Methods

Data Sources

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. The data analysed and presented in this report was obtained through the annual retention process doctors completed in 2025. The majority of 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 with the exception of interns, doctors finishing their posts on the supervised division and doctors with temporary EEA registration 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. In 2025, the question on barriers in providing patients with sufficient levels of care (introduced in 2024) was slightly modified. A new barrier was added "overcrowding" and a "no barriers" option was added, in order to better distinguish between doctors not answering the question, and those not selecting any barriers.

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. 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.

The division of the doctor reflects the division every doctor was on at the end of the retention period (August 2025). Doctors completed the ARAF between May and August 2025 and a small proportion of doctors may have been registered on a different division while completing their ARAF form.

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 2025, 29,428 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 they are defined as being clinically active, and a follow up question was asked about their place of practice. In 2025, 27,716 doctors self-reported currently practising medicine. Place of practice offered the following options:

- Within the Republic of Ireland only
- Outside the Republic of Ireland only
- Both within and outside the Republic of Ireland.

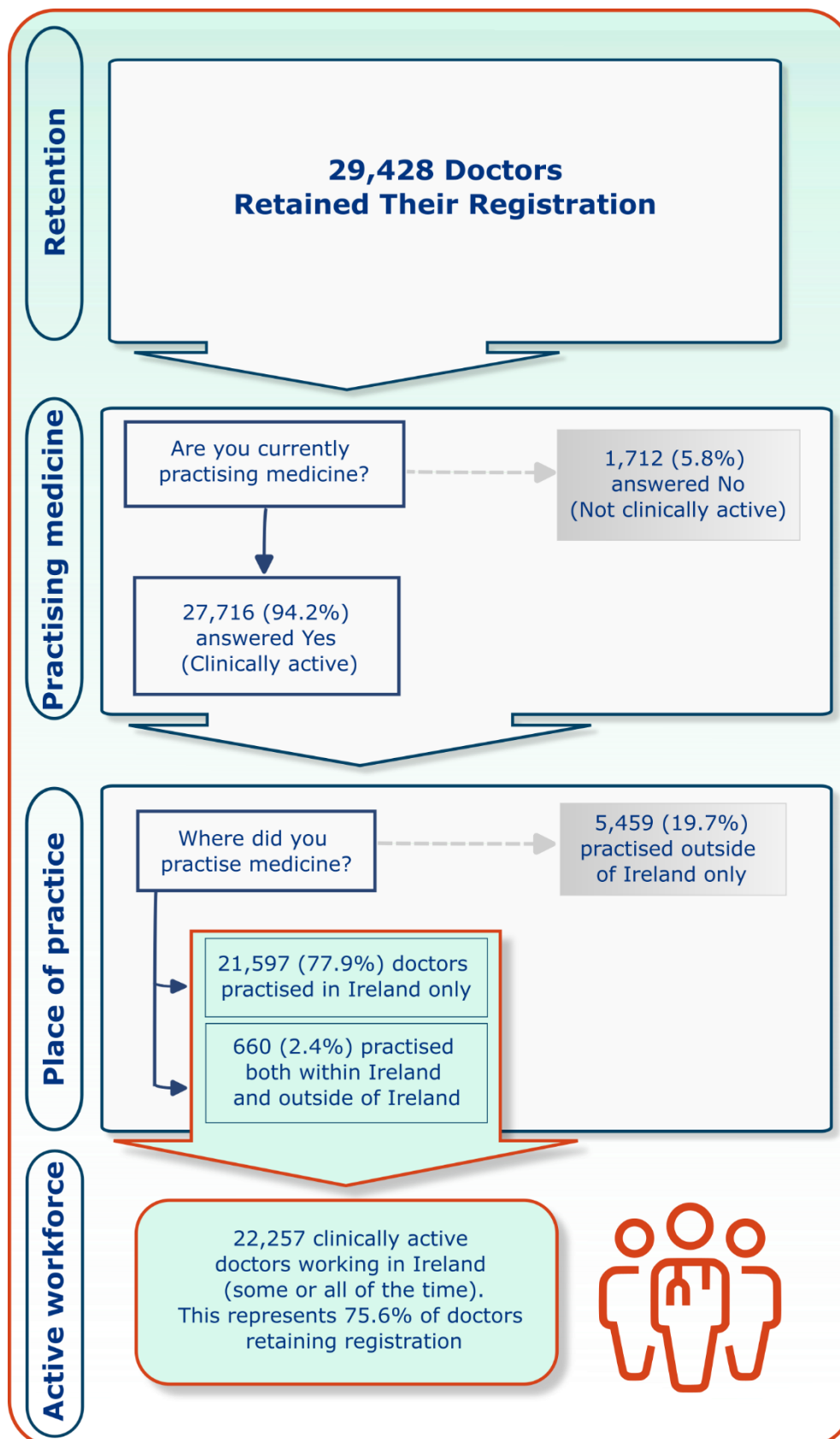
The clinically active workforce in Ireland consists of those **clinically active** doctors who work in the Republic of Ireland only (all of the time) and those working both within and outside the Republic of Ireland (some of the time).

In 2025, the clinically active medical workforce consisted of 22,257 doctors, which represents 75.6% 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 2025. 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.

This clinically active workforce can also vary between divisions. For example, overall there was 75.6% of doctors retaining and clinically active in the Republic of Ireland. However, when broken down by division over 95% of doctors on the Trainee Specialist Division (95.4%) and doctors on the Supervised Division (95.6%) self-report being clinically active in Ireland. A high proportion of doctors on the Specialist Division also report being clinically active in Ireland (84.5%), however only 58.7% of doctors on the General Division retaining their place on the Register are clinically active in Ireland (see Appendix A for more detail).

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 summarised in Table 1. The mean age of doctors clinically active in Ireland in 2025 was 43.6 years (SD = 11.9 years) and 1 in 5 doctors (20.1%) were 55 years or older, therefore approaching the typical retirement age. The proportion of females was 47.6% continuing the slight but steady increase observed in previous years (47.2% in 2024 and 47.0% in 2023). Figure 2 shows age groups by gender. The gender split was almost equal in all groups except for the oldest cohort, where almost two thirds of those doctors aged 55 and older were male ($n = 2,955$, 66.0%).

As in 2024 doctors were categorised as belonging to one of three groups based on their Basic Medical Qualification (BMQ). In 2025 a total of 12,599 (56.6%) doctors obtained their BMQ in Ireland, while 3,090 (13.9%) did so in the EU or UK, and the remainder ($n = 6,568$, 29.5%) qualified outside of Ireland, the EU or the UK and were categorised as International. From the latter international cohort, the top five countries of international graduates remained the same as in 2024 (see Table 1). In terms of division, 49.9% were registered on the Specialist Division.

Figure 2. Age Group by Gender

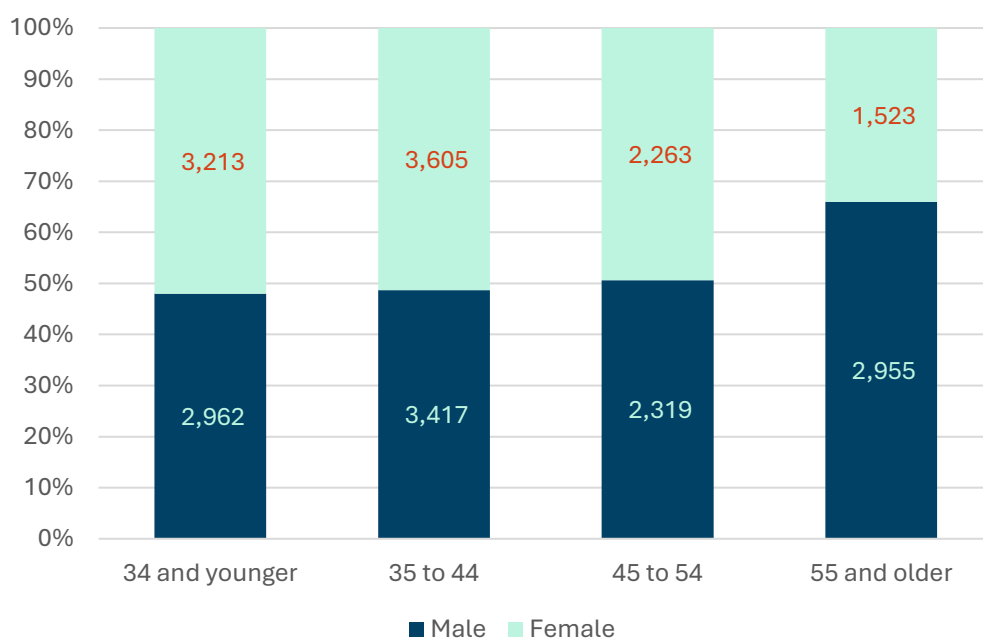


Table 1. Clinically Active Doctors in Ireland

Clinically Active Doctors (n = 22,257)		
Age	Mean	SD
	43.6	11.9
Age group	N	%
34 and younger	6,175	27.7
35 to 44	7,022	31.5
45 to 54	4,582	20.6
55 and older	4,478	20.1
Gender	n	%
Male	11,653	52.4
Female	10,604	47.6
Division	n	%
Trainee Specialist	3,923	17.6
Supervised	195	0.9
General	7,030	31.6
Specialist	11,109	49.9
BMQ	n	%
Irish	12,599	56.6
EU or UK	3,090	13.9
International	6,568	29.5
Top 5 Countries of International Graduates	n	%
Pakistan	2,741	41.7
Sudan	1,336	20.3
South Africa	686	10.4
India	314	4.8
Egypt	240	3.7

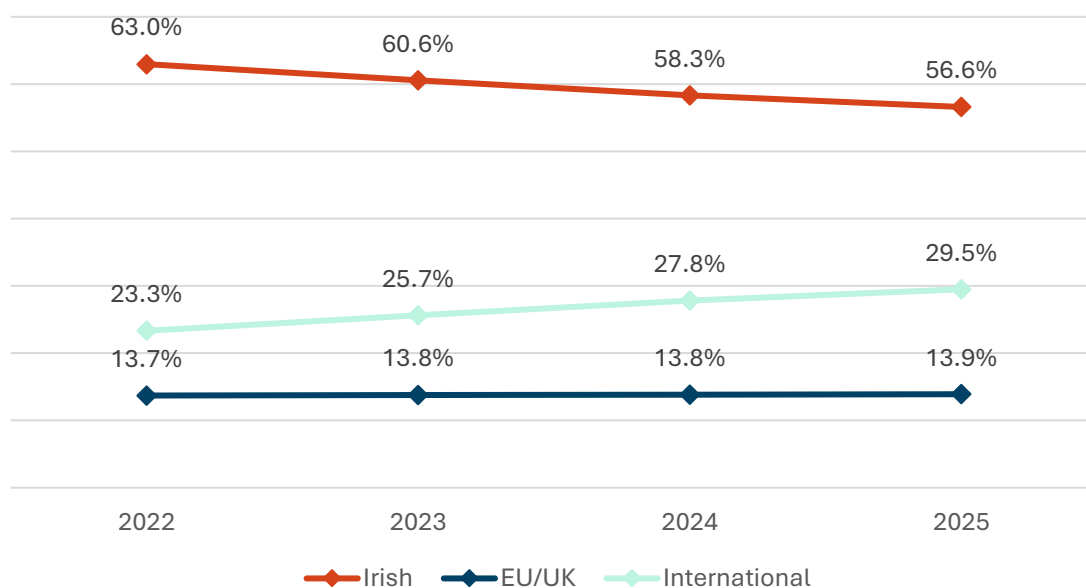
In terms of Division by qualification category (Irish, EU or UK, International), 71.4% ($n = 7,931$) of doctors on the Specialist Division and 67.8% ($n = 2,658$) of doctors on the Trainee Specialist Division had Irish Qualifications. Regarding the General Division 59.2% ($n = 4,163$) had international qualifications and a further 12.2% ($n = 857$) had qualifications from the EU or UK leaving only 28.6% ($n = 2,010$) with Irish Qualifications (Figure 3).

Figure 3. Division by Qualification Category



The proportion of different BMQ categories among doctors continue to illustrate similar trends observed in previous years. As illustrated in Figure 4, the proportion of clinically active doctors with an Irish BMQ continues to fall steadily, while the proportion of doctors with international qualifications continues to grow. The proportion of doctors with EU/UK qualification, on the other hand, has shown virtually no change in the depicted period from 2022 to 2025, remaining close to 14%.

Figure 4. Proportion of BMQ Categories 2022-2025



Employment and Practice

County of Practice

Table 2 shows clinically active doctors by county. The majority reported practising in County Dublin ($n = 9,474$, 42.6%), followed by County Cork ($n = 2,530$, 11.4%) and County Galway ($n = 1,667$, 7.5%).

Table 2. Doctors' County of Practice

County	n	%	County	n	%
Dublin	9,474	42.6	Wexford	363	1.6
Cork	2,530	11.4	Meath	320	1.4
Galway	1,667	7.5	Offaly	306	1.4
Limerick	1,291	5.8	Laois	296	1.3
Waterford	746	3.4	Cavan	280	1.3
Louth	606	2.7	Wicklow	196	0.9
Kerry	567	2.5	Clare	180	0.8
Donegal	554	2.5	Carlow	114	0.5
Sligo	503	2.3	Roscommon	100	0.4
Kildare	441	2.0	Monaghan	76	0.3
Mayo	430	1.9	Longford	48	0.2
Kilkenny	404	1.8	Leitrim	33	0.1
Westmeath	369	1.7			
Tipperary	363	1.6	Total	22,257	100.0

Medical Disciplines

Table 3 groups medical specialties, describing doctors' current or most recent practice of medicine by medical disciplines (total and Specialist Division only). A full disaggregated table with details on medical specialties is available in Appendix B. Note that a small percentage of doctors ($n = 293$, 1.3%) chose aesthetics, urgent care, medicolegal, or gynaecology only as an answer while completing their annual registration application form, and they are not included in these and other tables dealing with medical specialties.

The two most concentrated medical disciplines were General Practice ($n = 5,686$, 25.9%) and Medicine ($n = 5,014$, 22.8%). 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	1,547	7.0	798	7.2
Emergency Medicine	1,180	5.4	243	2.2
General Practice	5,686	25.9	4,117	37.3
Medicine	5,014	22.8	1,764	16.0
Obstetrics and Gynaecology	817	3.7	302	2.7
Occupational Medicine	175	0.8	115	1.0
Ophthalmology	172	0.8	98	0.9
Paediatrics	1,242	5.7	478	4.3
Pathology	737	3.4	469	4.2
Psychiatry	1,712	7.8	849	7.7
Public Health Medicine	293	1.3	183	1.7
Radiology	734	3.3	521	4.7
Sports and Exercise Medicine	33	0.2	27	0.2
Surgery	2,622	11.9	1,088	9.8
Total	21,964	100.0	11,052	100.0

Note. 293 doctors chose a limited scope of practice of aesthetics, urgent care, medicolegal, or gynaecology only and are not grouped under any discipline above.

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 78.2% and 70.0% respectively. The two disciplines with the lowest percentages of females were Sports and Exercise Medicine (18.2%) and Surgery (25.0%). In relation to doctors 55 years of age and older, Sports and Exercise Medicine had the greatest proportion (42.4%), followed by Occupational Medicine (35.4%). Public Health Medicine features also as the discipline with most doctors holding an Irish BMQ, with a striking 91.8%. In contrast, only 31.4% of doctors working in Emergency Medicine had an Irish BMQ.

Table 4. Doctors' Descriptives by Discipline

Medical Discipline	Total	% Female	% 55 and older	% Irish BMQ
Anaesthesiology	1,547	38.6%	20.2%	47.4%
Emergency Medicine	1,180	36.5%	8.4%	31.4%
General Practice	5,686	53.7%	27.3%	69.4%
Medicine	5,014	45.7%	13.0%	55.0%
Obstetrics and Gynaecology	817	70.0%	18.5%	42.5%
Occupational Medicine	175	59.4%	35.4%	70.3%
Ophthalmology	172	57.0%	32.6%	54.7%
Paediatrics	1,242	63.2%	16.4%	46.8%
Pathology	737	60.4%	21.8%	71.4%
Psychiatry	1,712	51.8%	22.1%	50.3%
Public Health Medicine	293	78.2%	33.4%	91.8%
Radiology	734	38.3%	22.2%	77.7%
Sports and Exercise Medicine	33	18.2%	42.4%	78.8%
Surgery	2,622	25.0%	19.5%	49.3%

Columns are shaded with gradations: the darker the tone, the higher the value within the column.

Note. 293 doctors chose a limited scope of practice of aesthetics, urgent care, medicolegal, or gynaecology only and are not grouped under any discipline above.

Self-Reported Role, Service Provision and Training

In regard to the categories best describing doctors' roles, just over a quarter of doctors reported working as hospital consultants ($n = 5,856$, 26.3%) followed by General Practitioners ($n = 5,128$, 23.0%) (Table 5).

Table 5. Doctors' Self-Reported Role

Self-reported Role	n	%
Non-consultant hospital doctor, on a formal training scheme	4,534	20.4
Non-consultant hospital doctor, not on a formal training scheme	5,034	22.6
Hospital Consultant	5,856	26.3
Other Consultant or Specialist	856	3.8
General Practitioner	5,128	23.0
Community Health Doctor	222	1.0
In-house doctor/ Medical officer	143	0.6
Industry, e.g., Pharmaceuticals	28	0.1
Others	456	2.0
Total	22,257	100.0

The proportions of doctors working on each of the different categories describing service provision arrangements are shown in Table 6. Over half of doctors provided publicly funded services only ($n = 11,243$, 52.2%), compared with only 7.8% ($n = 1,691$) who provided privately funded services only (Table 6).

Table 6. Service Provision Arrangements

Service Provision	n	%
Provision of publicly funded services only	11,243	52.2
Provision of privately funded services only	1,691	7.8
Provision of publicly and privately funded services	8,613	40.0
Total	21,547	100.0

Note. Data on 710 doctors (3.2%) was not available for this question.

One third of doctors ($n = 7,232$, 33.4%) reported that they trained other doctors as part of their role. Another 30.7% ($n = 6,645$) of doctors also reported training, although this was not a formal part of their role. Furthermore, doctors offering training were asked if they had protected time for it, and among those who provided training as a formal part of their role, more than half ($n = 3,353$, 51.8%) answered they did not (Table 8).

Table 7. Doctors Training Others

Do you train other doctors?	n	%
Yes, it's part of my role to train other doctors	7,232	33.4%
Yes, but it's not a formal part of my role to train other doctors	6,645	30.7%
No, I do not train other doctors	7,776	35.9%
Total	21,653	100.0%

Note. Data on 604 doctors (2.7%) was not available for this question.

Table 8. Doctors Training Duties and Protected Time

Doctors Training Other Doctors ($n = 12,391$)				
	Part of doctor's role		Not a formal part of doctor's role	
Protected time for training doctors	n	%	n	%
No	3,353	51.8%	4,482	75.7%
Yes	3,114	48.2%	1,442	24.3%
Total	6,467	100.0%	5,924	100.0%

Note. Data on protected time for training was not available for 1,486 doctors who trained others.

Table 9 offers additional information on doctors providing training (whether this was a formal part of their role or not) in relation to their role. The majority of doctors who reported training other doctors as a formal part of their role were hospital consultants ($n = 4,194$, 58.0%). Conversely, among doctors providing training not as a formal part of their role, the majority were NCHDs, either on a formal training scheme ($n = 1,990$, 29.0%) or not on a formal training scheme ($n = 2,074$, 31.2%).

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

Self-Reported Role	Providing Training is Formal Part of Role			
	Yes		No	
	n	%	n	%
Non-consultant hospital doctor, on a formal training scheme	944	13.1%	1,990	29.9%
Non-consultant hospital doctor, not on a formal training scheme	719	9.9%	2,074	31.2%
Hospital Consultant	4,194	58.0%	1,075	16.2%
Other Consultant or Specialist	312	4.3%	178	2.7%
General practitioner	972	13.4%	1,130	17.0%
Community Health Doctor	11	0.2%	65	1.0%
In-house doctor/ Medical officer	15	0.2%	41	0.6%
Industry, e.g., Pharmaceuticals	4	0.1%	7	0.1%
Others	61	0.8%	85	1.3%
Total	7,232	100.0%	6,645	100.0%

Self-Reported Working Hours

Doctors were asked to report which option best described their current practice of medicine in relation to hours worked on an average week. A total of 4,776 doctors (22.1%) reported working more than 48 hours on average per week, in contravention of the European Working Time Directive (EWTD). This represents a decrease from 23.1% reported in 2024.

Information on working hours is compared by division in Table 10. More doctors appear to have worked excessive hours (48 hours on average per week or more) in the Trainee Specialist Division than the other divisions. For example, 35.3% ($n = 1,361$) of Trainee Specialists worked more than 48 hours on average per week, compared to 17.5% ($n = 1,882$) of those on the Specialist Division.

Table 10. Doctors' Average Weekly Working Hours by Division

Weekly Hours		Trainee	Supervised	General	Specialist	Total
		Specialist				
<10hs	n	28	0	155	390	573
	%	0.7%	0.0%	2.3%	3.6%	2.7%
10 to 20hs	n	29	0	268	727	1,024
	%	0.8%	0.0%	3.9%	6.8%	4.7%
21 to 30hs	n	44	0	390	1,122	1,556
	%	1.1%	0.0%	5.7%	10.4%	7.2%
31 to 40hs	n	751	76	2,245	3,625	6,697
	%	19.5%	48.1%	32.8%	33.7%	31.0%
41 to 48hs	n	1,643	58	2,284	2,996	6,981
	%	42.6%	36.7%	33.3%	27.9%	32.3%
> 48hs	n	1,361	24	1,509	1,882	4,776
	%	35.3%	15.2%	22.0%	17.5%	22.1%
Total	n	3,856	158	6,851	10,742	21,607
	%	100.0%	100.0%	100.0%	100.0%	100.0%

Note. Data on 650 doctors (2.9%) was not available for this question.

As a follow-on question, doctors were asked the average number of hours they spent in direct patient care on an average week. From those who responded (753 doctors did not answer) 9.3% ($n = 2,002$) of doctors reported working more than 48 hours directly in patient care while 18.4% ($n = 3,949$) reported working directly in patient care 41 to 48 hours a week (Table 11).

When divisions are considered, 18.1% ($n = 695$) of doctors on the Trainee Specialist Division spent 48 hours or more on an average week in direct patient care, compared with 13.1% ($n = 896$) on the General Division and 3.7% ($n = 394$) on the Specialist Division.

Table 11. Doctors' Average Weekly Direct Patient Care Hours by Division

Direct patient care hours		Trainee Specialist	Supervised	General	Specialist	Total
<10hs	n	161	0	342	901	1,404
	%	4.2%	0.0%	5.0%	8.4%	6.5%
10 to 20hs	n	210	12	509	1,500	2,231
	%	5.5%	7.6%	7.5%	14.0%	10.4%
21 to 30hs	n	455	17	883	3,229	4,584
	%	11.8%	10.8%	13.0%	30.2%	21.3%
31 to 40hs	n	1,169	78	2,429	3,658	7,334
	%	30.4%	49.7%	35.6%	34.2%	34.1%
41 to 48hs	n	1,157	33	1,759	1,000	3,949
	%	30.1%	21.0%	25.8%	9.4%	18.4%
> 48hs	n	695	17	896	394	2,002
	%	18.1%	10.8%	13.1%	3.7%	9.3%
Total	n	3,847	157	6,818	10,682	21,504
	%	100.0%	100.0%	100.0%	100.0%	100.0%

Note. Data on direct patient care hours was not available for 753 doctors.

When average weekly hours were cross tabulated with hours spent in direct patient care (Table 12), it can be observed that 41.5% ($n = 1,970$) of doctors working more than 48 hours on average per week were spending more than 48 hours in direct patient care. Therefore, this particular group of doctors reported excessive working hours, while also reporting that those hours were mostly dedicated to patients in their care. These 1,970 doctors represented a decrease from 2,147 doctors defined by the same criteria in 2024 (a reduction of 8.2%).

Table 12. Doctors' Average Weekly Working Hours by Average Time Spent in Direct Patient Care

	Average Weekly Working Hours			
	48hs or less		> 48hs	
Direct patient care	n	%	n	%
<10hs	1,319	7.9	81	1.7
10 to 20hs	2,065	12.4	159	3.3
21 to 30hs	4,068	24.3	511	10.8
31 to 40hs	6,412	38.4	906	19.1
41 to 48hs	2,817	16.9	1,120	23.6
> 48hs	-	-	1,970	41.5
Total	16,710	98.2*	4,747	100.0

*Note. 29 doctors self-reported working more than 48 hours in direct patient care despite reporting working less than 48 hours total. This is a result of these questions being self-reported and likely an error on data entry. Since this should not be possible, they have been excluded from the above table.

Table 13 offers more information on this cohort of doctors. Almost half of doctors ($n = 983$, 49.9%) were in the youngest age group of 34 and younger, and just over 60% ($n = 1,225$, 62.2%) were male.

Table 13. Doctors Working More than 48hs a Week in Direct Patient Care

Doctors Working More Than 48Hs a Week in Direct Patient Care ($n = 1,970$)		
Age	Mean	SD
	38.0	10.1
Age group	n	%
34 and younger	983	49.9
35 to 44	559	28.4
45 to 54	234	11.9
55 and older	194	9.8
Gender	n	
Male	1,225	62.2
Female	745	37.8
Division	n	
Trainee Specialist	689	35.0
Supervised	17	0.9
General	879	44.6
Specialist	385	19.5
BMQ	n	
Irish	1,053	53.5
EU or UK	222	11.3
International	695	35.3
Top 5 Countries of International Graduates	n	
Pakistan	305	43.9
Sudan	172	24.7
South Africa	58	8.3
India	27	3.9
Egypt	24	3.5
Main Specialties Within Cohort	n	
Anaesthesiology	256	13.0
General Surgery	230	11.7
Trauma and Orthopaedic Surgery	178	9.0
General (Internal) Medicine	163	8.3
Obstetrics and Gynaecology	153	7.8
Paediatrics	100	5.1
General Practice	94	4.8

The majority were registered either on the General Division ($n = 879$, 44.6%) or the Trainee Specialist Division ($n = 689$, 35.0%). Over half of doctors had an Irish BMQ ($n = 1,053$, 53.5%) and just over a third had an international BMQ ($n = 695$, 35.3%). From that third of doctors with an international BMQ, 43.9% ($n = 305$) had obtained their qualifications in Pakistan (an increase from 39.4% in 2024), and almost a quarter had done so in Sudan ($n = 172$, 24.7%). The main specialties

where doctors practised medicine were Anaesthesiology ($n = 256$, 13.0%) and General Surgery ($n = 230$, 11.7%).

Table 14 shows the percentage of doctors in each medical discipline working more than 48 hours on an average week, as well as percentage of doctors in each medical discipline spending more than 48 hours in direct patient care on an average week. The disciplines that suggest the highest percentage of doctors working more than 48 hours on an average week were surgery ($n = 2,540$, 50.1%) and obstetrics and gynaecology ($n = 794$, 34.8%). The same pattern was observed for the percentage of doctors spending more than 48 hours on an average week in direct patient care.

Table 14. Doctors' Medical Discipline by Average Weekly Working Hours and Hours in Direct Patient Care

Medical Discipline	Average Weekly Working Hours*		Average Weekly Direct Patient Care Hours**	
	n	% Working > 48hs	n	% Working > 48hs
Anaesthesiology	1,505	28.3	1,501	17.9
Emergency Medicine	1,160	10.8	1,158	6.6
General Practice	5,484	9.7	5,467	1.8
Medicine	4,896	26.4	4,860	9.4
Obstetrics and Gynaecology	794	34.8	798	19.3
Occupational Medicine	165	3.6	164	0.0
Ophthalmology	167	15.0	166	7.8
Paediatrics	1,208	22.4	1,205	8.4
Pathology	710	20.7	707	5.5
Psychiatry	1,671	9.2	1,656	1.3
Public Health Medicine	275	5.8	271	0.4
Radiology	716	29.6	711	8.6
Sports and Exercise Medicine	30	13.3	31	3.2
Surgery	2,540	50.1	2,525	27.8

Columns are shaded with gradations: the darker the tone, the higher the value within the column. n represents the number of doctors in each discipline responding to either question. Some doctors answered both whereas others might have only answered one and some answered neither.

*Note. Data was not available for 936 doctors.

**Note. Data was not available for 1,037 doctors.

Difficulties Providing Sufficient Patient Care

Doctors were asked how frequently, if at all, they found it difficult to provide a patient with the sufficient level of care needed over the last 12 months (Table 14). From the doctors who answered this question, 30.7% ($n = 6,582$) said never, while 8.7% ($n = 1,866$) reported experiencing difficulties at least once a day, and 18.9% ($n = 4,056$) at least once a week.

Considering the first two options of Table 15 together, 27.6% ($n = 5,922$) of doctors experienced barriers at least once a week or more frequently (an increase from 26.1% in 2024). Detailed information on this group is outlined in Table 16. Just under a third of doctors ($n = 1,916$, 32.4%)

were aged between 35 and 44. In terms of division, 60.5% ($n = 3,580$) were registered on the Specialist Division. The majority of doctors had an Irish BMQ ($n = 4,639$, 78.3%). Only 11.2% ($n = 662$) had an international BMQ.

Table 15. How Frequently You Find it Difficult to Provide a Patient with Sufficient Care?

Difficulties providing care	N	%
At least once a day	1,866	8.7
At least once a week	4,056	18.9
At least once a month	2,024	9.4
Occasionally	6,931	32.3
Never	6,582	30.7
Total	21,459	100.0

Note. Data on 798 doctors (3.6%) was not available for this question.

Table 16. Doctors Experiencing Difficulties to Providing Care at Least on a Weekly Basis

Doctors Reporting Barriers to Providing Patient Care at Least Once a Week ($n = 5,922$)		
Age	Mean	SD
	42.6	10.7
Age group	n	%
34 and younger	1,682	28.4
35 to 44	1,916	32.4
45 to 54	1,391	23.5
55 and older	933	15.8
Gender	n	
Male	2,803	47.3
Female	3,119	52.7
Division	n	
Trainee Specialist	1,302	22.0
Supervised	7	0.1
General	1,033	17.4
Specialist	3,580	60.5
BMQ	n	
Irish	4,639	78.3
EU or UK	621	10.5
International	662	11.2
Top 3 Countries of International Graduates	n	
South Africa	173	26.1
Pakistan	165	24.9
Sudan	112	16.9
Main Specialties Within Cohort	n	
General Practice	1,890	31.9
Psychiatry	475	8.0
Emergency Medicine	412	7.0
General (Internal) Medicine	327	5.5
Paediatrics	251	4.2

Doctors were also 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 15 different barriers, covering issues related to work pressure, healthcare quality, support, training, supervision, and communication. Another option was also available where doctors could choose “no barriers”. Doctors could select either any number of barriers as relevant or “no barriers”.

There were 2,987 doctors (13.4% of clinically active doctors in Ireland) who reported not experiencing or observing any barriers. A minority of 4.9% ($n = 1,085$) doctors did not answer the question. Table 17 shows the results from this question based on the 18,185 doctors who selected at least one barrier (81.7% of clinically active doctors in Ireland). The barrier most often included in doctors’ answers was “pressure on workloads”, representing 16.7% of total responses and being selected by 68.8% of doctors who identified a barrier. In second place, “time spent on bureaucracy/administration” was selected by 58.8% of doctors and in third place, “overcrowding” was identified by 42.2%.

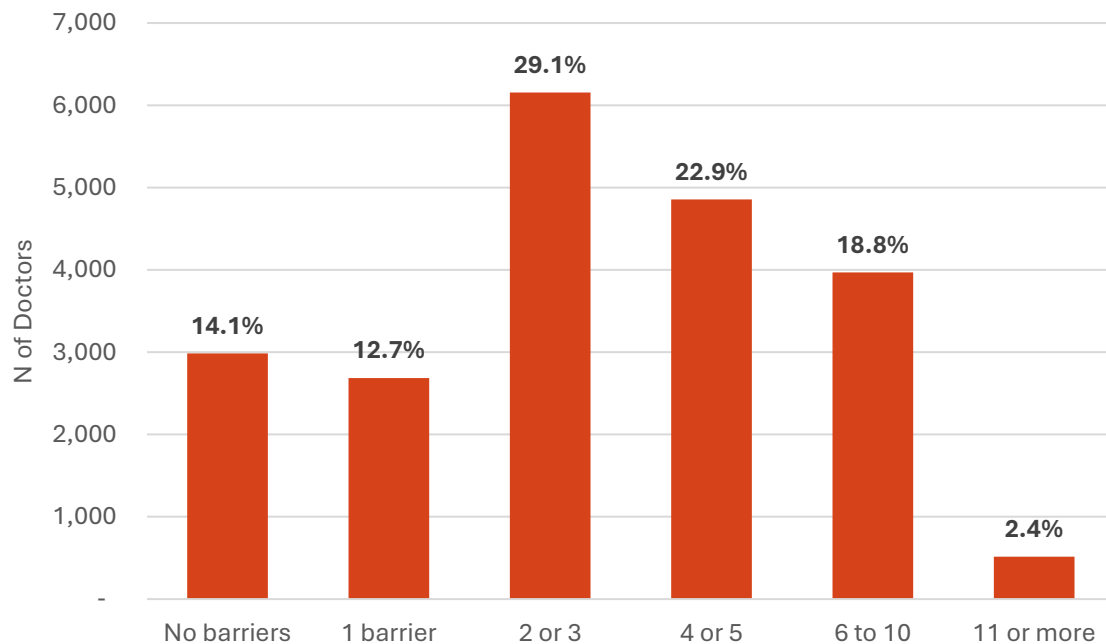
Table 17. Barriers to Good Patient Care

Barriers to Good Patient Care (n=18,185*)	% of Doctors	Total Responses	
		n	%
Pressure on workloads	68.8%	12,504	16.7%
Time spent on bureaucracy/administration	58.8%	10,700	14.3%
Overcrowding	42.2%	7,679	10.3%
Delays to providing care, treatment and screening	39.1%	7,107	9.5%
Lack of access to necessary equipment or services	37.0%	6,737	9.0%
Inadequate access to specialist opinion	29.5%	5,364	7.2%
Inadequate communication between healthcare professionals	28.6%	5,192	7.0%
Rota gaps	26.7%	4,850	6.5%
Lack of appropriately qualified staff	25.4%	4,613	6.2%
Unsafe systems	19.5%	3,544	4.7%
Insufficient support from senior colleagues, peers and non-clinical management	12.2%	2,224	3.0%
Inadequate communication with patients	8.0%	1,456	2.0%
Inadequate training or preparation	6.2%	1,120	1.5%
Insufficient supervision carrying out tasks	4.6%	845	1.1%
Providing patient care remotely	4.0%	728	1.0%

*Note. 2,987 doctors selected the option "no barriers" for this question, and 1,085 did not select any of the options given. These are not included in the table.

In terms of the total number of barriers chosen by each doctor in their answers, Figure 5 shows the percentages for different amounts of barriers being selected, including those who reported having experienced or observed no barriers at all. Almost 30% of doctors selected two or three barriers ($n = 6,155$, 29.1%) in their answers, and 22.9% ($n = 4,855$) chose 4 or 5. A small percentage of doctors ($n = 517$, 2.4%) chose 11 or more barriers, and 14.1% ($n = 2,987$) reported no barriers.

Figure 5. Percentage of Doctors Selecting Barriers

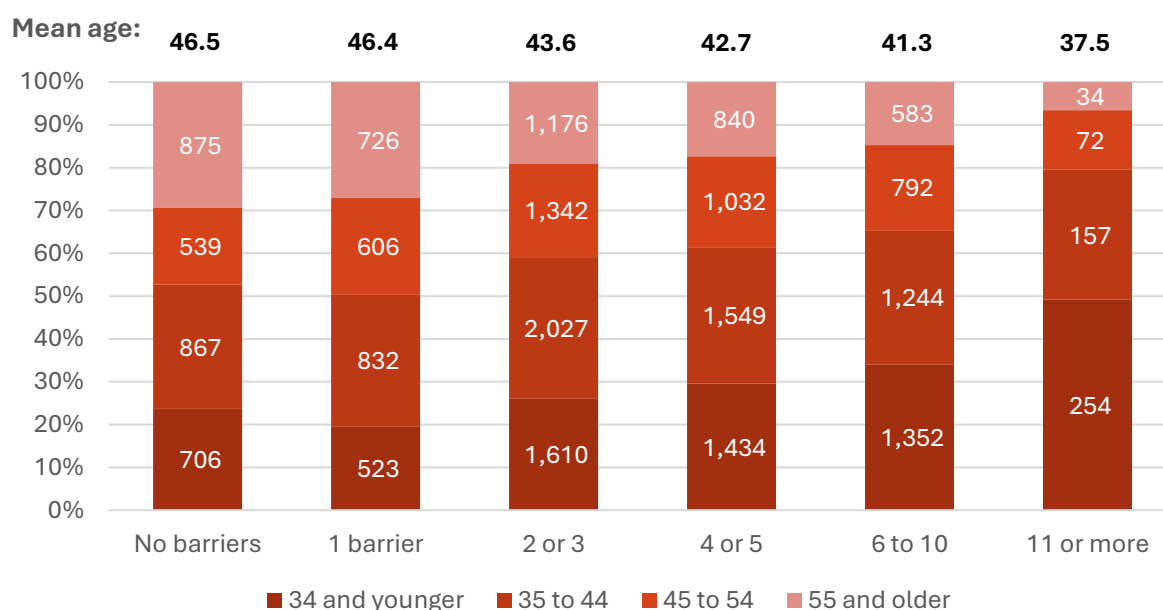


Note. 1,085 doctors did not provide information on this question as they did not select any of the options.

The categories of number of barriers chosen shown above were contrasted in relation to doctors' age, gender, division and qualification category. As can be observed at the top of Figure 6, the mean age of doctors on each of the number of barriers categories decreases progressively as the number of barriers experienced/observed increases. This is also clearly reflected when age groups are compared across barrier categories. For example, only 23.6% ($n = 706$) of doctors reporting no barriers were 34 years of age and younger, while almost 50% ($n = 254$, 49.1%) of those reporting 11 barriers or more were on the same age group.

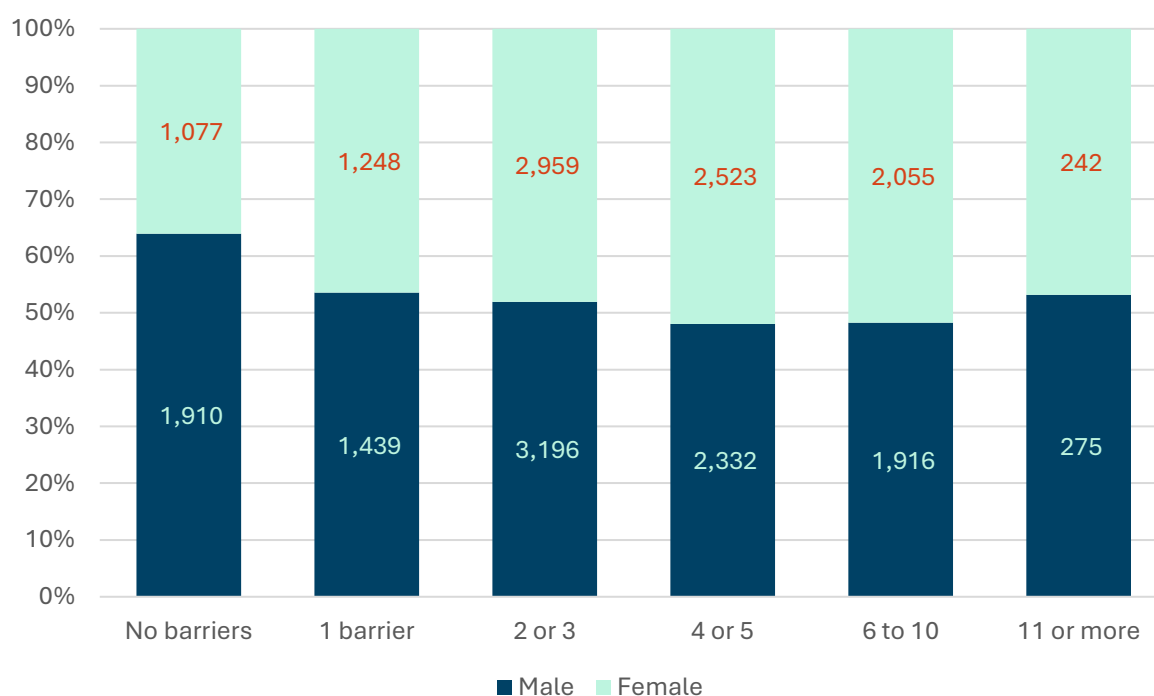
Regarding gender, the proportion of males and females reporting different numbers of barriers was quite balanced, close to 50/50 for all categories, except the no barriers group, where males reached 63.9% ($n = 1,910$) (Figure 7).

Figure 6. Categories of Number of Barriers by Doctors' Mean Age and Age Groups



Note. 1,085 doctors did not provide information on this question as they did not select any of the options.

Figure 7. Categories of Number of Barriers by Gender



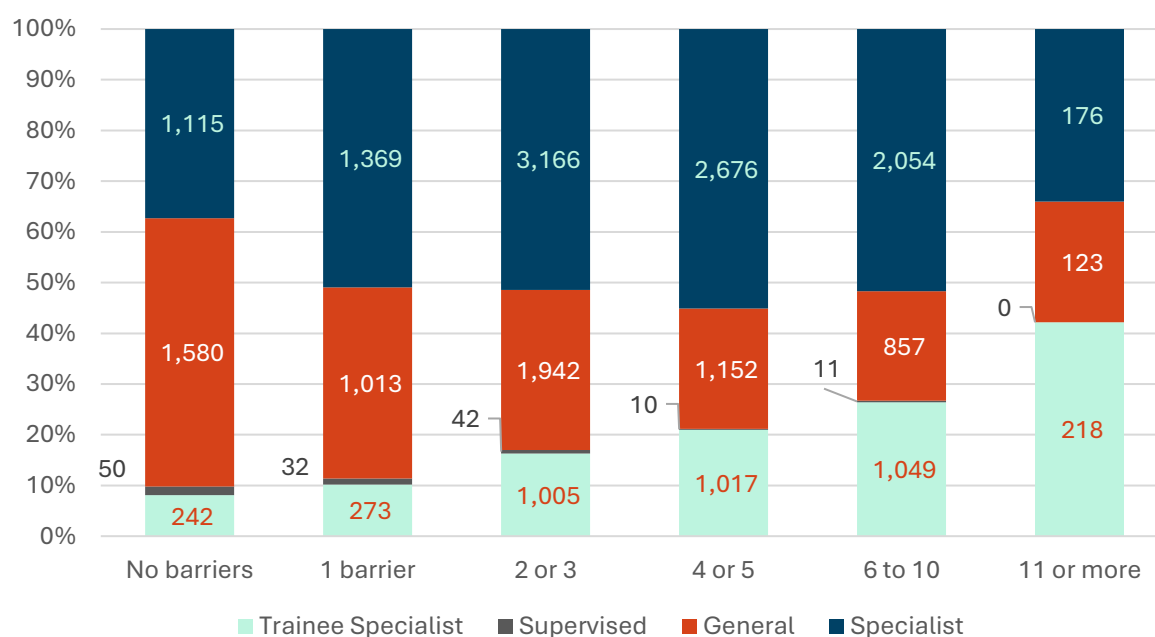
Note. 1,085 doctors did not provide information on this question as they did not select any of the options.

When observing divisions across different barrier groups, as shown in Figure 8, categories with higher number of barriers tended to progressively have greater proportions of doctors on the Trainee Specialist Division. For example, 26.4% ($n = 1,049$) doctors reporting six to ten barriers

were on this division, as well as 42.2% ($n = 218$) of doctors reporting 11 barriers or more. A relatively opposite pattern was observed for doctors on the General Division across the different barrier groups, with proportions diminishing as the number of barriers increased. For example, more than half of doctors reporting no barriers ($n = 1,580$, 52.9%) were registered on the General Division, compared to 37.7% ($n = 1,013$) in the one barrier group and 31.6% ($n = 1,942$) in the two to three barriers group.

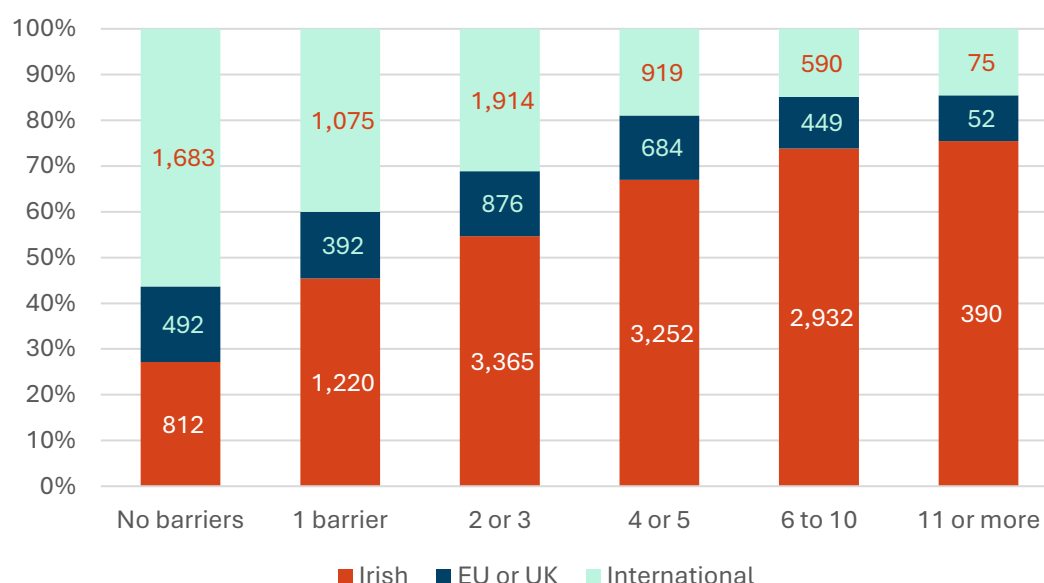
Considering doctors' qualification categories, the higher the number of barriers in each category, the greater the proportion of doctors with an Irish qualification, while the opposite was true for proportions of doctors with an international qualification. As Figure 9 illustrates, less than 30% of doctors reporting no barriers had an Irish qualification ($n = 812$, 27.2%). This figure then surpasses 40% in the one barrier group, and reaches more than 70% on each of the last two categories with the most barriers.

Figure 8. Categories of Number of Barriers by Division



Note. 1,085 doctors did not provide information on this question as they did not select any of the options.

Figure 9. Categories of Number of Barriers by Qualification Category

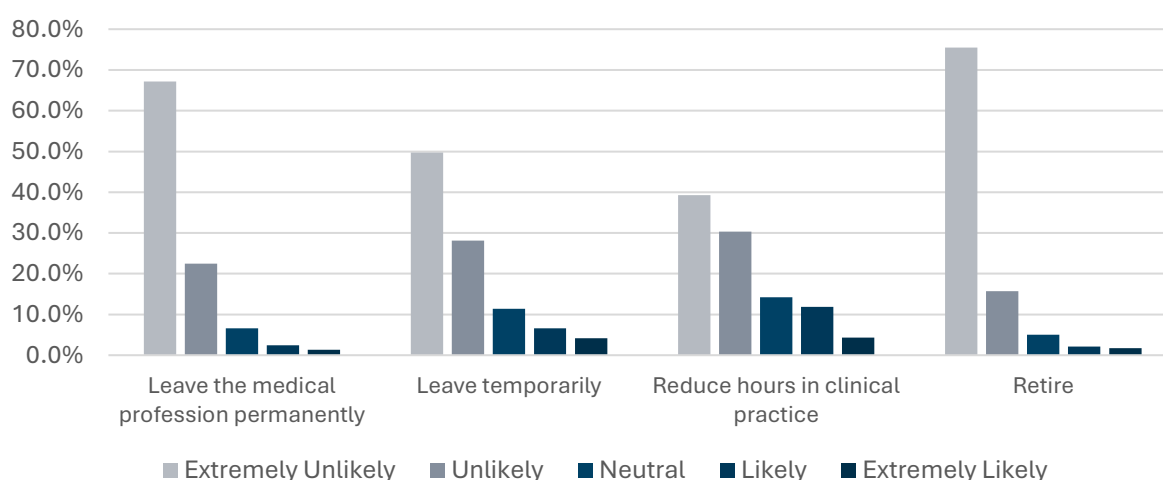


Note. 1,085 doctors did not provide information on this question as they did not select any of the options.

Career Changes

Doctors were asked how likely they were to make a number of career changes in the next year. These changes were: leaving the medical profession permanently, leaving temporarily, reducing hours in clinical practice, and retiring. Figure 10 below shows that the vast majority of doctors were extremely unlikely or unlikely to make any of the mentioned career changes. However, 11.9% and 4.3% of doctors were likely or extremely likely to reduce hours in clinical practice, making this the most likely career change among doctors.

Figure 10. Career Changes



Note. 793 doctors did not answer question on leaving medical profession permanently; 881 did not answer question on leaving temporarily; 860 did not answer question on reducing hours in clinical practice; 828 did not answer question on retiring.

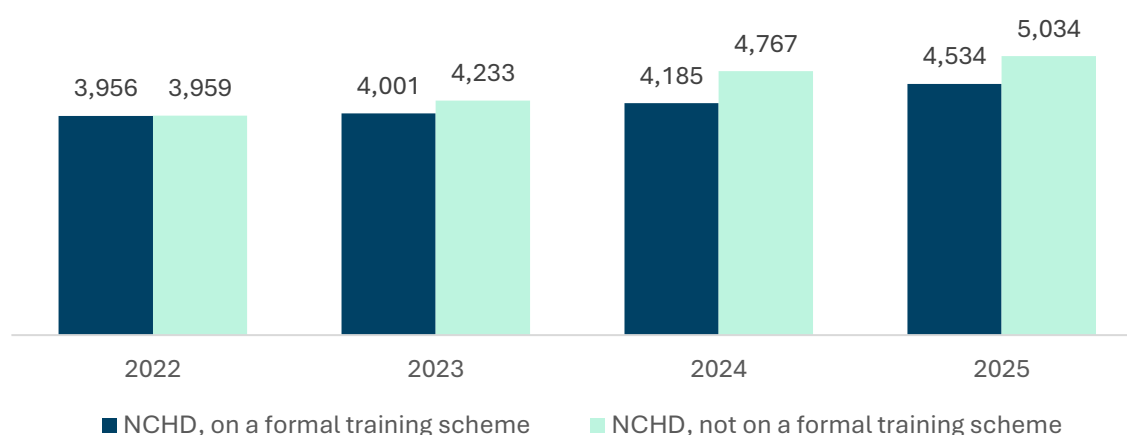
Non-Consultant Hospital Doctors

In 2025 there was a total of 9,568 NCHDs clinically active in Ireland. Just over half of NCHDs ($n = 5,034$, 52.6%) were not on a formal training scheme. This increased by 5.6% in comparison to the same time in 2024. The rate of change at which this group grew in 2025 was slower than the previous year (12.6%). More detailed information on comparative figures from the previous four years can be seen in Table 18 and Figure 11.

Table 18. NCHDs Figures 2022 - 2025

Year	NCHD, in training	% Change from Previous Year	NCHD, not in training	% Change from Previous Year
2022	3,956	▲ 5.3	3,959	▲ 6.0
2023	4,001	▲ 1.1	4,233	▲ 6.9
2024	4,185	▲ 4.6	4,767	▲ 12.6
2025	4,534	▲ 8.3	5,034	▲ 5.6

Figure 11. NCHDs Figures 2022 - 2025



Details on both NCHDs groups (on a formal training scheme and not on a formal training scheme) are presented in Table 19. NCHDs on a training scheme were younger (mean age 33.4, SD = 4.7) than those not on a training scheme (mean age 37.1, SD = 8.9). Most doctors in both groups were 34 years or younger. There were more females among NCHDs on a training scheme ($n = 2,516$, 55.5%) than among doctors not on a training scheme ($n = 2,089$, 41.5%).

In terms of Division, almost three quarters ($n = 3,333$, 73.5%) of doctors who self-reported being NCHDs on a formal training scheme were on the Trainee Specialist Division when the data was extracted. Generally, all doctors on a formal training scheme should be on the Trainee Specialist Division. However, as outlined above doctors complete annual retention between May and August, reporting their role at that time (e.g. NCHD, on a formal training scheme). The division variable is assigned later, when the data is extracted in August. Because doctors can change

division during this period, and may move roles, there can be discrepancies whereby someone reports being on a formal training scheme but is no longer classified as being on the Trainee Specialist Division when the data is extracted. Some doctors may temporarily move back to the General Division after completing a period of training, others may complete their training and transfer to the Specialist Division. The opposite is also possible whereby a doctor may self-report being an NCHD, not on a formal training scheme and then move into a training role. There may also be cases where doctors are undertaking training separate to the area in which they have specialised.

Table 19. NCHDs on a Formal Training Scheme and Not on a Formal Training Scheme

NCHDs (n = 9,568)		In Training		Not in Training	
Age		Mean	SD	Mean	SD
		33.4	4.7	37.1	8.9
Age group		n	%	n	%
34 and younger		3,056	67.4	2,454	48.7
35 to 44		1,355	29.9	1,715	34.1
45 to 54		105	2.3	553	11
55 and older		18	0.4	312	6.2
Gender		n	%	n	%
Male		2,018	44.5	2,945	58.5
Female		2,516	55.5	2,089	41.5
Division		n	%	n	%
Trainee Specialist		3,333	73.5	442	8.8
Supervised		171	3.8	20	0.4
General		799	17.6	4,406	87.5
Specialist		231	5.1	166	3.3
BMQ		n	%	n	%
Irish		3,081	68	1,021	20.3
EU or UK		433	9.6	643	12.8
International		1,020	22.5	3,370	66.9
Top 3 Countries of International Graduates		n	%	n	%
Pakistan		420	41.2	1,620	48.1
Sudan		251	24.6	842	25
South Africa		107	10.5	260	7.7
Working More Than 48hs on an Average Week		n	%	n	%
		1,575	35.6	1,250	25.4
Spent More Than 48hs on Direct Patient Care Weekly		n	%	n	%
		808	18.3	785	16.0

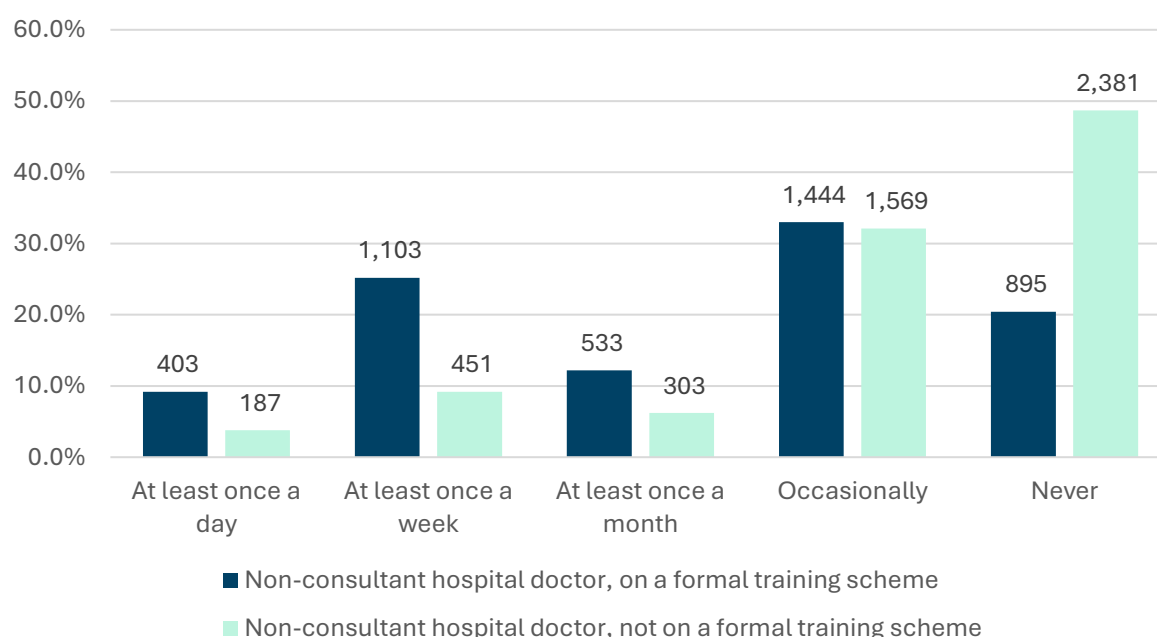
In relation of BMQ, the most notable change was an increase in the proportion of NCHDs on a training scheme with international qualifications: in 2024 this was 17.1%, whereas in 2025 it

reached 22.5%. Just as in 2024, the top three countries where NCHDs (both groups) with international BMQ obtained their qualifications were Pakistan, Sudan, and South Africa.

When considering the number of hours worked and spent in direct patient care, both groups showed a fall in the proportion of doctors self-reporting working more than 48 hours on an average week, compared to 2024. Notably, 18.3% ($n = 808$) of doctors in training self-reported working more than 48 hours in direct patient care weekly, a decrease from 22.5% in 2024.

When considering the question of how frequently, if at all, NCHDs have found it difficult to provide a patient with the sufficient level of care needed over the last 12 months, substantial differences can be seen between both groups. As can be observed in Figure 12, around double the amount of NCHDs in training experienced different levels of difficulties compared to those not in training. For example, 9.2% ($n = 403$) of NCHDs in training reported experiencing difficulties at least once a day, compared to only 3.8% ($n = 187$) of NCHDs not in training, and one in four NCHDs in training found providing care difficult at least once a week, compared with less than 10% of NCHDs not in training.

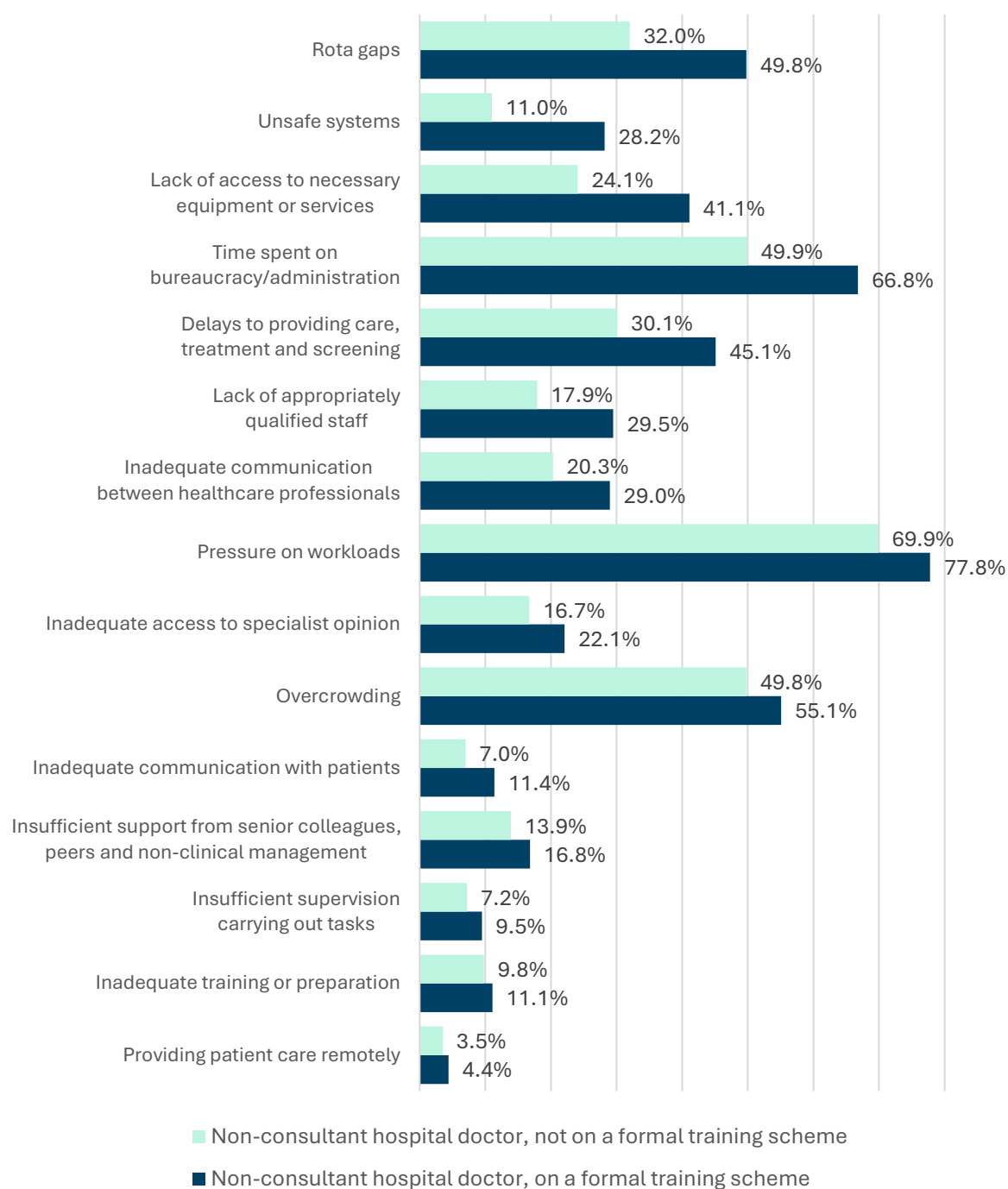
Figure 12. Difficulties Providing Patients with Sufficient Care by NCHD Group



Note. 299 NCHDs did not answer this question.

Experienced or observed barriers to providing good patient care in the past year were analysed for both NCHDs cohorts and compared in Figure 13. Percentages indicate the proportion of NCHDs who included each of the barriers in their answers (from those NCHDs who selected at least one barrier, $n = 7,704$). As it can be observed in the figure, some barriers appear to be more prominent among NCHDs in training compared to those not in training (barriers are ordered from largest to smallest, in terms of the magnitude of this difference).

Figure 13. Percentage of NCHDs, by Group, Choosing a Given Barrier in their Answers

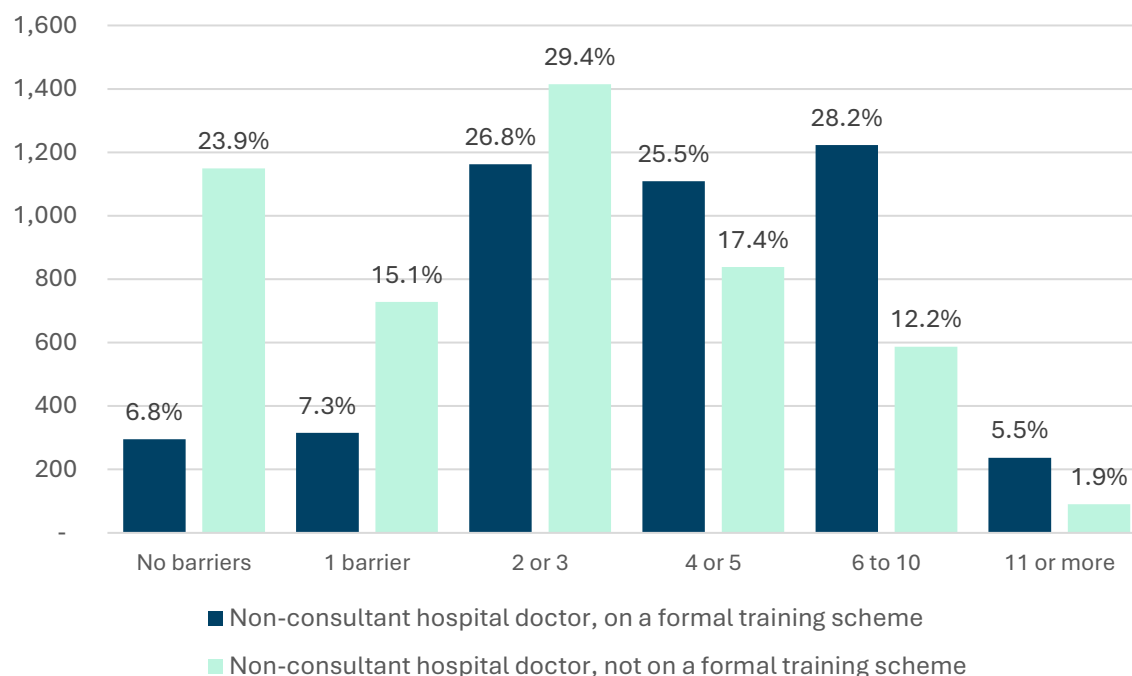


Note. This figure includes information provided by the 7,704 NCHDs who selected at least one barrier in their answer. 1,864 NCHDs who selected the option “no barriers” or who did not select any options are not included.

Categories of different number of total barriers chosen (including no barriers) were also compared among NCHDs who are on a formal training scheme and those who are not. Results are shown in Figure 14. NCHDs in training tended to include a higher number of barriers in their answers, compared to NCHDs not in training. For example, 25.5% ($n = 1,109$) of NCHDs in training reported four or five barriers, compared to only 17.4% ($n = 838$) of NCHD not in training.

Following the same pattern, almost a quarter ($n = 1,149$, 23.9%) of NCHDs not in training reported no barriers at all, while only 6.8% ($n = 295$) of NCHDs in training did.

Figure 14. Categories of Number of Barriers by NCHD Group



Note. 420 NCHDs did not answer this question.

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. In 2025, there were 5,017 doctors comprising this cohort, an increase of 5.3% from the 2024 figure (4,764). Details on this group are outlined below in Table 20. The mean age was 49.0 (SD = 11.7) and the proportion of GPs aged 55 years and older was 29.7%. There were slightly more females ($n = 2,648$, 52.8%) than males.

In terms of division of the Register, 78.9% ($n = 3,959$) of GPs were registered on the Specialist Division, and almost one in five ($n = 968$, 19.3%) were on the General Division. Regarding qualifications, 69.9% ($n = 3,505$) of GPs had obtained their BMQ in Ireland, while the rest was split almost equally among EU or UK, and International BMQ. From the international BMQ group, the top three countries where doctors gained their qualifications were Pakistan, South Africa and Sudan. Pakistan was in the first place in 2025, representing 28.2% ($n = 203$) of international GP graduates, an increase from 25.6% and second place in 2024. Among all GPs, the proportion reporting working more than 48 hours on average week was 10.2% ($n = 493$), and the proportion of GPs spending more than 48 hours in direct patient care was 1.7% ($n = 82$).

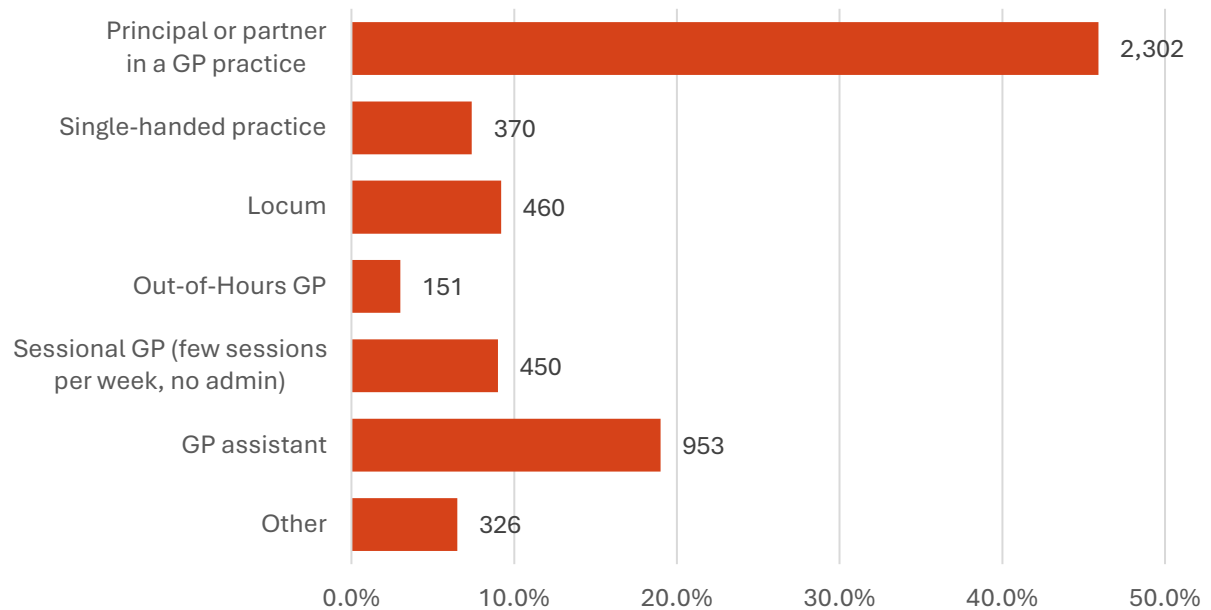
Table 20. GP Demographic Details

GPs (n = 5,017)		
Age	Mean	SD
	49.0	11.7
Age group	n	%
34 and younger	391	7.8
35 to 44	1,730	34.5
45 to 54	1,408	28.1
55 and older	1,488	29.7
Gender	n	%
Male	2,369	47.2
Female	2,648	52.8
Division	n	%
Trainee Specialist	89	1.8
Supervised	1	0
General	968	19.3
Specialist	3,959	78.9
BMQ	n	%
Irish	3,505	69.9
EU or UK	791	15.8
International	721	14.4
Top 3 Countries of International Graduates	n	%
Pakistan	203	28.2
South Africa	175	24.3
Sudan	79	11.0
Working More Than 48hs on an Average Week	n	%
	493	10.2
Spent More Than 48hs on Direct Patient Care Weekly	n	%
	82	1.7

GP categories are broken down in Figure 15. As can be seen, near 50% ($n = 2,302$, 45.9%) of GPs reported working as principal or partners in a GP practice, and 19.0% ($n = 953$) as GP assistants. A further breakdown of GP categories by Gender is shown in Figure 16. The gender split among GPs working as principal or partners in a GP practice was almost equal, with 51.6% ($n = 1,187$) females. The majority of GPs working in a single-handed practice, locum, and out of hours were male, whereas most GPs doing sessional work, working as assistant or other, were female.

In terms of county of practice 31.5%, ($n = 1,579$) of all GPs practised in county Dublin, followed by county Cork with 12.3% ($n = 617$) (Table 21).

Figure 15. GP Categories



Note. Data was not available for this question for 5 GPs.

Figure 16. GP by Gender

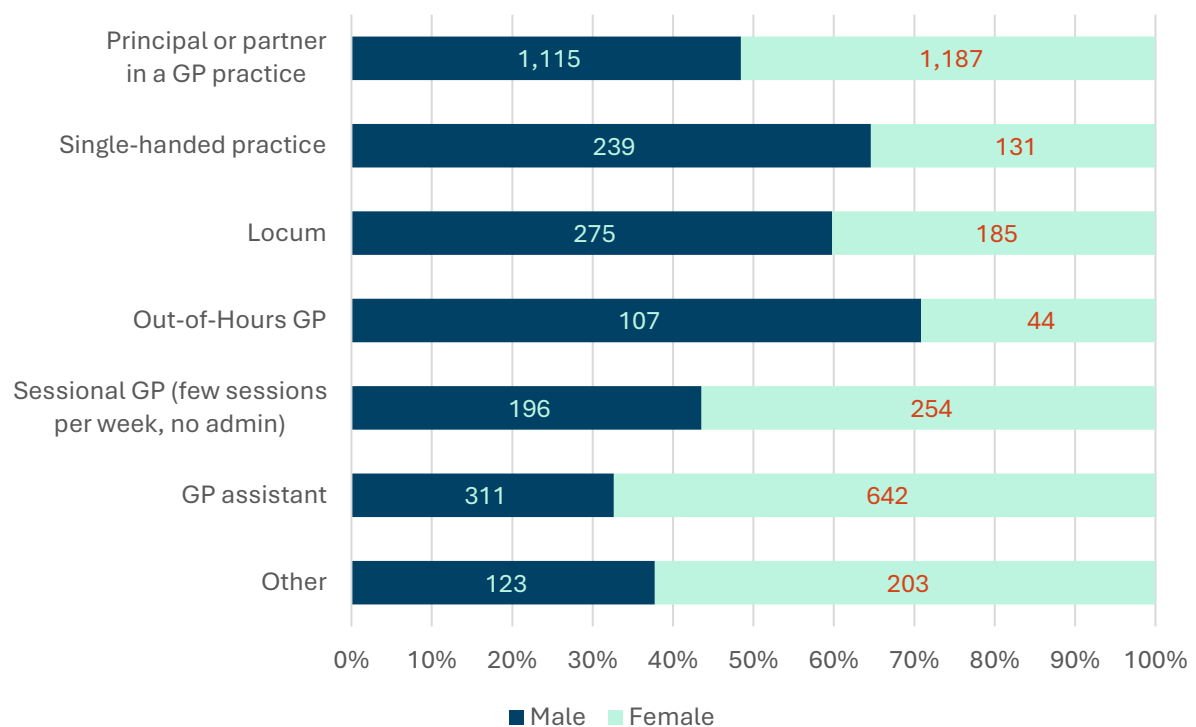
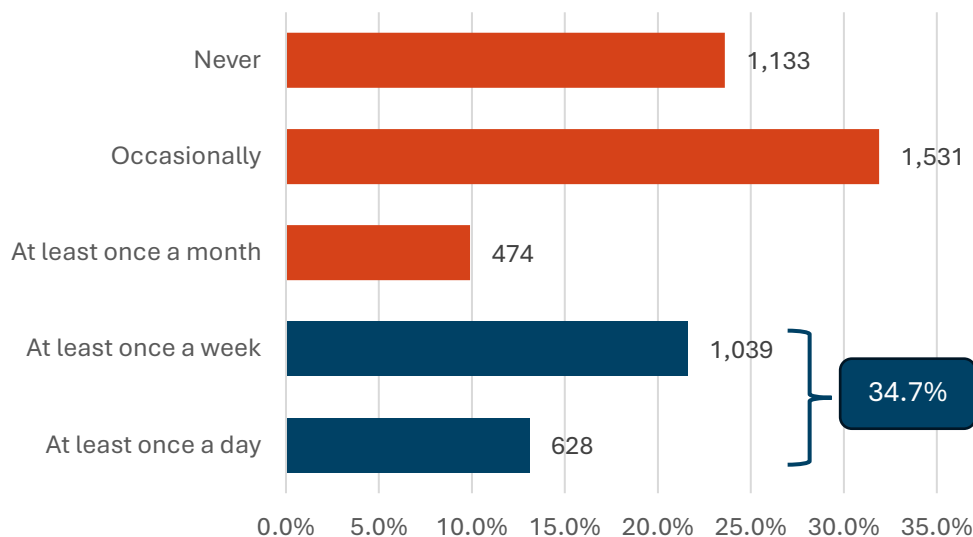


Table 21. GPs by County

County	N	%	County	n	%
Dublin	1,579	31.5	Mayo	116	2.3
Cork	617	12.3	Clare	103	2.1
Galway	306	6.1	Carlow	102	2.0
Limerick	229	4.6	Sligo	81	1.6
Kildare	175	3.5	Laois	80	1.6
Kerry	170	3.4	Kilkenny	76	1.5
Donegal	161	3.2	Offaly	74	1.5
Meath	146	2.9	Cavan	66	1.3
Wicklow	142	2.8	Longford	46	0.9
Wexford	139	2.8	Roscommon	46	0.9
Tipperary	130	2.6	Monaghan	39	0.8
Waterford	130	2.6	Leitrim	27	0.5
Louth	119	2.4			
Westmeath	118	2.4	Total	5,017	100.0

Regarding how frequently, if at all, GPs found it difficult to provide a patient with the sufficient level of care needed over the last 12 months, 13.1% ($n = 628$) of respondents said this happened at least once a day, and 21.6% ($n = 1,039$) at least once a week. Taken together, this represents just over one third of GPs (34.7%) (Figure 16).

Figure 17. GPs: How Frequently You Find it Difficult to Provide a Patient with Sufficient Care?



Note. 212 GPs did not answer this question.

Table 22 shows GPs' responses when experienced or observed barriers to providing good patient care. From the 4,297 GPs who selected at least one barrier, just over two thirds selected "Time spent on bureaucracy/administration" ($n = 2,895$, 67.4%), as well as "Pressure on workloads" (n

= 2,891, 67.3%). The third most selected barrier included in responses was “Inadequate access to specialist opinion”, with almost another two thirds of GPs including it in their answers.

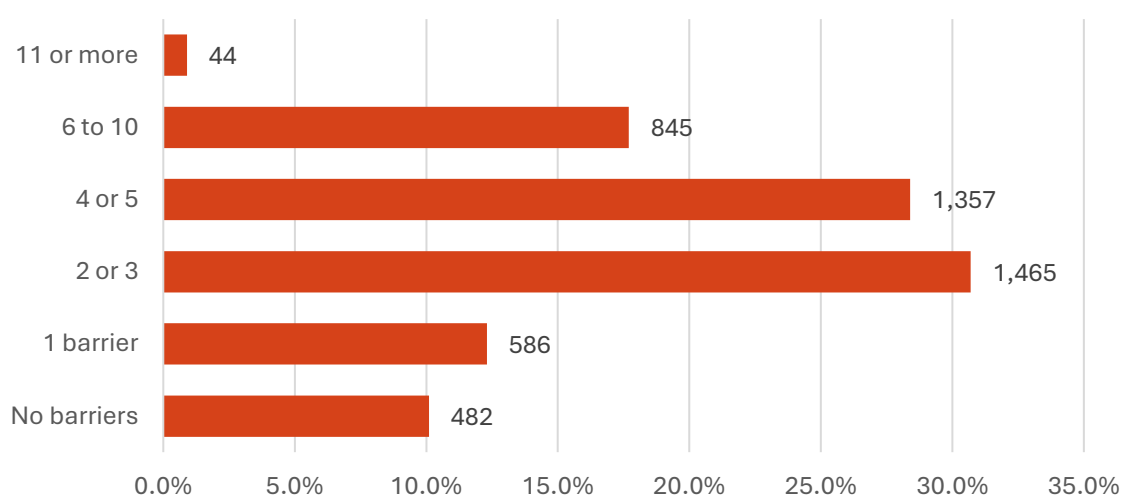
Table 22. Barriers to Good Patient Care for GPs

Barriers to Good Patient Care (n = 4,297)	% of GPs	Total Responses	
		n	%
Time spent on bureaucracy/administration	67.4%	2,895	17.4%
Pressure on workloads	67.3%	2,891	17.3%
Inadequate access to specialist opinion	64.7%	2,780	16.7%
Inadequate communication between healthcare professionals	41.8%	1,796	10.8%
Delays to providing care, treatment and screening	41.1%	1,764	10.6%
Lack of access to necessary equipment or services	35.5%	1,527	9.2%
Overcrowding	23.0%	987	5.9%
Unsafe systems	12.2%	526	3.2%
Lack of appropriately qualified staff	11.1%	476	2.9%
Inadequate communication with patients	7.1%	303	1.8%
Insufficient support from senior colleagues, peers and non-clinical management	5.1%	221	1.3%
Rota gaps	4.6%	199	1.2%
Providing patient care remotely	4.5%	195	1.2%
Inadequate training or preparation	1.6%	68	0.4%
Insufficient supervision carrying out tasks	1.1%	48	0.3%

Note. 720 GPs who selected the option “no barriers” or who did not select any options are not included.

When considering the number of barriers to providing good patient care in the past year selected by GPs, over three quarters of GPs selected at least two. Four or five barriers were selected by 28.4% ($n = 1,357$) GPs and six to ten by 17.7% ($n = 845$). Only one in ten GPs reported no barriers at all (Figure 15).

Figure 18. Percentage of GPs Selecting Barriers



Note. 238 GPs did not answer this question.

Conclusions

Analysis of our workforce data provides a picture of a nuanced and heterogeneous medical workforce that is highly diverse, fluid and in a state of flux in terms of demographics, specialities, and practices. Planning for the medical workforce in Ireland requires a view of the health and social care workforce as a whole and requires not only setting out the right numbers but also a vision on the right match between skills available in the workforce and patient needs.

Retaining doctors who have trained in Ireland and who come to Ireland to work is challenging, and as the data indicate, high proportions of doctors are working long hours that contravene the EWTD, which can lead to stress, burnout, absenteeism, and increased risk to patient safety. The NDTP's 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 Medical Council's 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.

Doctors must be supported to work effectively in their roles in workplaces that are safe and appropriately resourced. Addressing changing ways of working among all doctors, work-life balance, workplace culture, supportive environments and management, career progression and workplace safety will have a positive impact on recruitment and retention. The heterogeneous dynamic of the workforce, as indicated in our data, suggest that tailored interventions may be required to address the needs of our diverse and nuanced medical workforce, regarding age groups, specialities, geographic locations, family demands and life stages. The Medical Council is currently undertaking research into the diverse groups of doctors on the General Division of the Register, which could help identify how we can strive to support specific cohorts of doctors in a tailored and appropriate way.

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. 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.

The development of Electronic Health Records (EHRs) and emerging technologies including artificial intelligence can be understood as a shift from over-dependency on international medical workers towards self-sufficiency, and indeed, the Department of Health's workforce report, *Ireland's Future Health and Social Care Workforce* (2025), an evidence-based strategic direction for the health and social care workforce for the next 15 years, focusing on building future domestic supply in keeping with the WHO Code of Conduct.

The above report states the goal of long-term workforce planning as identifying the "steady state", which looks beyond possible economic and health crises that can lead to fluctuation in

workforce supply. It is vital that we ensure the right type of data to plan effectively and build capacity in terms of increasing domestic supply and optimising the workforce. The Medical Council is committed to improving and optimising its workforce data in order to contribute to three key workforce measures, as set out in the above report: strategic workforce planning, workforce reform and workforce productivity, thereby systematically supporting the medical workforce to deliver equitable and patient-centred care. The workforce data contained in this report can support an evidence base that proactively ensures the right people with the right skills in the right place. A collaborative data-driven approach is key to support workforce modelling and informed decision-making 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 – Breakdown of Clinically Active Workforce by Division and Qualification Category

Overall, 75.6% of doctors retaining self-reported being clinically active in Ireland. This however varies by division, ranging from 58.7% of those on the General Division to over 95% of those on the Trainee Specialist or Supervised Division.

Table. Clinically Active Workforce Data By Division

	Trainee Specialist		Supervised		General		Specialist		Total	
	n	%	n	%	n	%	n	%	n	%
Total Retaining	4,113	100.0	204	100.0	11,970	100.0	13,141	100.0	29,428	100.0
CA Ireland	3,923	95.4	195	95.6	7,030	58.7	11,109	84.5	22,257	75.6
CA Abroad Only	45	1.1	7	3.4	3,853	32.2	1,554	11.8	5,459	18.6
Not Practising (Ireland or Abroad)	145	3.5	2	1.0	1,087	9.1	478	3.6	1,712	5.8

Note. CA = Clinically Active

Table. Clinically Active Workforce Data By Qualification Category

	Irish		EU or UK		International		Total	
	n	%	n	%	n	%	n	%
Total Retaining	14,249	100.0	4,509	100.0	10,670	100.0	29,428	100.0
CA Ireland	12,599	88.4	3,090	68.5	6,568	61.6	22,257	75.6
CA Abroad Only	882	6.2	1,173	26.0	3,404	31.9	5,459	18.6
Not Practising (Ireland or Abroad)	768	5.4	246	5.5	698	6.5	1,712	5.8

Note. CA = Clinically Active

Appendix B - Detailed Doctors' Descriptives by Medical Disciplines and Specialties

Medical Discipline / Specialty	n	% in Specialist Division	% Female	% 55 and older	% Irish BMQ
Anaesthesiology	1,547	51.6%	38.6%	20.2%	47.4%
Anaesthesiology	1,455	49.6%	38.7%	20.1%	46.3%
Intensive Care Medicine	67	79.1%	43.3%	13.4%	65.7%
Pain Medicine	25	92.0%	20.0%	40.0%	68.0%
Emergency Medicine	1,180	20.6%	36.5%	8.4%	31.4%
General Practice	5,686	72.4%	53.7%	27.3%	69.4%
General Practice	5,675	72.5%	53.9%	27.3%	69.4%
Military Medicine	11	27.3%	0.0%	27.3%	63.6%
Medicine	5,014	35.2%	45.7%	13.0%	55.0%
Cardiology	393	55.7%	22.9%	18.6%	64.1%
Clinical Genetics	19	68.4%	57.9%	47.4%	63.2%
Clinical Neurophysiology	23	73.9%	39.1%	43.5%	69.6%
Clinical Pharmacology and Therapeutics	16	43.8%	43.8%	31.3%	87.5%
Dermatology	209	57.9%	75.6%	18.7%	78.9%
Endocrinology and Diabetes Mellitus	246	52.0%	45.5%	16.3%	64.6%
Gastroenterology	293	59.0%	35.5%	20.1%	68.3%
General (Internal) Medicine	1,855	8.7%	43.2%	7.7%	31.4%
Genito-Urinary Medicine	25	52.0%	76.0%	44.0%	80.0%
Geriatric Medicine	474	41.6%	55.3%	11.2%	72.4%
Infectious Diseases	135	46.7%	62.2%	8.1%	81.5%
Medical Oncology	239	42.3%	51.9%	11.3%	63.2%
Nephrology	161	49.1%	39.8%	16.8%	65.8%
Neurology	190	53.2%	45.8%	14.7%	65.8%

<i>Continued</i>					
Medical Discipline / Specialty	n	% in Specialist Division	% Female	% 55 and older	% Irish BMQ
Palliative Medicine	168	49.4%	69.6%	13.1%	76.8%
Pharmaceutical Medicine	28	32.1%	57.1%	25.0%	78.6%
Rehabilitation Medicine	41	46.3%	58.5%	19.5%	51.2%
Respiratory Medicine	326	50.6%	38.3%	13.8%	68.1%
Rheumatology	163	57.7%	45.4%	20.2%	61.3%
Tropical Medicine	10	10.0%	50.0%	20.0%	70.0%
Obstetrics and Gynaecology	817	37.0%	70.0%	18.5%	42.5%
Occupational Medicine	175	65.7%	59.4%	35.4%	70.3%
Ophthalmology	172	57.0%	57.0%	32.6%	54.7%
Paediatrics	1,242	38.5%	63.2%	16.4%	46.8%
Neonatology	105	57.1%	57.1%	9.5%	57.1%
Paediatric Cardiology	14	57.1%	35.7%	21.4%	100.0%
Paediatrics	1,123	36.5%	64.1%	17.0%	45.1%
Pathology	737	63.6%	60.4%	21.8%	71.4%
Chemical Pathology	23	73.9%	43.5%	43.5%	56.5%
Haematology (Clinical and Laboratory)	238	51.3%	52.9%	20.2%	64.7%
Histopathology	278	70.5%	62.2%	21.9%	74.8%
Immunology (Clinical and Laboratory)	22	45.5%	72.7%	18.2%	77.3%
Microbiology	167	69.5%	68.9%	21.0%	76.0%
Neuropathology	9	88.9%	55.6%	33.3%	77.8%
Psychiatry	1,712	49.6%	51.8%	22.1%	50.3%
Child and Adolescent Psychiatry	257	62.3%	61.5%	24.5%	47.5%
Psychiatry	1,286	44.2%	49.4%	20.1%	48.7%
Psychiatry of Learning Disability	56	75.0%	55.4%	35.7%	62.5%
Psychiatry of Old Age	113	69.9%	55.8%	32.7%	69.0%
Public Health Medicine	293	62.5%	78.2%	33.4%	91.8%

<i>Continued</i>					
Medical Discipline / Specialty	n	% in Specialist Division	% Female	% 55 and older	% Irish BMQ
Radiology	734	71.0%	38.3%	22.2%	77.7%
Radiation Oncology	106	50.9%	50.9%	12.3%	70.8%
Radiology	628	74.4%	36.1%	23.9%	78.8%
Sports and Exercise Medicine	33	81.8%	18.2%	42.4%	78.8%
Surgery	2,622	41.5%	25.0%	19.5%	49.3%
Cardiothoracic Surgery	109	36.7%	18.3%	22.9%	45.9%
General Surgery	917	31.1%	29.0%	17.4%	36.2%
Neurosurgery	77	44.2%	11.7%	19.5%	51.9%
Ophthalmic Surgery	155	72.3%	39.4%	26.5%	75.5%
Oral and Maxillo-Facial Surgery	34	58.8%	17.6%	44.1%	91.2%
Otolaryngology	202	45.5%	29.7%	27.2%	55.0%
Paediatric Surgery	45	35.6%	37.8%	22.2%	35.6%
Plastic, Reconstructive and Aesthetic Surgery	179	53.1%	40.2%	20.7%	68.7%
Trauma & Orthopaedic Surgery	603	41.0%	11.8%	17.2%	49.6%
Urology	193	51.3%	22.3%	17.6%	57.5%
Vascular Surgery	108	44.4%	28.7%	14.8%	57.4%

Note. 293 doctors chose a limited scope of practice of aesthetics, urgent care, medicolegal, or gynaecology only and are not included in the table.

Appendix C - 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 internship training.

Doctors Retaining: All doctors who choose to retain their registration. Doctors retain their registration by completing the annual retention process and paying the required fee. By engaging in this process doctors maintain their name on the Medical Council's Register of Medical Practitioners.

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.

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 select 'no' to this question they are not clinically active and defined as not practising.

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 on an average week.

Appendix D – Abbreviations

ARAF	Annual Retention Application Form
BMQ	Basic Medical Qualification
CA	Clinically Active
DOH	Department of Health
EEA	European Economic Area
EHR	Electronic Health Record
EU	European Union
EWTD	European Working Time Directive
GP	General Practitioner
HSE	Health Service Executive
IMG	International Medical Graduate
ICGP	Irish College of General Practitioners
LTFT	Less than Full Time
NCHD	Non-Consultant Hospital Doctor
NDTP	National Doctors Training and Planning
OECD	Organisation for Economic Co-Operation and Development
PGTB	Post Graduate Training Body
SD	Standard Deviation
UK	United Kingdom
WHO	World Health Organisation



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