INSTITUTE
OF MEDICINE

ROYAL COLLEGE OF
PHYSICIANS OF IRELAND

OPTIMISE
Interim Report

REVIEW OF INTERNAL MEDICINE TRAINING
AUGUST 2023

BY PROFESSOR ANTHONY O'CONNOR

ROYAL
COLLEGE OF
PHYSICIANS
OF IRELAND

A Note from the Clinical Lead

A chara,

Is mór an chúis áthais dom an tuairisc seo a chur in iúil daoibh le phlé conas a d'fhéadfaimis dochtúirí míochaine a thraenáil amach anseo. Ghabhaim buíochas o chroí leis an gColáiste Ríoga na Lianna in Eirinn as ucht an seans seo a fháil agus an sár-thacaiocht a thug siad dom.

It is a privilege for me to introduce this report to you on how we train the Internal Medicine physicians of the future. I wish to thank the Royal College of Physicians of Ireland, and especially the Institute of Medicine for the sage advice, trust and unstinting support the OPTIMISE project has received.

Training matters. It matters primarily for the generations of patients, ourselves, our loved ones, families and friends who will come to rely on the professionalism and skill of the doctors trained by this college. The recommendations will no doubt provoke debate and mark the most radical change to training in Internal Medicine since the advent of Basic and Higher Specialist Training (BST/HST) in the early years of this century. I wanted to give you a bit of insight into how we have arrived at them. There are five key pillars to the interim report:

- **A new Approach for the Practice of the 2020s and beyond**
- **A new Approach for the Patients of the 2020s and beyond**
- **Providing the Resources to Train**
- **A new paradigm for the Trainer-Trainee relationship**
- **Championing Generalism**

For many years, Ireland was well-served in a sense by its model of basic specialist training. However, our former training model, based around doctors embedded in the same clinical firm and the master-apprentice model has been significantly disrupted by changes in work patterns, clinical demand and patient factors. It is my view that in the overall, the changes that have arisen in recent years are necessary and will be for the betterment of patients and physicians, and no matter how nostalgic we feel about the ways of old, things will not return to them. The onus is therefore on training programmes to adapt how learning, both on and off the job, is delivered.

I believe that training in Internal Medicine should be seen as a continuum, beginning in medical school and following on into a lifetime of practice. Specific to the aspects governed by RCPI, we are proposing an integrated training programme in internal medicine running from the end of intern year to CSCST, to replace the current BST and HST programmes.

The main focus of the interim report is on Stage 1 Internal Medicine Training (IMT) which we recommend should span the SHO period and early registrar years. This would span a variety of hospital models and take in valuable training opportunities in critical care, integrated care, and cross subspeciality issues such as frailty, multimorbidity, polypharmacy, care of the dying patient and sensible, judicious use of scarce resources, as well as allowing for Trainee choice in their field of interest. The aim would be to produce a doctor with the firmest grounding achievable in Internal Medicine, to further pursue subspeciality training in a field of their choosing. Trainees will make use of the most up-to-date technologies in simulation and Point-Of-Care Ultrasound to augment the time-honoured training opportunities inherent in on-the-job learning and in various other teaching modalities that currently exist.

The success or otherwise of our training programmes will ultimately rest with how the Trainee-Trainer interaction is managed. Again, changes in work patterns in hospitals have created a different milieu for this relationship. We are therefore proposing that each Trainee in IMT should have a named educational supervisor who will be a source of continuity over the period of their training and work alongside their clinical supervisor which will change from post to post. The Trainee experience should be an important corporate priority for hospital sites and to that end we are proposing a set of standards and metrics for how training is evaluated on sites and how poor performance can be addressed.

We have received a great deal of feedback on the desirability of a scheme for single-specialty training in Internal Medicine. A key factor here is whether or not the health service at a strategic level intends to support such appointments. While this is beyond the scope of this review, we have commented on how the proposed training scheme could support this type of training were it to be desirable.

Given IMT will be by far the biggest training programme in RCPI we are proposing the appointment of a 1.0WTE Director of Training, with appropriate administrative support and backfill for Regional Programme Directors (RPD) with administrative support at each hub.

It is ironic that even though General Internal Medicine is the core business of our hospitals and has never been more important to the overall functioning of the health service, the discipline has become burdensome, stressful, low-status and unattractive to Trainees who fear burnout and frustration. While this project is concerned with training only, we hope it will nudge hospital and health service managers and planners into valuing those who contribute most to this important area. We are recommending RCPI sets up a working group or task force to champion generalism with all relevant political and administrative stakeholders and that specialities training towards single accreditation be encouraged to think again about dual speciality training.

I would like to pay tribute to everyone who has helped with the compilation of this report. Special thanks must go to Roisin Craven, project manager of the OPTIMISE project who has done by far and away the most amount of work to get it to where it is today, and both Sean O'Donnell and more recently Anjitha Radhamoney who have ably deputised for Roisin when needed. Jessica Dowling, manager of Accreditation & Improvement projects for RCPI oversaw all of this work with wisdom, insight and creativity. OPTIMISE is only possible because of the sterling work done by Prof John McDermott on the BST programme over the years and his contribution was and is immense. Aisling Smith Education Manager, Medical Education and Training at RCPI has been indispensable and eternally focussed on the needs of Trainees and supported by Stephen Capper will be critical in developing the curriculum to support our recommendations. Louis Lavelle, Ann O'Shaughnessy, Colm Small provided valuable leadership, support and counsel from RCPI. The Institute of Medicine, in the person of Anthony O'Regan, Ed McKone, Lucy-Ann Behan, Emer Kelly, Sean Fleming, Marcia Bell and Mike Watts were as wise as they were tenacious in pursuit of the best programme for our Trainees and were extraordinarily generous with their time, goodwill and patience. I got great co-operation too from Louise Guyett and Brian O'Murchu. Janet O'Farrell, Niamh O'Sullivan and Hadas Levy provided invaluable specialist support along the way and no request was too much for them. The members of our steering group are listed in the report, and they could not have been more helpful or kind. I would pay particular tribute to the Trainees who took part in the steering group. Medicine and the College is in safe hands. We were welcomed and assisted by a myriad of external stakeholders including the HSE Acute Medicine Programme, led by Garry Courtney and Mary Ryan, the NDTP with Brian Kinirons and his team, the Chief Clinical Officer of the HSE via the integrated care programme led by Siobhan Ni Bhriain. Fascinating insights were obtained by overseas colleagues like Mike Jones, Adrienne van Zambergen and Toby Gilbert to name but a few.

I hope you will enjoy reading this report and look forward to receiving any feedback you may have. The success of any reform of the training programme in Internal Medicine will rely on collaborative effort and co-operation.

Ní neart go cur le chéile.

Anthony O'Connor *MD, MSc, FRCPI*
Clinical Lead

Foreword

The Institute of Medicine (IoM) was established in 2020 to enhance the oversight and practice of 18 clinical medicine specialties in Ireland. The IoM is the largest training body in Ireland, and by far its biggest training programme relates to training in general internal medicine.

The initial priorities for the Board of the IoM were to embed governance, enhance national engagement, and quality improve training relevant to the healthcare needs of the Irish population. As in many jurisdictions, it was clear that general medical skills and the role of generalists in medicine was a key priority. Covid-19 could easily have derailed this focus but in fact further highlighted this priority by demonstrating in so many ways the vital role of the general physician in our health service and the value and adaptability of this group of doctors. It also underlined the key role of the IoM in responding and guiding in this area. As such the IoM Board agreed we should progress an important review of Internal Medicine Training in Ireland as soon as possible, and we drew up the term of reference of OPTIMISE (Optimise and Progression of Internal Medicine in Ireland – in Search of Excellence)

I am delighted that we have already reached the stage of publishing the initial recommendations of the OPTIMISE project. It is clear that these recommendations are focused entirely on future healthcare needs and on optimizing the training experience to produce the appropriate physician workforce into the future. This paper represents the remarkable work of the clinical lead for OPTIMISE, Professor Anthony O'Connor, and his tireless efforts to represent a consensus of Trainees, consultants, healthcare policy experts and patients. He has been supported by a great team, Ms Roisin Craven, Ms Jessica Dowling, and more recently Ms. Anjitha Radhamoney as well as a broad and dedicated working group.

These recommendations lay out our vision and are clearly aligned to HSE policy and healthcare plans. We realize there is an immense amount of work still required before we can launch this new IM programme. The next phase will involve developing a new curriculum, exploring how outcomes can best be assessed, and what resources are required to support this programme, which will exceed the Intern Programme in its number of Trainees. We do not underestimate the work, nor the resources required but you will see from the recommendations that Professor O'Connor, and his team are clearly focused on shaping a workforce that will continue to deliver outstanding clinical care for the Irish population.

I would like to thank Professor O'Connor for taking on this essential work and for his careful consideration, and indeed everyone involved for this reaching this important milestone. I am excited to be part of a project that is so central to future clinical care in this country.

Professor Anthony O'Regan
Dean Institute of Medicine

Executive Summary

Internal Medicine (IM) is the core business of Irish hospitals, accounting for approximately two-thirds of hospital bed days. As such the preservation of general medical skills in an era of increased specialisation is critical to maintaining standards of care in Ireland, more so than ever in an era of demographic change with resulting multimorbidity, frailty and polypharmacy. Such pressures on IM manifest across the system as longer waiting times in emergency departments, increased numbers of patients placed in beds that are not suited to their needs, decreased efficiency of the discharge process, increased errors, and greater stress within the workplace. In all likelihood, what is frequently described as an Emergency Department crisis could more accurately be described as an IM crisis hosted in the Emergency Department.

This review was commissioned by the Institute of Medicine to ensure that the training programme in Internal Medicine (IM) remains fit-for-purpose and ensures that graduates are being provided with the skills and expertise required to meet the needs of patients and society into the future. The Project has been titled *'OPTIMISE'* (Optimisation and Progression of Training in Internal Medicine – In Search of Excellence), and work has been carried out under the leadership of Prof Anthony O'Connor as clinical lead.

Recommendations have been developed for an integrated, outcome-based training programme, with flexibility for change into the future. Recommendations on the resources required to deliver change into the future, and on continuous quality assurance and improvement for internal medicine training have also been outlined. A short, medium, and long-term timeline for rolling out and implementing changes in the programme will be developed.

Recommendations

1. **An Integrated Training Programme in Internal Medicine (IMT) will be established to replace the BST and HST programmes in General Internal Medicine.**
   It will span the career from the end of intern year to CSCST. It will be divided into two phases. Stage 1 IMT will consist of the senior house officer years and early registrar years, followed by Stage 2 IMT which will incorporate higher subspeciality training alongside continued training in Internal Medicine.

2. **Stage 1 IMT should prepare the Trainee for Stage 2 IMT.**
   The three years of Stage 1 IMT will have distinct emphases, exposures, and competencies with the aim of preparing the Trainee for entry into Stage 2 IMT and practice as a Specialist Registrar.

3. **Trainees receive feedback on admissions.**
   All hospitals receiving Internal Medicine Trainees must put in place formal, verifiable arrangements where Trainees involved in frontline medical take receive dedicated feedback on some or all the admissions that have been completed by IM Trainees.

4. **Trainees must log learning exercises based on the entirety of the Patient Journey.**
   Once a month, each Trainee must log a learning exercise based on following a patient they admitted through their hospital stay and post-discharge. This is mandatory for satisfactory completion of the module.

5. **Integrated care module to teach Trainees about the role of internal medicine in the wider team.**
   An integrated care module is to be developed, consisting of a mix of teaching methods to instruct Trainees on the role of internal medicine physicians as part of integrated care.

6. **Pilot a model of partial or complete decoupling of IM from subspeciality commitments.**
   A partial or complete decoupling of the Internal Medicine commitments of doctors from subspeciality work has the potential to improve patient care, training and reduce burnout. This should be piloted on an appropriately resourced site.

7. **RCPI should form a working group to promote IM in Ireland.**
   RCPI should form a working group or taskforce to promote the role of Internal Medicine (IM) in Ireland, and educate doctors, patients, the public, administrators and politicians about this vital function.

8. **Participation in general medical rota and training is important for physician career advancement.**
   Participation in the general medical rota, and in the training of future general internal medicine specialists should be recognised by health service providers, training colleges and universities as important factors for academic and professional advancement of physicians.

9. **Internal Medicine physicians should be adequately represented on IMT/HST interview panels for dual accreditation.**
   Greater representation on Stage 2 IMT/HST interview panels for dual accreditation should be afforded to Internal Medicine physicians. Accepting that exigencies may arise, the best practice would be for not fewer than two Internal Medicine physicians who are not dual trained in the relevant subspeciality to sit on the interview panel.

10. **Physicians with generalist roles should be centrally involved in curriculum development.**
    Physicians whose primary roles are as generalists should play a key role in Curriculum development in Internal Medicine training at stage 1 and stage 2.

11. **Specialities should be encouraged to take part in dual accreditation training.**
    Specialities who are currently not engaged in dual accreditation training at HST level should be regularly invited and incentivised to take part in the Stage 2 IMT/HST training programme.

12. **Trainees in Stage 1 IMT must have critical care experience.**
    Each Trainee in Stage 1 IMT should have a period in a defined critical care setting.

13. **Curriculum should focus on cross-subspeciality issues such as frailty, multimorbidity and polypharmacy.**
    Curricula in frailty, multimorbidity and polypharmacy should be devised and embedded in the Internal Medicine training programme.

14. **Trainees must learn to use medical interventions responsibly.**
    Trainees must receive instruction and complete reflective practice exercises on the limits of medicine and the appropriate and judicious use of medical interventions and investigations.

15. **Single speciality training in IM should be explored by IoM in relation to future workforce configuration.**
    The possibility of single speciality training in IM should be explored by RCPI in conjunction with relevant stakeholders. A mechanism exists whereby such a scheme of training can be harmonised with the changes proposed in this document.

16. **Clinical Practice Coordinators to support Trainees in internal medicine.**
    A network of Clinical Practice Coordinators should be established to support Trainees in internal medicine.

17. **Training hubs should have simulation facilities and a simulation lead.**
    Each training hub should be required to have facilities for simulation, and a dedicated simulation lead for Internal Medicine Training.

18. **Training hubs should have POCUS facilities and accredited Trainers.**
    Each training hub should be required to have facilities for Point of care ultrasound (POCUS), and a curriculum and network of accredited Trainers be established in this topic.

19. **RPDs should have 0.5 WTE backfill and 1.0 WTE administrative support.**
    Each Regional Programme Director (RPD) should have 0.5 WTE backfill for their clinical duties and a 1.0 WTE administrative support for the running of their programme, which does not need to be in the same hospital as the RPD.

20. **Establish 1.0 WTE DIMT post to set standards and manage RPDs.**
    A 1.0 WTE Director of Internal Medicine Training (DIMT) post should be established by RCPI at consultant physician grade, whose responsibility it is to set standards in IMT and manage the network of RPDs.

21. **Trainees must be able to access technology in all training sites to access virtual learning and link with other Trainees and Trainers.**
    Trainees must be able to access technology in all training sites to access virtual learning and link with other Trainees and Trainers. Appropriate technology should be in place to allow Trainees at all sites to take part in remote learning, allowing integrated learning opportunities across all sites in a training region.

22. **Educational supervisor for Trainees in Stage 1 IMT.**
    Each Trainee in Stage 1 IMT should have a named educational supervisor who will be a source of continuity over the three-year period of their training and work alongside their clinical supervisor which will change from post to post.

23. **Trainees should be asked to provide feedback on training and supervisors.**
    Trainees should have an opportunity to and be requested to provide feedback on their training, and their educational and clinical supervisors.

24. **Supervisors should earn internal CPD points for supervising Trainees.**
    Time spent supervising Trainees should be reckonable for internal CPD points for educational and clinical supervisors.

25. **Sites offering IMT undergo 360-degree feedback review on a 2-yearly basis, with green being satisfactory, amber requiring an improvement plan, and red suspending training.**
    Sites offering IMT undergo 360-degree feedback review on a 2-yearly basis. This will encompass feedback from Trainees, adherence to training recommendations, provision of a clinical teaching programme, and pass rates in exams. This is co-ordinated by the DIMT and communicated from them to the RPD and site leads as well as hospital CEOs and medical/clinical directors. Sites will be graded green, amber and red. Green is satisfactory, amber requires an improvement plan and when red lights are triggered, DIMT may suspend IM training at that site.

26. **Establishing Speciality training Committee (STC).**
    An integrated IMT speciality training committee (STC) should be established to oversee IM training in its entirety through stage 1 and 2.

1.0 Introduction and Background

1.1 Context

Ireland has an excellent international reputation for training doctors, but it is imperative that we continue to ensure that our training programmes produce skilled, competent and experienced doctors to meet changing demographics and societal demands. Challenges to current training include an increasingly ageing population, increasing rates of co-morbidities, as well as system changes such as the introduction of the European Working Time Directive (EWTD), patient expectations and participation, and changing consultant contracts.

The Institute of Medicine (IOM) was established in 2020 to oversee training and professional affairs relating to specific affiliated specialties. A key aim of the IOM was to improve governance and integration of Internal Medicine (IM) training, and to ensure that training is reviewed, optimised, and benchmarked to international standards to graduate exceptional general physicians into the future.

The training and skills required by the physician medical workforce are dynamic and continuously evolving. Reflecting the complex co-morbid nature of acute medicine and the inherent training structures, the level of generalist skills in internal medicine appears to be declining *('Securing the future of excellent patient care', Greenaway Report 2013, U.K.)*. International standards for training have shifted to more structured internal medicine training. In some countries, this leads to a career as an internist/hospitalist, while in others, Trainees generally complete stage two training in another medical subspecialty.

In Ireland, training has also evolved over the last decade. The Imrie Report *'Training 21st Century Clinical Leaders'* was published in 2014, with a major recommendation from that being the protection and definition of the role of the Internal Medicine physician. Following from that, core training and subsequent higher training in Internal Medicine were reviewed and reorganised *(RCPI, Keane Reviews 2014 and 2016)*. These reports resulted in significant improvements in IM training, but an integrated assessment of training outcomes across grades is still required.

Given these reports and changes over the past decade, alongside the establishment of the IOM in2020, it is now an opportune time to review the outcomes and governance structures of IM training. This is essential to ensure optimal content and integration across training stages, such that doctors emerge from training with the required knowledge and skills in internal medicine relevant to the needs of patients in Ireland.

1.2 General Medicine Training in Ireland

The Medical Council accredits training in Internal Medicine through the awarding of specialist certification as part of dual speciality training, and subsequent registration on the specialist division of the register in IM. The IOM is the recognised training body tasked with the oversight and delivery of this training. Presently Trainees first complete basic specialist training (BST) over a 2-year period. The MRCPI examination and satisfactory periodic assessments are required to receive BST certification, and such certification is required to enter higher specialist training (HST). HST training in internal medicine occurs as a dual training programme in nine specialties (Cardiology, Clinical Pharmacology and Therapeutics, Endocrinology, Gastroenterology, Geriatric Medicine, Infectious Diseases, Nephrology, Respiratory Medicine, and Rheumatology). The programme duration is generally 5 years, including one full year of GIM training. Upon qualification, consultants in GIM have traditionally participated in both general on-call services, and also provide a subspecialty service. Increasingly, doctors in Internal Medicine practice have seen their roles expand, as presentations across a broad spectrum of specialisms are with ever-increasing frequency admitted under IM teams. These include but are not limited to conditions such as trauma, rehabilitation, acute neuropsychological distress and disturbance and a range of conditions that may previously have been managed surgically but are now within the compass of non-surgical interventions such as interventional endoscopy and radiology.

1.3 Aim and Objectives

The aim of the OPTIMISE project is to review internal medicine training at basic and higher specialty level in Ireland, and to report on the best programmatic structure required to deliver an integrated training experience and ultimately a clinical workforce that is equipped to provide healthcare to the Irish Population in the future.

The objectives of the *OPTIMISE* project are as follows:

- *Perform a detailed review of the present governance and structure of training in General Internal Medicine in Ireland.*
- *Benchmark against international and evolving standards of training in Internal Medicine.*
- *Develop a proposal for an integrated basic and higher training in an outcome-based programme with flexibility for change in the future – to include recommendations on the resources required to deliver that change.*
- *Recommend a continuous quality assurance and improvement for Internal Medicine training into the future.*

2.0 Methodology

2.1 Project Terms of Reference (TOR)

The Terms of Reference define the key themes and areas for review. A comprehensive process of evidence gathering, and consultation was undertaken to address these. The TOR are included in the appendix section (6.1).

2.2 Steering Group Formation

Membership of the Steering Group Committee was chosen by the Clinical Lead, in conjunction with the IOM Dean and Officers. Members were chosen to reflect the skill mix required to input and contribute to this review of GIM training. Membership included representation from Training Directors at basic and higher specialty level, Trainees, an external expert and lay membership.

Membership is outlined in Table 1 below:

Name	Role
Prof Anthony O'Connor	*Clinical Lead, OPTIMISE*
Prof Anthony O'Regan	*Dean, Institute of Medicine*
Dr Ed McKone	*Director of Training, Institute of Medicine*
Prof John McDermott	*Associate Director, BST*
Prof Mike Watts	*Associate Director, HST*
Dr Marcia Bell	*National Specialty Director, HST GIM*
Dr Seán Fleming	*National Specialty Director, HST GIM*
Dr Emer Kelly	*Fellow on Council*
Prof Cathy McHugh	*Regional Programme Director, BST*
Dr Pat Barry	*Regional Programme Director, BST*
Dr Lucy Ann Behan	*Director of Exams, RCPI*
Dr John McManus	*IOM Education and Training Committee Member*

Trainee Reps	Role
Dr Emily Buckley	*HST Trainee Representative*
Dr Elaine Loughlin	*HST Trainee Representative*
Dr Rachel Bourke	*BST Trainee Representative*
Dr Michael Strader	*Trainee Representative IMG*
Internal RCPI	**Role**
Colm Small	*Head of Training, Exams*
Ann O'Shaughnessy	*Head of Education*
Louis Lavelle	*Training Manager*
Jessica Dowling	*AIP Manager*
Roisin Craven	*Project Manager, AIP*
Anjitha Radhamoney	*Project Manager*
Aisling Smith	*Education Manager*
Janet O'Farrell	*Research Manager*
Hadas Levy	*Health and Wellbeing Manager*
Reps (other)	**Role**
Commandant Barry Ryan	*Lay Member*
Dr Mike Jones	*External GIM Expert*

The Terms of reference for the Steering Group is included in the appendix section (6.1).

The Workshop which took place in March 2023 provided invaluable feedback, the full list of attendees in appendix section 6.4

2.3 Working Group Exercise

As part of phase 1 of this project, three areas were identified for focused review and discussion:

1. People
2. Training Structures
3. Content & Methodology

Three working groups were formed from the membership of the Steering Group, each with a specific focus area. These working groups met twice over a 2-month period and were provided with a set of questions / considerations to provide feedback on.

2.4 Information Gathering

In order to collate the data and information required, meetings and workshops were held with a wide range of stakeholders. The stakeholder engagement process included meetings with the following individuals / groups:

Internal (RCPI)

- *Institute of Medicine Officers and Board*
- *Regional Programme Directors for BST*
- *National Specialty Directors for HST*
- *BST and HST Trainees*
- *Trainers*
- *RCPI Council, Executive and Senior Management Team*
- *RCPI Training Committee*
- *RCPI Trainees Committee*

External Committees / Organisations

- *Acute Medicine Programme*
- *National Doctors Training and Planning (NDTP)*
- *Chief Clinical Officer / Health Service Executive*
- *National Clinical Director for Integrated Care & National Clinical Advisors and Group Leads (NCAGLs)*
- *Irish Medical Council*

We also consulted with Internal Medicine physicians and experts internationally – including in England, the Netherlands and in Australia.

2.5 Communications

A communications plan was developed with the support of the RCPI Communications team. A dedicated email address (optimise@rcpi.ie) was set up as part of this to allow interested stakeholders to feedback directly on aspects of the project.

As part of the communications plan, a college-wide consultation was held requesting feedback and input on the OPTIMISE project via the President's monthly ezine (December 2022). This ezine is sent to all RCPI subscribers' Learners, Trainees, Members and Fellows.

The Annual Winter Symposium for the Institute of Medicine was held in January 2023. It was agreed that the focus of this meeting would be General Internal Medicine training. The meeting featured international leading experts in Internal Medicine, and all relevant stakeholders (both internal and external) were invited to this meeting. Attendees were provided with the opportunity to actively engage in discussions on the restructure of Internal Medicine training in Ireland.

Wider engagement with the medical community / general public was achieved by the publication of articles in the Medical Independent (January and March 2023). An OPTIMISE landing page on the RCPI website will be launched in August 2023.

3.0 Results

3.1.1 Internal Medicine Training in RCPI

Internal Medicine training falls under the remit of the Institute of Medicine, and in its first term, the Board identified Internal Medicine as an area of focus. The scale of the specialty is illustrated by the fact that, presently over 600 doctors are training in IM and this number is likely to increase over time. This represents almost half of all Trainees in the RCPI at a given time.

An overview of the current status of IM training at both basic and higher specialty level is outlined below.

3.1.2 Basic Specialist Training

BST IM is a relatively broad programme and offers Trainees the chance to experience a range of subspecialties, providing an excellent foundation for further specialist training. The programme duration is two years, and Trainees rotate 3 monthly through acute specialties. A Trainee will normally be informed of their assigned rotations for the two years of the scheme. Training takes place nationally across nine schemes utilising a common core curriculum.

During BST, Trainees must rotate through three of five core specialties (Table 2 below), and a full rotation must include time in a level 4 hospital, and a level 3 or level 2 hospital, with a minimum of 6 months spent outside of the metropolitan area (Dublin/Cork/Galway). Each Trainee must spend at least 18 months on-call – with a minimum of 12 months on general medical unselected call.

During the programme, Trainees will be assigned a registered RCPI Trainer for each of their 3-month rotations, and it is also advised that posts include registrar cover. In addition to supervised clinical training, the Membership of the Royal College of Physicians of Ireland (MRCPI) examination in General Medicine must be passed, and Trainees must attend a number of study days and mandatory courses (see Table 3) to complete BST and receive certification. This will enable Trainees to apply for entry to Higher Specialist Training.

Table 2: *BST IM Core specialties*

Speciality
Cardiology
Respiratory Medicine
Geriatric Medicine
Endocrinology
Gastroenterology

Table 3: BST GIM Mandatory Courses

Mandatory Courses
BST Leadership in Clinical Practice: Online
BST Leadership in Clinical Practice: Leadership Skills
BST Leadership in Clinical Practice Communication Skills
Ethics, Prescribing Skills & Blood Transfusion for GIM
Advanced Cardiac Life Support (ACLS)
Infection Control (Hospital Induction)
Additional Resource Courses
How to Survive Acute Take
Online Video Tutorials

3.1.2.1 BST Hub and Spoke Model

Following the Keane Review of basic specialist training in 2014, it was recommended that a hub and spoke model be introduced for the BST GIM programme. A resulting nine 'hubs' with associated 'spoke' sites were identified (Table 4) - this was a reduction from 19 individual schemes. Each BST hub and spoke programme has an appointed Regional Programme Director (RPD) overseeing the delivery of the regional programme, and there are also appointed Training Leads in 'spoke' hospitals.

During a Trainees' application process, hubs are ranked in order of preference. First-round matching of Trainees to a hub is based on interview scores, followed by second-round matching against specific rotations over the 2-year programme. RCPI will send the details of all Trainees and matched posts to Medical Manpower teams on the relevant sites.

Table 4: BST IM Hub and Spoke Model

BST IM Hub	Spokes and number of posts per hub
Galway	GUH
	Sligo Regional Hospital
	Letterkenny General
	Mayo General Hospital
	Portiuncula Hospital Ballinasloe
	Roscommon Hospital
	Mayo Clinic USA

BST IM Hub	Spokes and number of posts per hub
Mater	Mater
	Connolly Hospital
	Our Lady's Hospital Navan
	Our Lady's Hospital Drogheda
	Mullingar General Hospital
	Letterkenny General Hospital
	Mayo Clinic USA
South	Cork University Hospital
	Mercy University Hospital
	Marymount Hospice
	Mallow General Hospital
	Bantry General Hospital
	University Hospital Kerry
	South Tipperary Hospital Clonmel
	University Hospital Waterford
Mid-West	University Hospital Limerick
	Ennis Hospital
	Nenagh General Hospital
	St John's Hospital
	South Tipperary Hospital Clonmel
Mayo/Sligo	GUH
	Mayo
	Sligo
	Roscommon
James's/Tallaght	James's
	AMNCH
	Mullingar
	Portlaoise
	Tullamore
	Naas
	Waterford
	Wexford
	St. Luke's Hospital, Kilkenny
	St Colmcilles
	St Luke's Rathgar
	Peamount

BST IM Hub	Spokes and number of posts per hub
Beaumont-Connolly	Beaumont
	Connolly
	Our Lady's Hospital Navan
	Our Lady's Hospital Drogheda
	Cavan
	St Luke's Rathgar
	National Rehab
	St Joseph's Rahey
	Bons Glasnevin
Vincents	Vincents
	Waterford
	St. Luke's Hospital, Kilkenny
	Wexford
	St Colmcilles
	National Rehab
	St Michaels Dún Laoghaire
	Letterkenny University Hospital, Donegal
South-East	Waterford
	Wexford
	Kilkenny
	South Tipperary Hospital Clonmel
	CUH

3.1.3 Higher Specialist Training

HST programmes are designed to produce doctors who are leaders in their fields. Through participation in a training programme, Trainees will develop the advanced skills and knowledge required for practicing independently, leading a clinical team and managing the everyday challenges of our health service. HST is generally a four-to-six-year training programme, depending on specialty, and is completed in Specialist Registrar (SpR) posts. Upon successful completion of HST, Trainees receive a Certificate of Satisfactory Completion of Specialist Training (CSCST) and become eligible to register with the Medical Council of Ireland as a specialist.

Higher specialist training in Internal Medicine occurs as a dual training programme in the following nine specialties: *Cardiology; Clinical Pharmacology & Therapeutics; Endocrinology; Gastroenterology; Geriatric Medicine; Infectious Diseases; Nephrology; Respiratory Medicine; Rheumatology.*

For clarification, the IOM also offers standalone higher training in eight single specialties *(Clinical Genetics, Dermatology, Genito-Urinary Medicine, Medical Oncology, Neurology, Palliative Medicine, Pharmaceutical Medicine, and Rehabilitation Medicine)*, which does not involve internal medicine training after basic specialist qualification.

The HST programme in IM is currently delivered alongside the specialty curriculum, and dual-programme Trainees are expected to complete the requirements for both programmes over the course of training. The programme duration for dual training is generally 5 years and Trainees may prospectively request approval of one year of research as part of their training programme. Additional out-of-programme clinical experience may also be approved e.g., to complete a PhD/MD.

Trainees on a dual programme are required to complete one full year of their HST in an IM role, and this year should be undertaken in a post supervised by a Trainer who is not a Trainer for their subspecialty. In this post, Trainees will cover the general medical on-call rota and are required to complete requirements for the IM curriculum only, including requirements for procedures, general medicine outpatient clinics and workplace-based assessments. It is also expected that over the course of HST dual training in its entirety, Trainees will be exposed to and partake in general medicine commitments in order to fulfil curriculum requirements.

Following the Keane review of HST GIM training in 2016, a number of conditions were put in place for the IM component of dual training:

- *The IM year must be completed within the first 3 years of specialty training.*
- *The dedicated IM year should comprise a minimum of two rotations in different subspecialties, teams, and settings (not the Trainee subspecialty).*
- *The IM year should comprise a maximum of 4 months in a level 4 hospital; a minimum of six months in a level 3 hospital and may also include an approved post in a level 2 hospital - but for not more than 4 months.*
- *The IM year rotations should be geographically close enough to each other not to require Trainees to move house during that period.*

Trainees are generally assigned to training posts for their first 3 years on a HST programme. Posts are generally assigned by National Speciality Directors of the respective training programme, based on the following criteria: *Training Needs; Trainee Preferences; Seniority (or ranking at interview in case of candidates who interview for entry into the programme); Post availability/geographic distribution.* Final allocations are reviewed and agreed by the relevant Speciality Training Committee. IM training posts are required to be signed off by both the National Speciality Director for the Speciality and for IM. At a minimum Trainees will be informed within 13 weeks of the commencement of the post.

3.1.3.1 Examinations

Specialty examination requirements vary across RCPI programmes within the Institute of Medicine. Nine programmes require Trainees to sit a specialty examination during higher specialist training – see Table 5 below. There is no knowledge-based assessment for general internal medicine. The requirement for this is something that is currently being considered internationally and may need to be explored further in the fullness of time.

At present, knowledge-based specialty exams at HST level are not offered by RCPI, and where a training programme requires the completion of an exam, Trainees will complete an examination from another jurisdiction. RCPI Trainees are not required to pass examinations from external providers in order to attain CSCST unless a formal agreement is in place with the provider where the curriculum is aligned to the examination and data is reportable to the college e.g., FRCPATH examination.

Table 5: *Speciality Examination Requirements – Dual training Programmes*

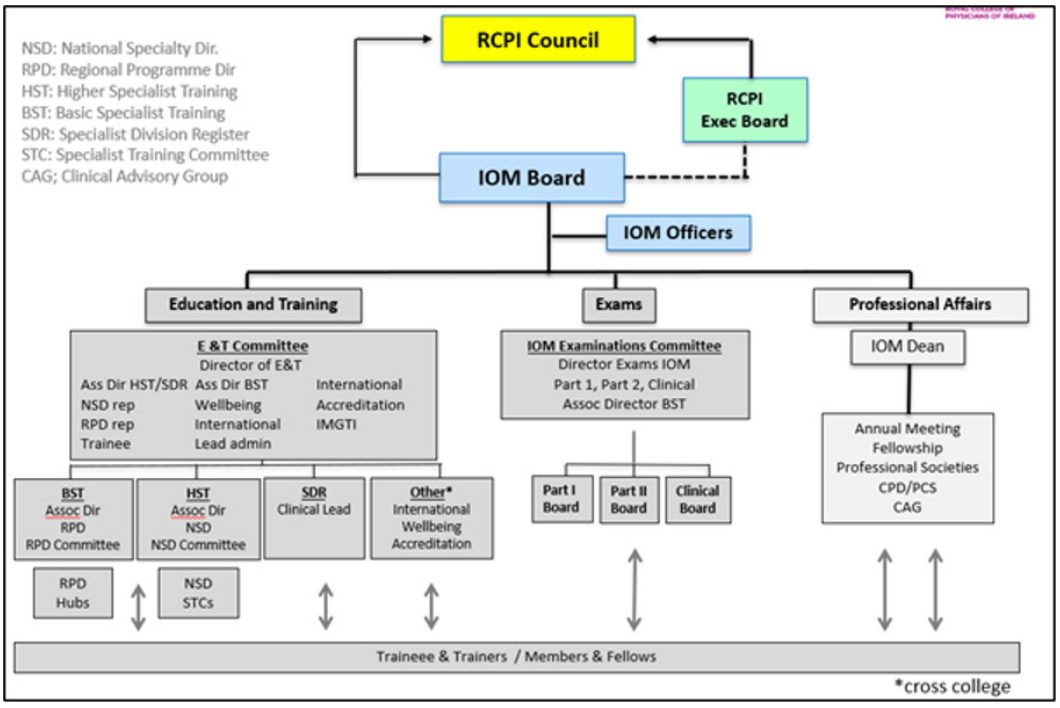
Specialty	Exam
Cardiology	Specialty exam ***desirable*** as per curriculum
Clinical Pharmacology and Therapeutics	No Exam
Geriatric Medicine	Exam ***desirable*** as per curriculum
Infectious Diseases	Infectious Diseases Society of America Fellows In-Training Exam – ***required***
Nephrology	American Society of Nephrology In-Training Exam – ***required*** ASN NephSAP online multiple-choice continuous assessment questions - ***required*** European Speciality Exam in Nephrology (ESENeph) – ***desirable***
Respiratory Medicine	Trainees are ***encouraged*** strongly to sit the Harmonised Education in Respiratory Medicine for European Specialists (HERMES) exam before the end of their second clinical respiratory year (no later than year 3 in the GIM/Resp program). We would also encourage the results of this test to be made available to the two National Speciality Directors.
Rheumatology	European Alliance of Associations for Rheumatology (EULAR) - ***mandatory*** for new entrants to the programme
Gastroenterology	Attempt one exam e.g., European Fellowship – ***desirable***
Endocrinology	MRCP – UK Endocrinology and Diabetes special certificate examination in year 3 or 4 - ***required***

3.1.4 Governance of Internal Medicine Training

The Institute of Medicine is the overarching governing body for Internal Medicine Training. At present, the BST and HST IM programmes operate independently with limited governance, curricular, or operational integration. This is suboptimal as training involves building skills and experience in a formative and summative manner. With the establishment of the IOM in 2020, structures and processes are being put in place to address this.

The Dean and Director of Training and Education for the IOM oversee the delivery and development of the BST and HST training programmes. Supporting them in their roles are the Associate Director for BST, Associate Director for HST IM and the National Speciality Directors for HST. This is illustrated in Figure 1 below.

Figure 1:



In basic speciality training, the Associate Director oversees the development and delivery of the BST IM Programme. Supporting the Associate Director are the Regional Programme Directors (RPDs). Each BST hub and spoke programme has an appointed RPD overseeing the delivery of the regional programme, working alongside appointed Training Leads in 'spoke' sites. The Associate Director chairs the RPD Forum which meets quarterly and reports to the IOM Education and Training Committee.

At HST level, each specialty training programme has an appointed National Speciality Director(s) (NSDs), who chairs the Speciality Training Committee (STC). NSDs are supported in their roles by Regional Advisors and integrated Internal Medicine Leads where required. A key responsibility of the NSD(s) is to provide advice, career guidance and support to Trainees on issues relating to training, examination and general queries relating to the specialty. The NSD and STC report to the

IOM Education and Training Committee and meet at a minimum quarterly. Given the nature of dual training, a separate STC exists for GIM training, chaired by 2 NSDs for Internal Medicine.

The function of the RPD Forum at BST level and STC at HST level is to actively participate in the development and delivery of postgraduate specialist training in the defined specialty, under the governance of the training body. All decisions and proposals for changes relating to the development and delivery of a training programme must be approved by the IOM prior to implementation by the STC/RPD Forum.

3.1.5 Trainer and Trainee Data

3.1.5.1 Trainers

Trainers play a crucial role in the delivery of Basic and Higher Specialist Training programmes. RCPI recognises that the quality of training depends to a large extent on Trainers' clinical experience and expertise, along with competence, aptitude, attitudes, and abilities as good role models. The primary focus of the RCPI Trainer is to oversee RCPI Trainees' development and education at all training levels, through their involvement in teaching, training, evaluation, and supervision.

The following criteria are required to be a registered Trainer:

- *Be registered on the relevant specialist division of the Medical Council Register*
- *Be registered on a professional competence scheme*
- *Practise at a consultant level/equivalent post in Ireland (must hold permanent contract)*
- *Complete and submit the online Trainer application form*
- *Complete the Physicians as Trainers Essential Skills course*
- *Complete the Trainer's Refresher course when required*
- *It is also desirable for the Trainer to be a Fellow of the relevant training body.*

Presently, there are over 800 Trainers registered with the Institute of Medicine, the majority of whom will be involved in some capacity as a Trainer for IM Trainees at either or both BST and HST level. Current guidance suggests that at HST level no Trainer can have more than one HST Clinical Trainee - this rule can however be reviewed by the IOM under exceptional circumstances. At BST level it is recommended that no Trainer should have more than two RCPI Trainees. As it stands, it is also possible for a Trainer to supervise both HST and BST Trainees simultaneously.

3.1.5.2 Trainees

As previously alluded to, there are greater than 600 doctors training in IM in this training year (July 22 – July 23) and it is expected that this number will increase over time. The breakdown of Trainee numbers across BST and in dual specialty HST training programmes is outlined below:

- **BST** – *there are approximately 555 Trainees registered as part of the 2-year BST GIM programme. Trainees are placed across the nine hub and spoke sites, rotating on a 3-month basis.*

- **HST** – *Across the nine HST dual training programmes, there are approximately 80 Trainees in an IM post. The number of Trainees on their IM year varies per specialty in any given year, and the breakdown for this training year across each of the specialties is outlined in the table below. The figure on the left is the number of Trainees in their IM year, and the figure on the right (in brackets) is the total number of Trainees registered on that HST dual specialty programme.*

Table 6: *HST IM Trainee data*

Specialty	#IM Trainees 2022 – 23
Cardiology	10 (59)
CPT	0 (6)
Geriatric Medicine	20 (94)
Infectious Diseases	7 (37)
Nephrology	8 (31)
Respiratory	9 (58)
Rheumatology	4 (27)
Gastroenterology	11 (57)
Endocrinology	4 (39)
Total	80 (431)

3.1.6 Education – IM Curricula

The BST IM curriculum last underwent review in 2019 and is the first iteration of an outcome-based curriculum for this programme. The curriculum is aimed at Senior House Officers (SHOs) in training and their supervising Trainers. It outlines the knowledge, skills and professional attributes that should be attained and developed during BST. This Curriculum is aligned with the MRCPI examination syllabus. The curriculum can be viewed here: BST IM curriculum.

At HST level, there is no separate curriculum document for IM. The IM aspect of HST training is captured within the curricula of each of the dual specialty programmes. As per the curricula, it is expected that on completion of HST, the Trainee will be able to identify and treat immediate life-

threatening common medical presentations, form a differential diagnosis for non-life-threatening cases and effectively manage the patient, including further investigation and appropriate referral.

Examples below:

HST Geriatric Medicine Curriculum (IM section from page 30)

HST Respiratory Medicine Curriculum (IM section from page 14)

3.1.7 Training Sites

Trainees in IM programmes across both BST and HST rotate across level 2, 3, and 4 sites. Currently there are approximately 36 sites across Ireland where Trainees can be sent for their IM rotation. These are outlined in Table 7 below.

Table 7: *IM Training Sites*

IM Training Sites		
Bantry General Hospital	Mayo University Hospital	St James' Hospital
Beaumont Hospital	Mercy University Hospital	St John's, Limerick
Bons Secours Glasnevin (Under Beaumont)	Midland Regional Hospital, Mullingar	St Joseph's Raheny (under Beaumont Hospital)
Cappagh Hospital Dublin	Midland Regional Hospital, Portlaoise	St Luke's Hospital Kilkenny
Cavan General Hospital	Midland Regional Hospital, Tullamore	St Luke's, Rathgar
Connolly Hospital	Naas General Hospital	St Vincent's University Hospital
Cork University Hospital	Nenagh General Hospital	Tallaght University Hospital
Ennis Hospital	Our Lady of Lourdes, Drogheda	University Hospital Waterford
Galway University Hospital	Our Lady's Hospital, Navan	University Hospital, Kerry
Letterkenny General Hospital	Sligo University Hospital	University Hospital, Limerick
Mallow General Hospital	South Tipperary General Hospital	Wexford General Hospital
Mater Misericordiae University Hospital	St Columcille's Hospital	

Since the 2021 rollout of the new RCPI Site Quality Improvement visits, all sites are assessed on their delivery of training at both BST and HST level, including those hospital sites for IM outlined in Table 7 above. These visits evaluate the Trainee, Trainer and site environmental factors that influence training outcomes.

As part of this process, sites are asked to demonstrate their ability to meet specific generic as well as specialty standards for training, in order to maintain their training status and have BST and HST Trainees rotate through them. This is assessed by the NSDs for the training programme and by an independent extern from outside the Irish healthcare system.

The standards for which both BST and HST internal medicine sites are assessed against are detailed in the appendix section (6.2 and 6.3).

3.2 International benchmarking exercise findings

As part of this review, international models of IM training were taken into consideration. A number of countries were selected for review, with a focus on the following areas: *training duration*, *governance*, *admission*, *curricula*, *skills training*, *assessment and outcomes*.

A high-level overview of our findings from this piece of work is outlined in the sections below.

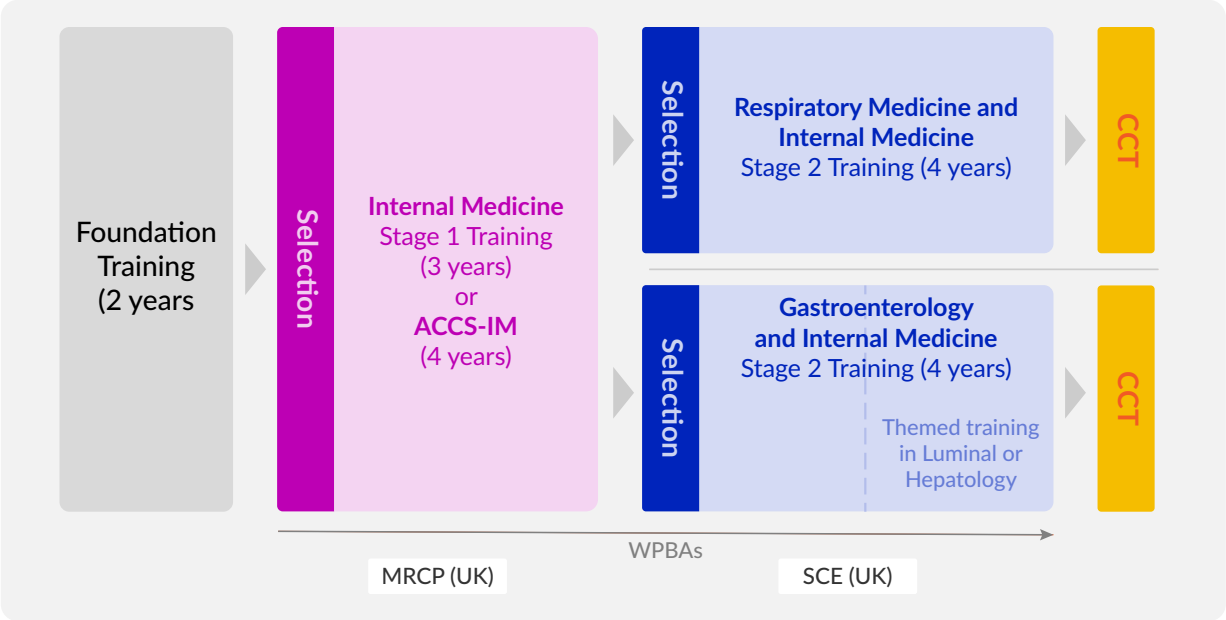
3.2.1 United Kingdom

In the UK, on the back of an in-depth review, the Internal Medicine Training (IMT) programme was restructured, and the new programme introduced in 2019.

Internal Medicine Training follows on from the completion of the foundation programme. The IMT programme is three years, although Trainees are eligible to apply for a number of specialties after completion of the second year. Training involves rotations of typically either four or six months in duration. Specialty training programmes have been categorised as Group 1 specialties that dual train in Internal Medicine and specialty, and Group 2 specialties that train in specialty alone (Group 2 specialties may recruit Trainees who have completed two years of IMT whereas the entry criteria for Group 1 specialties is to complete the entire three years of IMT or equivalent). For those specialties that dual train (Group 1), specialty training for the most part is 4 years in duration. This is the case for all specialties except cardiology, where specialty training lasts 5 years.

The curricula for Group 1 specialties have their learning outcomes for Internal Medicine and specialty inextricably linked so it is not possible to complete training in speciality without completing training in Internal Medicine. Higher specialty training in Group 1 specialties mandates a further indicative year of Internal Medicine Training to fulfil the requirements of the Internal Medicine Stage 2 curriculum.

Example training pathways are illustrated below:



3.2.2 Netherlands

In order to gain insight into an Internal Medicine training pathway in central Europe, we reviewed the structure and detail of the Netherlands training programme.

At a high level, Internist training lasts six years and takes place across both academic and peripheral hospital settings. Over the six-year programme, training is structured as follows:

- *The first four years of training are divided into short medicine rotations / internships most, lasting approx. 4-8 months. Trainees will generally gain experience in the following areas:* ***outpatient clinics and consultation, ward-based medicine, ICU, emergency department, others (cardiology/pulmonology/geriatric medicine)****, as well as having time in an elective.*

- *Differentiation takes place in the 5th and 6th year, whereby a choice can be made for a single differentiation of 24 months, or a multiple differentiation, consisting of 2 or 3 differentiation components of at least 8 months each.*

In recent years, skills training in the areas of Point of Care Ultrasound (POCUS) and simulation have been introduced. Alongside these, there has been increased incorporation of professional skills (e.g., management, education, teaching) as part of training programmes.

3.2.3 Australia

In Australia, training in Internal Medicine takes place over six years. Three years of Basic Physician Training (BPT) in Adult Internal Medicine is followed by a three-year advanced programme in General and Acute Care Medicine.

During BPT, Trainees must complete at least 24 months of 'core' training and 12 months of 'non-core' training, with training rotations lasting 3 months (Information on core and non-core training here: https://www.racp.edu.au/Trainees/basic-training/adult-internal-medicine). In the final year of BPT, Trainees will generally attempt to complete the divisional written and clinical examination – completion of this exam is required for entry to an Advanced Training Programme.

Advanced training in General and Acute Care Medicine is a three-year programme during which again Trainees must complete core and non-core training. Core training over 24 months is generally broken into 6-month terms in the following areas: *Core General Medicine, General Medicine Related specialties, Acute Medicine and Sub-Speciality terms.* Non-core training can be done in one 12-month or two 6-month blocks (more info here: https://www.racp.edu.au/Trainees/basic-training/adult-internal-medicine). In addition to this, Trainees are also required to complete an Advanced Training Research Project in order to complete the training programme.

Dual training is also possible in Australia, generally lasting 4 years in duration at Advanced Training level. However, this is uncommon and most General Medicine physicians are single-specialty trained (in General and Acute Care Medicine).

3.2.4 United States of America

In the USA, basic training in internal medicine is three years of residency training (termed 'categorical' training) following medical school. Residency may include rotations in a university or teaching hospital, intensive care unit, various subspecialty clinics, outpatient clinics, and often community medical practices. The structure of rotations can vary across institutions. For the most part, training occurs in blocks of approx. 4-6 weeks. During each block, residents will spend a defined number of weeks rotating across areas such as inpatients, consults, and elective, and this is often followed by a week of longitudinal continuity clinic where Trainees will usually have some academic and admin time (e.g., Cleveland clinic programme). The goal of this structure is to optimize and maximize residents' exposure to ambulatory medicine without interfering with training in the inpatient setting.

Following completion of three years of training, residents are eligible for board certification in internal medicine, once licensing exams have been passed.

Internal medicine training may also be combined with training in another specialty, leading to board certification in both fields. These dual training programmes are generally structured to be shorter than the time it would take to complete an independent residency in both fields, and graduates of these programs are particularly qualified to care for patients in both areas of focus. Examples include internal medicine and paediatrics, emergency medicine, and psychiatry.

3.3 Consultation and Stakeholder engagement – findings / feedback

As outlined in sections 2.3 and 2.4 above, an extensive stakeholder engagement and communications exercise was undertaken to gain feedback and input on the development of an improved Internal Medicine Training Programme. These meetings were structured and led by the Clinical Lead, Project Manager, and where required Facilitators were also brought in.

Feedback and findings from our meetings are captured below.

3.3.1 Working Group exercise

At an early stage of the project, the steering group was divided into three separate working groups and each group was given a specific focus area / theme and set of questions to consider. Two meetings were held with each working group and the feedback received has been summarized below:

Feedback from meeting 1 – October 2022

People	• Internal Medicine needs branding and champions • Transition from SHO to Reg should be improved – trainees feel unprepared and lack confidence • IM Trainers / consultants need more support and time – many competing priorities
Training Stuctures	• Introduction of 3-year BST could improve and standardize training (currently alot of variability across the 9 BST schemes) • Training experience in level 3 hospitals is valuable – could be improved and incentivized by offering simulation, POCUS, clinical / study blocks • 3-month rotation should remain for the most part • Medical ward rounds currently do not provide good learning experience given EWTD – need to reconsider how this works
Content and Mythology	• Handover needs to be emphasized as an important feedback and learning opportunity • Additional opportunities in ICU, CCU and AMU should be considered • Career planning and flexible opportunities are key to the success of the programme • Stronger governance and more strategic support from the HSE is required • MRCPI Exam review (in line with any curricular changes)

Feedback from meeting 2 – November 2022

- *Concern around lengthening BST GIM programme but acknowledgement of the benefit of having an additional year to facilitate the transition to Registrar level and improve trainee support –* **quality > duration**
- *Concern around practicalities of rolling out an additional year – impact on current BST programme, availability of posts etc*
- *If third year to be introduced, this year should be structured with an in-depth Trainee's assessment required to progress from year 2 to year 3, and decision around certification for those exiting after year 2 (need to market additional year well and ensure not perceived as service need)*
- *Level 3 hospitals – provide good learning opportunities for medical registrar roles given high volume of GIM unselected take – suggestion that part of the additional year should be spent in a level 3 hospital*
- *Discussions required with NSDs from each dual specialty to determine the impact this change would have on structure / content / length of HST programmes (does requirement remain for high-intensity IM year within HST block?)*
- *Cross subspecialty training would require engagement from all Trainers and disciplines involved - could be delivered / facilitated by study days, online tutorials, didactic learning*
- *Need to overcome issues in championing medicine – GIM needs more of an identity to make attractive*
- *IM activity should be better promoted at CPD, CME level / consideration for senior educational posts at consultant level to be rolled out with GIM programme*
- *If considering single specialty GIM training, would need clarity on job opportunities available at end of training programme and ensure appetite among Trainers and trainees*

3.3.2 Feedback from other sources

The majority of the feedback received was in line with those points raised through the working group exercise. Any additional points raised at meetings / submitted via the optimise email are outlined below:

- *Requirement for support from the HSE / NDTP emphasised*
- *Programmatic and administrative support will be key to the success of rolling out any recommendations / changes to the programme, at both central and local hospital site level*
- *Consider short medicine rotations of approx. 6-8 weeks in the first year of training in GIM (broad exposure)*
- *Emphasis on the importance of ensuring POCUS and Simulation training is rolled out at local sites and incorporated into training programmes – requirement for skilled Trainers in these areas is essential to the success of delivery*

- *BST IM Trainees should receive consistent high-quality feedback throughout the rotation and across all sites. Feedback should focus on the positives as well as areas for improvement and assist Trainees in their development*
- *BST core specialty rotation requirements should be reviewed*
- *Huge discrepancies in onsite clinical teaching in current BST GIM programme – many posts focus on service over training*
- *Governance of IM training should be reviewed and strengthened*
- *Importance of linking with community / integrated care to ensure captured in training programme*
- *De-coupling of IM from specialty on sites – for consideration*
- *Importance of adopting a culture of training (decouple from service)*
- *Increased supports for Trainers required*
- *Championing IM at management level in hospitals and universities is essential*
- *Importance of ensuring training in professional non-clinical skills is incorporated into the curriculum (leadership, management etc)*

3.3.3 Outcomes

The scope of the OPTIMISE project is vast and the level of engagement and feedback we received was enormous. As such, before embarking on the recommendations, we devised a set of outcomes that based on our consultations would define a good practitioner trained in Internal Medicine.

- *Gather and present an accurate and focused history from the patient and other sources as appropriate in order to formulate a sensible and accurate differential diagnosis.*
- *Be able to communicate information effectively and with civility to colleagues, patients and families, including where necessary open disclosure.*
- *Demonstrate an ability to identify and institute early management of the deteriorating medical patient.*
- *Prompt recognition of frailty and understanding of how to improve healthcare management and generate better health outcomes for frail older adults.*
- *Understand multimorbidity and its impact on patient outcomes and the healthcare systems and develop a framework for multimorbidity consultations.*
- *Understand polypharmacy and be able to conduct patient-centred consultations about it during a medication review.*
- *Understand the social determinants of health, social prescribing and the role of doctor as patient advocate.*

- *Demonstrate ability to lead care teams in chronic non-malignant disease.*
- *Understanding and implementing a judicious and evidence-based approach to investigations*
- *Use antimicrobials in a just and efficacious manner.*

3.4 Framework for optimised IM training

A framework for an optimised training programme in Internal Medicine should be based on the following five core principles:

- **Championing Internal Medicine**
  A broad range of Internal Medicine skills are the foundation of safe medical practice and are at least equal to subspecialist skills in the formation of the dual-trained specialist and of the greatest strategic importance to the hospital service.

- **A new Approach for the Practice of the 2020s and beyond**
  The current strategic training model of Internal Medicine, based around the clinical firm and apprenticeship is not reflective of modern-day hospital practice:

  — *The Trainee no longer has the same number of hours in direct clinical practice and continuity of care for medical inpatients as they would have expected when the current training programmes were designed.*

  — *New opportunities for feedback, learning and growth for learners in practice need to be developed.*

- **A new Approach for the Patients of the 2020s and beyond**
  Demographic factors, and advances in medical science and technology have and will continue to change the face of clinical practice at pace. To meet the challenges of clinical practice in the coming decades. training should be less about mastery of individual disciplines and more about cross-subspeciality work with emphasis on the acutely unwell patient, multimorbidity, frailty and polypharmacy.

- **Providing the Resources to Train**
  An increase in the complexity and breadth of training in internal medicine will require an increase in the human, administrative and technical resources to properly deliver it.

- **A new paradigm for the Trainer-Trainee relationship**
  Trainees no longer experience the master-apprentice model as practiced for so many years. A new method is required to ensure Trainers have the time, resources and skills needed to provide Trainees with the continuity of support, guidance and supervision they require to successfully complete training in Internal Medicine.

3.5 Recommendations

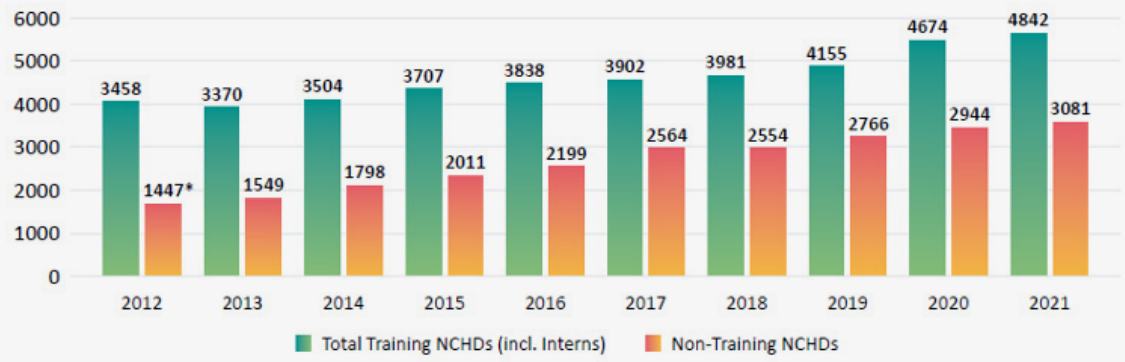
3.5.1 A new Approach for the Practice of the 2020s and beyond

While there is a common myth that postgraduate training in Ireland is longer and more arduous than in comparable countries, as illustrated in previous chapters, this is not necessarily borne out of reality. For example, a Trainee in Ireland currently is eligible to embark upon HST in PGY4, and as early as PGY3 in some specialties. By contrast, in the United Kingdom Trainees will complete two years of foundation year training, followed by three years of core medical training before being able to embark on HST in PGY6. In the European Union, the European Commission guidelines for dual specialty training with internal medicine is for a recommended duration of 9 years in total as a minimum, consisting for five years internal medicine and four years in an internal medicine specialty (Directive 2005/36/EC).

When BST training in Internal Medicine was first established in Ireland in the mid '00s, the average working hours of an NCHD were 75-77 per week as referenced in the Hanly report of 2003. The authors of that report, which was commissioned to reduce the average working hours to 48 hours per week to comply with the European Working Time Directive, would likely be shocked to learn that 20 years on that not only has this objective not been achieved, but that 38.8% of NCHDs are now operating in non-training scheme posts. However, while much progress is yet to be made, the average weekly hours have decreased significantly to an average of 53 hours per week. It can therefore be reasonably assumed that the amount of direct clinical contact and experience of acute medicine, unselected take and outpatient activity have decreased proportionally. Trainees themselves feel ill-prepared for the demands of the medical registrar role at the end of BST. In our consultation with Trainees, we were presented with an as yet unpublished survey by Trainee representatives conducted by and among BST Trainees in two of the larger Dublin Academic Teaching Hospitals, where EWTD compliance is at its highest found that an astonishing 94% of Trainees did not feel current BST teaching had prepared them to work as registrars. While this lack of preparedness reflects many issues, and is similar to experience in the UK, it is clear that EWTD compliance is necessary and appropriate to ensure the safety of doctors and patients. As such training programmes must adapt over time to changes in work practices, clinical demands, technology, and the science of medicine if they are to continue to train outstanding clinicians into the future.

As a consequence of this, Trainees in Internal Medicine frequently undertake a "gap year" working at registrar level in a chosen subspeciality between the end of BST and the start of HST. Almost half of successful applicants for HST have undertaken such a post with this number rising to 80-90% in certain specialties such as Gastroenterology. Such posts have contributed to the explosion in the proportion of NCHDs occupying unaccredited, non-training scheme doctor posts (NTSD), which now account for 38.8% of all NCHD posts in the system, at stark variance to the stated purpose of the Medical Practitioners Act 2007 which aimed to eradicate such roles. By contrast, their number has mushroomed over the period between 2012 and 2021 period from 1,447 to 3,081, in spite of a policy of reducing reliance on NTSDs (HSE NDTP 2022).

Figure 4.17 Non-training Scheme and Training Scheme NCHDs



**The number of NTSDs for 2012-2016 has been sourced from historic NCHD assessment reports, data from 2017-2021 is based on DIME.*

Taken from HSE NDTP Medical Workforce Report 2021-2022.

Taking into account these factors, the need for more posts to be part of accredited training schemes, the need to better prepare Trainees for working at registrar level and changes in work practices that have occurred since BST was instituted, we are proposing that the replacement for BST, which will be known as Stage 1 IMT will be extended to three years. Regarding HST training, there may not be a universal approach to how to determine the duration of training. In specialties where dual accreditation Trainees do not obtain considerable exposure to Internal Medicine, including the acute take and ongoing management of unselected medical patients, and dual accreditation is desired, then the high-intensity Internal Medicine year will likely need to remain. In other areas, where ongoing exposure to Internal Medicine is provided throughout IMT, the Internal Medicine curriculum review and the introduction of outcome-based training will facilitate looking at the duration of HST training into the future based on the individual training requirements. The IoM should be the final arbiter of the duration of training according to the derogation of authority in this area to IoM from the Medical Council of Ireland.

RECOMMENDATION 1

An Integrated Training Programme in Internal Medicine (IMT) will be established to replace the BST and HST programmes in General Internal Medicine. It will span the career from the end of intern year to CSCST. It will be divided into two phases. Stage 1 IMT will consist of the senior house officer years and early registrar years followed by Stage 2 IMT which will incorporate higher subspeciality training alongside continued training in Internal Medicine.

It is important for the development of Trainees that Stage 1 IMT is not a homogenous block of SHO rotations with little appreciable difference between them. There should be noticeable differences in emphasis and the learning experience across the three years. In principle, it is envisaged that the first two years of Stage 1 IMT will roughly approximate the current BST model with Trainees working at SHO level. The third year of Stage 1 IMT will involve practice at registrar level, with the aim of enabling Trainees to make the transition from SHO to Specialist Registrar in a safe, monitored manner, being equipped with the skills to practice at this level.

The principles upon which the years within Stage 1 IMT should be founded are as follows:

1. The initial focus of training must ensure experience and competencies in core acute skills and combine simulated with experiential learning. This training must be frontloaded for all new entrants (possibly within the first 6 months) and should ensure experience in acute internal medicine with on-call commitments, cardiology, acute respiratory care, and stroke.

2. There must be a protected clinical free time in the first 6 months to facilitate skills training in human factor issues (e.g., communication, teamwork, care of the dying patient), core procedural skills (including LP, intravenous access, paracentesis, thoracentesis, knee aspiration), and initial training in Point of Care Ultrasound (POCUS). This can be delivered in a hub and spoke manner and will entail a dedicated, scheduled period of study leave.

3. It is recommended that rotational structures are based on key experiential learning with acute on-call, clear post-call rounding, and patient follow up which is supported by a system of internal medicine learning (Ideally a morning report structure is recommended).

4. Protected time for curriculum-based teaching must be delivered on a weekly basis to all IM Trainees. An agreed minimum standard of protected time and clear curriculum is required, while understanding that emergency commitments attendance must be monitored, and an agreed minimum standard developed. The Curriculum must be completed by all Trainees.

5. Mentors must be appointed to support each Trainee.

6. The period of acute core training in the Corrigan year will be followed by an assessment of progress comprising clinical feedback and approval to progress.

7. Following the first period of acute core training, clinical training will occur using a rotational structure that facilitates broad exposure to a range of aspects of acute medicine. There will be time spent on acute care and elective care with a period of time in integrated care.

8. Rotations will be organized to maximize experiential learning and clinical exposure.

9. Trainees will be required to sit Part 1 MRCPI and will receive one week of study leave for preparation. It is expected that year 1 Trainees will attempt and pass Part 1 in most cases. Year 2 Trainees should pass part 2 and if possible, the clinical examination. The MRCPI examination should be mapped to the Curriculum.

10. In order to ensure broad exposure and training, it is expected that Trainees will spend a significant period of time in a Model 3 Hospital (based on experience this period is estimated to be 1 year during the 3-year training period which can involve up to 3 months in a model 2 hospital).

11. Trainees are expected to spend a reasonable period of time in intensive or high-dependency care units with a focus on acute emergent medical care and procedural skills. The duration of the clinical exposure will be determined by the learning goals as set out in the curriculum.

12. Trainees will be facilitated to spend a period of time in an elected specialty to gain experience relevant to their career choice in HST. The Trainee would work in this specialty but continue to participate in on-call experience at registrar level.

13. Toward the end of year 2, Trainees will be assessed to determine their ability to progress to junior registrar level. This will occur by a period of daytime on-call at a registrar level before night call is considered.

14. Trainees will develop skills as team leaders and as Trainers during year 3 with dedicated training in communication, ethics, report writing, and Trainer skills.

RECOMMENDATION 2

The three years of Stage 1 IMT will have distinct emphases, exposures, and competences with the aim of preparing the Trainee for entry into Stage 2 IMT and practice as a Specialist Registrar.

The three years will consist of:

YEAR 1 — Corrigan Trainees: Foundation in Practice

'The trouble with doctors is not that they don't know enough, but that they don't see enough'

Dominic Corrigan, 1802-1880

Corrigan was a past president of RCPI and Liberal Member of Parliament who won the respect and admiration of the population by his efforts to treat the poor and sick during the Great Famine. Corrigan was famed for his astute powers of clinical observation among other skills and excelled in many ways but he is particularly remembered for his studies of the basic tenets of the cardiorespiratory system. In the field of hemodynamics, the abnormal 'collapsing' pulse of aortic valve insufficiency is named Corrigan's pulse in his honour. He also attracted acclaim for his clinical descriptions of Pulmonary Fibrosis.

The Year 1 Corrigan Trainee will obtain core training in the principles of internal medicine and learn the basics of the acute unselected medical take in a safe and supportive manner.

YEAR 2 — Stokes Trainees: Formation in Practice

'Medicine is an inexact science, but to this there is no reproach'

William Stokes, 1804-1877

William Stokes is perhaps best remembered today for the eponymously named Stokes-Adams attacks or Cheyne-Stokes breathing patterns, familiar to students of medicine the world over. Another former president of RCPI, Stokes was renowned for his recognition of progress and modernity and was an early proponent of the use of laboratory medicine for the investigation of disease. Stokes was also highly regarded for the breadth of his knowledge and scholarship, making important observations across a

diverse range of internal medicine subspecialties. The Year 2 Stokes Trainee will develop and further their understanding across the breadth of medical presentations, with particular emphasis on the application and integration of those skills involved in the formation of differential diagnoses, data interpretation and the appraisal of evidence in clinical medicine acquired in the Corrigan year into everyday practice.

YEAR 3 — Lynn Trainees: Flourishing in Practice

'Red Cross Doctor. And Belligerent.'

Kathleen Lynn, (when asked for her occupation while captured during the Easter Rising), 1874-1955

Kathleen Lynn a TD, revolutionary and doctor was so greatly affected by the poverty and disease among the poor in the Mayo of her childhood that, at 16, she decided to study medicine at UCD and like many Trainees to this day went to the United States for further postgraduate study. The medical aspect of her varied career was defined by her establishment and development of St. Ultan's Hospital which she founded in 1919 for Dublin's inner-city poor.

The Year 3 Lynn Trainee will, like Lynn understand the role of the internal medicine doctor in the hospital team and broader society across healthcare interfaces. This year will provide a six-month option module where the Trainee will practice at registrar level in a specialty of their choice. In January of the Stokes year Trainees will be asked to rank preferences for the option module of the Lynn year. Where posts are oversubscribed, they will be allocated by random lottery.

The Lynn year should offer continued opportunities for hands-on training in integrated care. An example may be a Trainee conducting 1-2 sessions a week in integrated care in locations or practice sessions adjacent to their speciality of interest such as general practice or community care hubs or attending specialty clinics in Internal Medicine adjacent fields such as liaison psychiatry, orthogeriatric or obesity or addiction clinics.

It should not be assumed that a Lynn Trainee can cover overnight medical registrar shifts and when sufficient progress has not been made, they may continue to be part of the SHO on-call rota. No Lynn Trainee should be asked to take part in overnight rostered on-call until they have been signed off by their educational supervisor as being safe and competent to do so.

Consistent feedback from current and previous BST Trainees has referenced a lack of clinical teaching to prepare them for the registrar on-call role. Therefore protected, defined, bleep-free clinical teaching is expected for Lynn Trainees, delivered across protected study days across the clinical year to maximize the experience for Trainees. This will be focused on the most common medical presentations in unselected take. This should be penciled into the year using study leave.

RECOMMENDATION 3

All hospitals receiving Internal Medicine Trainees must put in place formal, verifiable arrangements where Trainees involved in frontline medical take receive dedicated feedback on some or all the admissions that have been completed by IM Trainees.

For many years, Ireland was well-served in a sense by its model of basic specialist training. However, our longstanding training model, based around doctors embedded in the same clinical firm and the master-apprentice model has been significantly disrupted by changes in work patterns, clinical demand, and patient factors. The formative feedback given to doctors in training on the post-take ward round is as important as ever but compliance with working time legislation has reduced these opportunities as the Trainee has quite often finished their shift before the round starts. In addition, many large hospitals now run systems of distributive take which means less exposure to general internal medical patients throughout the working week. Trainees have far fewer opportunities now to be in attendance through all of the patient's admission, from the emergency department to the ward and discharge and beyond. Thus, another important brick in the wall of a Trainee's learning is lost. The onus is therefore on training programmes to adapt how learning, both on and off the job, is delivered. We feel this feedback is one of the single most formative experiences a Trainee can avail of, therefore we are recommending that all hospitals receiving GIM Trainees must put in place formal, verifiable arrangements where Trainees involved in frontline medical take receive dedicated feedback on some or all of the admissions that have been completed by these Trainees.

RECOMMENDATION 4

Once a month, each Trainee must log a learning exercise based on following a patient they admitted through their hospital stay and post-discharge. This is mandatory for satisfactory completion of the modul.

Another aspect that has been affected by changes in how Trainees work in hospitals is the understanding of the entirety of the patient journey. Previously, SHOs would expect to be on call with their Trainer where they would clerk newly admitted patients whom they would then be responsible for on the post-call day. This imbued Trainees with a sense of when the newly admitted patient could deteriorate and how to respond, contributing to the development of the "sixth sense" of the good Internal Medicine physician for patients at risk.

Beyond this, the patient would historically have remained under the care of the admitting team throughout their hospital stay where the Trainee would see the patient through to discharge and beyond at outpatient review. For this reason, we are recommending that once a month, each Trainee must log a learning exercise based on following a patient they admitted through their hospital stay and post-discharge. This would be mandatory for satisfactory completion of the module.

RECOMMENDATION 5

An integrated care module is to be developed, consisting of a mix of teaching methods to instruct Trainees on the role of internal medicine physicians as part of integrated care.

The Slaintecare strategy places integrated care at the heart of the Irish health service.

The Committee's vision requires a system that is integrated in terms of all stages of an individual's life, from cradle to the grave, and also in terms of a comprehensive continuum of care from health promotion and disease prevention to diagnosis, treatment, disease management, rehabilitation and palliative care.
(Houses of the Oireachtas Committee on the Future of Healthcare, Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report, May 2017. Houses of the Oireachtas, Dublin)

There is a general consensus, promoted by many interests within the medical and healthcare community in Ireland that the system is excessively oriented towards the hospital service. This was voiced in the report of the Oireachtas Report on the Future of Healthcare (2017) which recommended a "decisive shift away from a hospital-centric model of care". Therefore, Slaintecare has as a stated aim reorienting the system towards primary and community care; delivering care at the lowest level of complexity and empowering people to play a pivotal role in managing their own health. It is therefore necessary for Internal Medicine Trainees to be conversant in and have a full understanding of the role of hospital services working across interfaces with community colleagues within a patient-centred model. In addition, hospital services in Ireland have become more and more reliant on the services of Internal Medicine physicians who have in recent years found themselves managing conditions and presentations that historically had been managed by other specialities. This has led to Internal Medicine physicians assuming a hospitalist-type role, that they never explicitly sought but neither have they resisted. To ensure that Trainees acquire skills necessary for their envisaged roles we are recommending that an integrated care module is to be developed, consisting of a mix of teaching methods to instruct Trainees on the role of internal medicine physicians as part of integrated care.

RECOMMENDATION 6

A partial or complete decoupling of the Internal Medicine commitments of doctors from subspeciality work has the potential to improve patient care, training and reduce burnout. This should be piloted on an appropriately resourced site.

In the medium to long term, it is clear that the current work practices of Trainers and Trainees in Irish hospitals are becoming less and less conducive to the training interaction and promote burnout. Most physicians participating in internal medicine do so in tandem with subspeciality commitments and in addition are assuming more of a "hospitalist" type role, with responsibility for the care of a growing number of patients with complex presentations that previously would have resided outside of Internal Medicine. The project team received feedback that a lot of the unselected post-take ward round work at consultant is being provided by locums (who may not be recognized, accredited Trainers) while established physicians are being required to focus on their subspecialities to clear backlogs in scheduled care. The current situation is unsustainable for training purposes. For the betterment of training, the sustainability of a specialist career of three decades or more and the provision of patient care, there is a clear need for the Irish healthcare system to carefully consider the decoupling of acute unselected take from specialty experience if we are to truly deliver change. For example, if Trainers were required to substantially reduce or fully

cancel elective work during condensed blocks of acute firm care this would allow Trainees to gain a more equitable, focused, and supported training experience and support the desired public policy of consultant-delivered care in Internal Medicine. This should be piloted on a site with sufficient additional resources added. It is clear that given the diversity of hospitals accepting acute internal medicine patients that there will not be a "one size fits all" solution to this problem, but it is one that must be tackled, nonetheless.

3.5.2 Championing Internal Medicine

Internal Medicine is the core business of any acute hospital. However, the extent to which this activity has been devalued should be a cause for concern amongst physicians, administrators and patients.

"General Medicine was the dustbin…. a professional cul-de-sac, drained of interest, resource and prestige. The one clinical activity colleagues immediately abandoned if the opportunity arose for them to do so."
Seamus O'Mahony, the Ministry of Bodies (2022)

Data from the Acute Medicine Programme copperfastens the importance of Internal Medicine as the unsung hero and workhorse of hospital practice in Ireland. Acute medical presentations account for over a quarter of a million bed days in Irish hospitals annually, with the breakdown per diagnosis tic group as illustrated in Tables 8 and 9. On any given day 9 of the top 10 reasons for bed occupancy are for acute medical presentations with fractures (an increasing proportion of which are now being admitted medically) coming in tenth.

Table 8. *Bed Occupancy Per Day by Diagnostic Group.*

Rank	Diagnostic Group	National	%
1	Cardiovascular	69,445	25.48%
2	Respiratory	50,090	18.38%
3	Neurological	26,990	9.90%
4	Other	19,868	7.29%
5	Gastrointestinal	17,018	6.24%
6	Renal/urogenital	15,889	5.83%
7	Injury and poisoning	14,748	5.41%
8	Cancer	13,194	4.84%
9	Musculoskeletal	12,308	4.52%
10	Endocrine	10,098	3.71%
11	Mental health	6,923	2.54%
12	Haematological	6,308	2.31%
13	Infection	4,874	1.79%
14	Dermatological	4,111	1.51%
15	Immunological	481	0.18%
16	Congenital anomaly	167	0.06%
	Total	**272,512**	**100.00%**

Table 9. *Beds Used Per Day by Diagnosis*

Rank	Diagnosis/Procedure	Beds/day	%
1	Pneumonia - non TB/STD	477	8.39%
2	Urinary tract infection	301.5	5.31%
3	Stroke ischaemic	237.7	4.18%
4	COPD & bronchiectasis	235.1	4.14%
5	Congestive heart failure	194.5	3.42%
6	Lwr respiratory infection other	158.4	2.79%
7	Sepsis agent	116.3	2.05%
8	Syncope	106	1.87%
9	Delirium dementia and amnestic and other cognitive disorders	103.7	1.82%
10	Fracture other	102.7	1.81%

However, many hospital specialists in Ireland facing competing demands on their time find this work more burdensome than ever, functioning simultaneously as subspecialists, internal physicians and more and more as hospitalists, assuming clinical governance for patients with a myriad of problems that fall outside the classical, understood realm of the physician. In addition, the demands of the specialist as Trainer encompass a wide range of mentees, from medical students to interns, BST Trainees, HST Trainees, mentoring early career consultants and having significant input into and sometimes supervision of the clinical specialist training of nurses and allied health professionals of their subspecialist fields.

Stakeholder engagement in this project has revealed that all too often it is the Internal Medicine aspects of the specialist role that are first to be deprioritised, both in terms of clinical and Trainer energies. It is undoubtedly true that in many, if not most hospitals, responsibility for driving the development of unselected internal medical services may not be as clearly defined or vigorously pursued as those pertaining to subspeciality and super subspecialty services. The same is true of training, where even higher Trainees in dual accredited specialities are educationally, academically, and tribally far more intimately aligned with their relevant "-ology" than they are with the discipline of Internal Medicine. Subspecialities that do not have commitments to medical take are highly sought-after among Trainees who fear burnout and see the more generalist aspect of the role as being burdensome, unattractive, and unrewarding. Similarly, there is a significant degree of fear among early career doctors as to the stresses and strains of the Medical Registrar role with a high proportion of Trainees feeling unprepared for this at the end of BST. Presciently, the Imrie review called for the role of the Internal Medicine Physician to be both defined and protected. On the ground, there is little evidence of either having been done.

RECOMMENDATION 7

RCPI should form a working group or taskforce to promote the role of the internal medicine (IM) in Ireland, and educate doctors, patients, the public, administrators, and politicians about this vital function.

There are no easy answers to the problem of Internal Medicine being perceived as low status. And while we may wish this were not so, or credibly and passionately argue the point that it ought not be, reality cannot be ignored. While this project is concerned with training only, we hope it will nudge those with influence in professional bodies, hospital and health service management and the wider political system into planners into valuing the contribution of Internal Medicine in general makes in our health service, and to promote and champion the merits of pursuing careers in this important area. It can be difficult to know sometimes at a broad level and within hospitals who it is that will speak for and champion the role of Internal Medicine. The Institute of Medicine is well-placed to co-ordinate such efforts and with that in mind we call upon RCPI to form a working group or taskforce to promote the role of the internal medicine (IM) in Ireland, and educate doctors, patients, the public, administrators, and politicians about this vital function.

RECOMMENDATION 8

Participation in the general medical rota, and in the training of future general internal medicine specialists should be recognised by health service providers, training colleges and universities as important factors for academic and professional advancement of physicians.

Reckonable factors for academic and professional advancement of doctors into leadership roles in the health system, including in professional bodies and universities are skewed towards easily measurable and definable metrics such as grant funding, publication counts, citation indices etc. While it is correct and proper that such excellence be recognised, a valid counterpoint shared by many practitioners is that it leads to esotericism and a disturbance to the time-honoured fabric of medical leadership within the system. It is not desirable for the domains of academic and clinical leadership in Internal Medicine to become ruptured so for that reason we propose that Participation in the general medical rota, and in the training of future general internal medicine specialists should be recognised by health service providers, training colleges and universities as important factors for academic and professional advancement of physicians. A desirable model may be for hospitals and universities to establish departments and chairs in Internal Medicine or Acute Medicine in order to promote excellence within the disciplines.

RECOMMENDATION 9

Greater representation on Stage 2 IMT/HST interview panels for dual accreditation should be afforded to Internal Medicine physicians. Accepting that exigencies may arise, best practice would be for not fewer than two Internal Medicine physicians who are not dual trained in the relevant subspeciality to sit on the interview panel.

While leadership roles such as chairs and professorships represent the zenith of a career, at entry level to both Stage 2 IMT/HST and the consultant grade, we also feel more needs to be done to prioritise the role of the Internal Physician. As earlier outlined, Internal Medicine is very much considered to be the junior partner in dual accreditation training programmes. Opportunities to address this imbalance should be availed of from the earliest juncture. We are proposing that greater representation on Stage 2 IMT/HST interview panels for dual accreditation should be afforded to Internal Medicine physicians. Accepting that exigencies may arise, best practice would be for not fewer than two Internal Medicine physicians who are not dual-trained in the relevant subspeciality to sit on the interview panel.

RECOMMENDATION 10

Physicians whose primary roles are as generalists should play a key role in Curriculum development in Internal Medicine training at stage 1 and stage 2.

At an earlier juncture, the curriculum for internal medicine training at both stage 1 and stage 2 should reflect the role of Internal Medicine as a skill and discipline in its own right, rather than simply being the accumulation of knowledge from medical subspecialities. The skills of the good Internal Medicine physician involve the exercise of judgment, clarity of thought, skill in the management of multimorbid and frail patients, those acutely unwell and those for whom the acute phase of illness may be progressing to management of chronic disease or rehabilitation, and thus an ability to work across interfaces. With that in mind, when the curricula are written it is important that physicians whose primary role is as a generalist, such as those with commitment to an Acute Medical Unit work alongside subspecialists. For example, it may be that a good acute internal physician, for instance practising in an Acute Medical Unit, may be as well, if not better placed, than a Gastroenterologist, in knowing what a well-trained Internal Medicine physician needs to know about that particular field.

RECOMMENDATION 11

Specialties who are currently not engaged in dual accreditation training at HST level should be regularly invited and incentivised to take part in the Stage 2 IMT/HST training programme.

A perusal of many of the national subspecialty society meetings from dual accreditation specialties in recent years shows that the benefits of withdrawing from or reducing engagement with Internal Medicine are considered worthwhile aspirations. This is understandable given the pressures which exist, but it is undeniably the case that a reduction in the IM commitments of any subspeciality or group of subspecialties is going to aggravate those pressures in a broader sense and reduce the quality of services available to patients. On the other hand, were more physicians to take part in Internal Medicine this would do the direct opposite.

We feel it is an essential goal that the current drift by subspecialties away from the commitment to Internal Medicine be not only resisted but actively reversed. There are several levers to do this, some of which we have already outlined in terms of professional and academic advancement. In addition, however, health service employers need to reflect on the versatility and flexibility inherent in dual-trained specialists who will service both the needs of patients requiring both unselected and speciality Internal Medicine expertise. This should form an important part of considerations for the funding of consultant positions in a manner in which it very apparently does not at the moment.

As such, we recommend that specialities who are currently not engaged in dual accreditation training at HST level should be regularly invited and incentivised to take part in the Stage 2 IMT/HST training programme.

The MRCPI examination is a satisfactory means of assessing progress and an accumulation of evidence exists that as a means of assessing progress, it performs very well. There is no specific recommendation for the exam, however, it should continue to reflect the nature of modern medical practice, and over time be modified to ensure that it does, with reference to burgeoning issues in clinical practice and society. The MRCPI should be mapped to the IM curriculum and examined following periods of training in the stage 1 IM training scheme.

3.5.3 A new Approach for the Patients of the 2020s and beyond

Health services around the world are struggling to keep up with the demands placed upon them. Irish hospitals, where the vast bulk of Internal Medicine training and practice takes place are no different in this regard. Multiple factors including a rising and ageing population with more diverse needs than ever before, higher patient expectations, and trying to provide ever more effective and complex, but expensive new treatments combine to create a set of challenges that Internal Medicine Physicians need to be in the vanguard of meeting. It is therefore of critical importance that training is tailored towards the multifaceted, holistic needs of the patients who will be in receipt of care from our IM Trainees and specialists.

RECOMMENDATION 12

Each Trainee in Stage 1 IMT should have a period in a defined critical care setting.

The lessons learned from the Covid-19 pandemic are highly instructive in how Internal Medicine physicians should be trained and practice into the future. The pandemic brought into extremely sharp focus factors such as the role of frailty and multimorbidity in patient outcomes, the need for doctors to be agile and promptly responsive to acutely deteriorating patients, and a need to be comfortable with the appropriate use and deployment of critical care technologies in managing patients across a range of settings. Ireland's infrastructure in critical care settings was a recurrent cause for concern throughout the Covid pandemic, particularly in its early phase. Consequently, interventions that previously would have been unthinkable outside of Intensive Care Units were out of necessity performed in locations such as operating theatres, medical wards, and emergency departments. It is to the great credit of healthcare staff, led by internal medicine physicians and their colleagues in intensive care and emergency medicine were able to reorient at speed to do this. A report by the National Office of Clinical Audit (NOCA) said the overall mortality rate of ICU patients with Covid-19

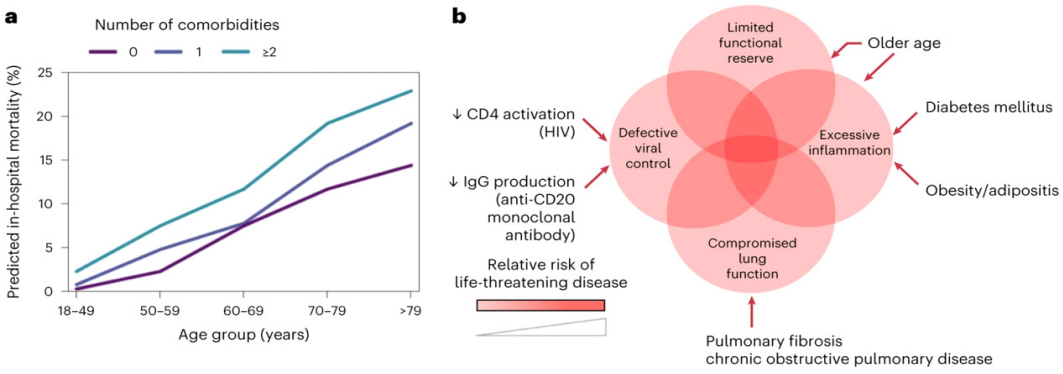
in Ireland was about 30 per cent, compared to 40 per cent in Britain. It is with the lessons gleaned from this in mind that we feel Ireland is well-primed for the development of the Medical HDU model where an intermediate Model 2 level of close monitoring and escalated treatment can be provided to patients as envisaged in the HSE National Clinical Programme for Critical Care's "Right Care Right Now" model of care for adult critical care. It can only be of benefit to patients, staff and the wider system for Internal Medicine physicians to be given greater exposure than is currently the case in Intensive Care medicine and that into the future this will be a core competency of IM.

RECOMMENDATION 13

Curricula in frailty, multimorbidity and polypharmacy should be devised and embedded in the Internal Medicine training Programme.

Also reflecting on the pandemic, it is clear that frailty, age and multimorbidity were by far and away the greatest predictors of serious illness and it is responding to the needs of such patients that presents the challenge for internal medicine in the 2020s and beyond. While multimorbidity it is a growing issue in Ireland affecting 38.6% of older adults this compares favourably to international counterparts in England, the US and Canada (Hernández, B., Voll, S., Lewis, N.A. *et al*. Comparisons of disease cluster patterns, prevalence and health factors in the USA, Canada, England and Ireland. *BMC Public Health* 21, 1674 (2021).)

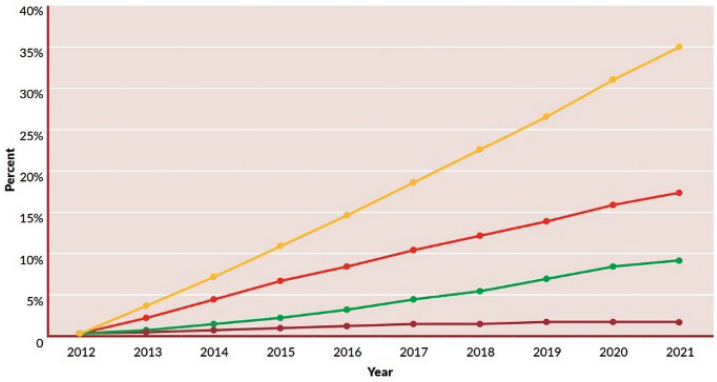
Fig. 1: Effect of multimorbidity and comorbidity on risk of life-threatening disease.



Taken from Russell, C.D., Lone, N.I. & Baillie, J.K. Comorbidities, multimorbidity and COVID-19. Nat Med 29, 334–343 (2023).

However, Ireland now has the longest life expectancy at birth in Europe, and as such the population is expected to age faster here than anywhere else in Europe over the next 25 years.

Fig. 1.1: Cumulative Percentage Increase in Population, All Ages and 65+ for Ireland and EU-27, 2012 t0 2021



Source: Eurostat.

Note:
(i) Data for 2017-2021 are provisional

- EU 27 – Total Population
- EU 27 – Aged 65+
- Ireland – Total Population
- Ireland – Aged 65+

Beyond the acute phase of illness, understanding frailty and multimorbidity is critical to allow the Internal Medicine physicians of the future to work across interfaces both within the hospital and outside it, with a view to facilitating discharge home and the provision of holistic medical and health care proximate to the patient. We believe the current subspeciality-driven curriculum would be augmented by the promotion of curricula encompassing cross-subspeciality teaching that emphasises overall patient condition rather than seeing them as a collection of independent diagnoses.

RECOMMENDATION 14

Trainees must receive instruction and complete reflective practice exercises on the limits of medicine and the appropriate and judicious use of medical interventions and investigations.

While the amount and accessibility of medical knowledge and the growing empowerment of patients has been of great overall benefit, a growing body of evidence now exists as to negative effects of overdiagnosis and overtreatment. Such factors risk harm to patients from unnecessary or inadvisable diagnostic and therapeutic interventions. In addition, Abbasi (2022) argues that they drive medical inflation, threaten the financial and environmental sustainability of health services, escalate workload pressure on staff.

Antimicrobial resistance, described by the World Health Organization (WHO) as one of the top 10 threats to global health, specifically is a very real and concerning outcome of overdiagnosis and overtreatment of what are often likely to be minor, self-limiting illnesses. There is widespread fear among medical practitioners in Ireland that recent legal and political developments concerning tragic patient adverse events in areas such as screening and sepsis in particular are likely to exacerbate the potential harms that accrue from overdiagnosis and overtreatment.

We, therefore, contend that the time is opportune to offer IM Trainees formal instruction in these topics. This may be delivered across a number of modalities but should include reflective practice exercises based on the clinical observations of the Trainee themselves.

RECOMMENDATION 15

The possibility of single speciality training in IM should be explored by RCPI in conjunction with relevant stakeholders. A mechanism exists whereby such a scheme of training can be harmonised with the changes proposed in this document.

The idea of a scheme for single specialty training in IM has emerged repeatedly in our conversations with a broad range of stakeholders. A standalone single speciality IM HST scheme existed in Ireland in the early 2000s but as the employment prospects of Trainees were observed to be poor and the programme withered and was abandoned. We agree with the sentiment that IM training should not prepare Trainees for jobs that are unlikely to exist in the Irish public health service, which is the overwhelming majority destination for our Trainees. While this is beyond the scope of this report, we believe the advantages of reviving a single-speciality Internal Medicine scheme, should suitable career opportunities exist for successful candidates, are very clear to the broader health service and could significantly truncate the training journey for doctors who choose this option over dual-training.

To ensure a realistic expectation of a career pathway for potential Trainees, such a programme should only be embarked upon following consultation with other relevant stakeholders such as the Department of Health, the HSE and the Irish Medical Council and a commitment obtained to promote such roles in Irish hospitals. We recommend the group established to promote IM in the college (see recommendation 6), in conjunction with the DIMT, should pursue this objective. As such we feel redesigned IM training should cater for this eventuality. Our suggestion as to how this could harmonise with the training as proposed in this document would be to allow two entry points for Trainees who intend to pursue single speciality training in IM, in order to comply with relevant EU directives.

(i) *Having completed Stage 1 IMT or after one year of Stage 2 IMT, the Trainee must complete a further two years in training delivered at Stage 2 level, either in a model 2 or 3 hospital, or if in a model 4 hospital in an AMU/AMAU setting.*

(ii) *Having completed two full years of Stage 2 IMT, the Trainee must complete a further one year in training delivered at Stage 2 level, either in a model 2 or 3 hospital, or if in a model 4 hospital in an AMU/AMAU setting.*

Such a scheme would offer a real opportunity to develop a network of dedicated postgraduate Trainers in IM. As such, Trainees embarking on such a programme as outlined should consider, in their 1-2 years of Stage 2 IM HST, completing defined modules in Medical Education.

3.5.4 Providing the Resources to Train

Much feedback was received that early postgraduate career development of doctors in Internal Medicine has not been prioritised by hospitals who have tended to emphasize service needs instead. This viewpoint is supported by the findings of the Medical Council's Your Training Counts report where Trainees have consistently rated the quality of clinical learning experience as being lower in hospitals than in General Practice and Community Mental Health settings. In other jurisdictions we examined in our work, such as the USA, Australia, and The Netherlands it was clear that training sites competed for the best Trainees and, as such, being an attractive training site was considered a key priority for clinical and administrative leaders.

While great efforts are made in Ireland by dedicated individuals, there is no cohesive sense that the Trainee experience is a key priority. This understandably increases the quality of offering to Trainees and offers ballast to educators who advocate on behalf of training in the ever-difficult balance hospitals try to strike between service and training needs. In Ireland, physician educators report frustrations when trying to implement even modest policies in favour of training such as protected bleep-free time for tutorials. By contrast in Australia, pass rates for postgraduate examinations are widely published and available, which leads to increased interest in and emphasis on the academic progression of Trainees.

RECOMMENDATION 16

A network of Clinical Practice Coordinators should be established to support Trainees in internal medicine.

The nursing profession has made great strides in Ireland towards the goal of supporting early career practitioners. Irish hospitals have now firmly embedded Nurse Practice Development Units, staffed by Clinical Placement Co-ordinators and Clinical Facilitators and led by Nursing Practice Development Co-ordinators, as a continuous process of improvement towards increased effectiveness in patient-centred care. This is achieved by empowering health care teams to develop their knowledge and skills and transforming the culture of safe patient care. It is supported by facilitators committed to a continuous process of change that reflects the needs of service users (Garbett and McCormack, 2002). Nursing Practice Development Units support pre and post-registration nursing staff in developing nursing practice to facilitate high standards of patient-focused nursing care.

It is clear that Ireland needs to professionalise training in clinical medicine. We recommend that possibly in conjunction with other stakeholders such as medical schools and the Intern Network, Clinical Practice Coordinators should be established to support Trainees in internal medicine. There are several interesting mechanisms that could be employed to support this. Many hospitals in Ireland now, especially with the planned increases in the retirement age and the increasing demands of unstructured on-call work, are examining ways to change the work plans of doctors coming towards the end of their careers. We believe that an opportunity exists here to harness the vast experience across clinical practice and education that these doctors possess to support younger colleagues. This could be augmented where necessary by doctors in the late stages of Stage 2 HST or post-CCST who are doing research-based out-of-Programme experience modules or clinical fellowships.

RECOMMENDATION 17

Each training hub should be required to have facilities for simulation, and a dedicated simulation lead for Internal Medicine Training.

Longstanding learning models in Internal Medicine Training are based around the apprenticeship model, and traditionally relied on a ‘see one, do one’ approach to learning and experience. This, however, inevitably exposes patients to inexperienced healthcare practitioners, and the dangers and harm associated with this are increasingly unacceptable. (Aggarwal et al, 2010). Simulation-based training is defined by the Society for Simulation in Healthcare as ‘a technique to replace or amplify real-patient experiences with guided experiences, artificially contrived, that evokes or replicates substantial aspects of the real world in a fully interactive manner.’. Simulation is already

widely and successfully used in the training of Internal Medicine physicians in areas such as ACLS, Endoscopy and communication, and more and more Trainees are encountering simulation-based teaching at undergraduate level. The increasing sophistication of simulation devices that are commercially available has expanded the utility of simulation within medical education and the time is opportune to leverage this to the betterment of Internal Medicine training. In addition to the clear benefits accruing from the acquisition of technical skills simulation offers opportunities to develop clinical judgment in a safe manner as well as promoting cognitive and human factor skills such as dynamic decision-making, teamwork, communication, and professionalism.

RECOMMENDATION 18

Each training hub should be required to have facilities for Point of care ultrasound (POCUS), and a curriculum and network of accredited Trainers be established in this topic.

Point of care ultrasound (POCUS) is now considered an essential competency in training programmes such as anaesthesia and emergency medicine. Such techniques also have significant value in internal medicine training in order to perform focused examinations and aid complicated procedures. A standardised POCUS curriculum should be developed which will involve the training and accreditation of instructors on local sites. Pending this, we are recommending POCUS training facilities be established and available in each training hub.

We are keen to emphasise that simulation and POCUS should absolutely not be the sole preserve of Model 4 hospitals. In fact, on the contrary, the acquisition and application of such skills may be of most relevance in Model 2 and Model 3 training sites where Internal Medicine is often better valued and sub-specialism less embedded.

RECOMMENDATION 19

Each Regional Programme Director (RPD) should have 0.5 WTE backfill for their clinical duties and a 1.0 WTE administrative support for the running of their programme, which does not need to be in the same hospital as the RPD.

The changes proposed to Stage 1 IMT will add several layers of complexity to the task of those running the programmes locally, namely Regional Programme Directors (RPDs) and site leads for training. The number of Trainees will also increase by at least 50% as 3-year Stage 1 IMT replaces 2-year BST. In recent years, RPDs have done sterling work implementing great and much-needed reforms to BST and adapting to the unique demands of delivering training during a pandemic which caused so much illness, death and upheaval in hospital and training practices. The RPD structures should remain in place, with appropriate backfill for clinical duties of 0.5 WTE. It is now clear that without dedicated administrative support, it will not be possible for RPDs to continue to carry out their functions in reformed Stage 1 IMT. Removing the burden of administrative work from RPDs will give them the time and space they require to focus on improving standards in educational delivery. A full-time administrator is required to assist with this. The administrator should not be required as a matter of course to be based in the same training site as the RPD and may be located in a different site in the same hub, to avoid dominance of Model 4 units over training hubs.

RECOMMENDATION 20

A 1.0 WTE director of internal medicine training (DIMT) post should be established by RCPI at consultant physician grade, whose responsibility it is to set standards in IMT and manage the network of RPDs.

Internal Medicine is by far the largest training programme undertaken by RCPI and should be resourced and afforded status accordingly. With an estimated 900 Trainees undertaking reconstituted IMT, it is no longer feasible that the infrastructures that apply to subspeciality HST programmes can sustain IMT. Therefore, we are recommending a 1.0 WTE director of internal medicine training (DIMT) post should be established by RCPI at consultant physician grade, whose responsibility it is to set standards in IMT and manage the network of RPDs. It would be preferable for this to be occupied by at least two individuals working 0.5WTE.

3.4.5 A new paradigm for the Trainer-Trainee relationship

RECOMMENDATION 21

Trainees must be able to access technology in all training sites to access virtual learning and link with other Trainees and Trainers.

Another learning from the Covid pandemic was the ease and comfort with which doctors and healthcare professionals adapted to remote and online models of learning (Cassidy et al, 2023). Trainees began to expect a "digital first" approach enabling them to access high-quality teaching across interfaces and the use of technology also enabled them to access teaching at times of their own choosing, which given the patterns of shift work they undertake was highly favourable to Trainees. Trainees built on this with their own initiatives such as podcasts to help one another prepare for the MRCPI examination. Dedicated ICT and audiovisual facilities should be made available for IMT Trainees to enable them to access training opportunities across the hub and those opportunities centrally provided by RCPI.

RECOMMENDATION 22

Each Trainee in Stage 1 IMT should have a named educational supervisor who will be a source of continuity over the three-year period of their training and work alongside their clinical supervisor which will change from post to post.

The success or otherwise of our training programmes will ultimately rest with how the Trainee-Trainer interaction is managed. It is clear that changes in work patterns in hospitals brought about by legislation, patient expectations and progress in medical technology have created a very different milieu for this relationship. For the Trainee, time spent with one specific named Trainer consultant is considerably less than before and Trainees are more likely to be nested in a team of consultant Trainers working together across a service. This offers several advantages to the learner in terms of exposure to a wider range of expertise, subspeciality teaching and leadership styles. There is however also a cost associated with this. Trainers

interact more tangentially with their Trainees than before and there is less opportunity to identify and remediate deficiencies in learning. Trainees may feel more isolated without being attached to one specific Trainer clinically and especially in larger departments in bigger specialities in Model 4 hospitals, Internal Medicine Trainees at SHO level may find themselves functioning in specific areas of those departments and failing to even obtain broad training within that subspeciality.

From the perspective of Trainers, there have never been more demands on their time both in terms of clinical practice and educational commitments. Current BST Trainers have multiple training obligations including for example medical students, BST Trainees and HST Trainees, all of whom in recent years have become better organised and more muscular in their appropriation of Trainer time. In addition, the Trainer is expected to take on training and supervision functions for non-physicians such as nurse practitioners and prescribers, and allied health professionals. Hospitals will also lean on Trainers to provide public education talks and engage with local media. It is not hard to imagine how BST Trainees are squeezed in this environment and based on the feedback we have received from Trainees and Trainers alike; it is the BST supervision relationship that is most likely to suffer. We are therefore proposing that each Trainee in IMT should have a named educational supervisor who will be a source of continuity over the period of their training and work alongside their clinical supervisor which will change from post to post in the manner in which currently occurs. The educational supervisor must complete an online quarterly review of the Trainee's progress including feedback from the clinical supervisor, progress with MRCPI examination, adherence to training activities such as mini-cex, case-based discussions etc and audit. On an annual basis, the Trainee and Trainer will meet and devise and monitor a personal professional development plan.

RECOMMENDATION 23

Trainees should have an opportunity to and be requested to provide feedback on their training, and their educational and clinical supervisors.

Trainees for their part should have an opportunity to and be requested to provide feedback, either anonymously or not, on their educational and clinical supervisor to the RPD or site training lead. Where issues arise around negative interactions between Trainees and Trainers, the RPD or site training lead should try to resolve this collaboratively on a local basis first and may escalate to DIMT subsequent to this. There is a subtle overlap and at times a difficult friction between the role of Trainer as educational mentor and line manager. While having a separate educational supervisor for the bulk of the training will help in this regard, Trainers must have a mechanism to support them in resolving such conflicts with the support of RPDs and the DIMT.

RECOMMENDATION 24

Time spent supervising Trainees should be reckonable for internal CPD points for educational and clinical supervisors.

Recognising the demands on Trainer time, we recommend that Trainers be appropriately incentivised to take part in IM training, especially at Stage 1. We suggest a mechanism for this by which the Trainer receives internal CPD points for the supervision of Trainees amounting to 1 point per Trainee per month, to assist them with their CDP requirements. The commitment to the supervision of Trainees should also be embedded in job plans and form a part of contracts of employment for doctors.

RECOMMENDATION 25

Sites offering IMT undergo 360-degree feedback review on a 2-yearly basis. This will encompass feedback from Trainees, adherence to training recommendations, provision of a clinical teaching programme, and pass rates in exams. This is co-ordinated by the DIMT and communicated from them to the RPD and site leads as well as hospital CEOs and medical/clinical directors. Sites will be graded green, amber and red. Green is satisfactory, amber requires an improvement plan and when red lights are triggered, DIMT may suspend IM training at that site.

While honouring the key relationship between the Trainee and Trainer, there must also be an institutional relationship between the training site and the RCPI that places the learner at the centre. RCPI benefits hugely from the access provided to training opportunities and the staff at training sites, many of whom are its members and fellows. For their part, the hospital sites are supplied with a steady stream of very highly qualified doctors that are in international demand to provide services, staff on-call rotas. If such Trainees were not provided the hospitals would face an unprecedented staffing challenge in a highly competitive environment. With that in mind, we are proposing that all training sites undergo 360-degree audit on a biennial basis by the DIMT supported by the RCPI education department and the development of a weighted system for institutional feedback to hospitals.

Audit standards may include:

- *Access to protected training time*
- *Compliance with annual personal professional development plans, quarterly online assessments*
- *Provision of tutorials*
- *Trainee wellbeing survey*
- *Employment practices including payment of wages (including overtime) and provision of on-call facilities*
- *Exam success rates*
- *Access to training facilities (ICT, simulation/POCUS where appropriate).*

This would allow for all training sites to be graded GREEN, AMBER, or RED.

GREEN (Rating 80-100): Very satisfactory training site for IMT

AMBER (Rating 60-80): Generally satisfactory training site for IMT but improvements needed. These sites will be required to outline a Training Development Plan to illustrate how they plan to rectify the deficiencies observed and for this to be signed off on by the RPD/Site training lead, the Clinical Director of the hospital and a member of the hospital's Executive Management Team (EMT).

RED (Rating <60): Unsatisfactory training site for IMT. DIMT is empowered to and is expected to suspend IM training accreditation at that site. The training site may devise an emergency improvement plan and request a re-audit. In such a setting the DIMT may at their discretion decide not to suspend training but allow a grace period of no longer than 6 months where training may continue before re-audit, the cost for which should be borne by the training site. A RED rating in two consecutive audits will result in automatic de-accreditation of the training site without exception.

The scale and integrated nature of the proposed reformed IMT scheme represents the biggest training programme ever undertaken by the college. As such it is important that clear governance

structures appropriate for its magnitude apply to it. An integrated IMT speciality training committee (STC) should be established that will oversee IM training in its entirety through stage 1 and 2. This STC will have responsibility for the broad issues of governance, assessment, recruitment and ongoing curriculum development and reform subject to Terms of Reference agreed with the IoM.

RECOMMENDATION 26

An integrated IMT speciality training committee (STC) should be established to oversee IM training in its entirety through stage 1 and 2.

The scale and integrated nature of the proposed reformed IMT scheme represents the biggest training programme ever undertaken by the college. As such it is important that clear governance structures appropriate for its magnitude apply to it. An integrated IMT specialty training committee (STC) should be established that will oversee IM training in its entirety through stage 1 and 2. This STC will have responsibility for the broad issues of governance, assessment, recruitment and ongoing curriculum development and reform subject to Terms of Reference agreed with the IoM.

4.0 Conclusion and Implementation Plan (Year 2 Workplan for OPTIMISE)

The work done to date on the OPTIMISE project has led us to believe that there is great appetite for and goodwill toward improving the experience of IMT training and that the importance of Internal Medicine is understood and appreciated across a broad range of stakeholders in the system. The level of engagement the project team encountered was remarkable. This is welcomed and contrasts with a perception which had taken hold that the general skills of internal medicine were in terminal decline. This enthusiasm must now be carried forward into the second year of the OPTIMISE project where several workstreams are required in order to allow Trainees to apply for entry onto an integrated IMT programme from July 2025 onwards.

It is envisaged that 5 workstreams would be created based on the recommendations above:

- *Curricula review*
- *Workforce implementation review*
- *Governance review*
- *Training resources review*
- *Training Structures review*

Workstream	Tasks/Subtasks	Work to Date	Timelines
Curriculum Review	• Establish IMT Curriculum Review Group with Education Department including cross-subspecialty themes outlined in Interim Report.	• Review Group Appointed in line with recommendations of OPTIMISE interim report	• Preliminary Report by December 2023
	• Develop Curriculum in POCUS	• Factfinding	• Outline Curriculum in POCUS for IMT by Feb 2024 • Report on Training Resources and Structures needed for POCUS in IMT by May 2024

Workstream	Tasks/Subtasks	Work to Date	Timelines
Curriculum Review *(continued)*	• Devise and embed Structures around Simulation in IMT.	• Early liaison with National Simulation Leads	• Report on Training Resources and Structures needed for POCUS in IMT by May 2024
	• Establish advice and structure on how to embed the need for critical care attachment	• Discussion with stakeholders	• Address in OPTIMISE final report July 2024
Workforce Implications Review	• Establish Working Group to report on the structure of the Corrigan training year with all relevant stakeholders. Will require engagement with Trainees and Trainers, medical manpower managers, clinical programmes and NDTP.	• Quarterly stakeholder briefings in Year 1 of OPTIMISE.	• Group to be invited to meet before end of September 2023. • Group to be invited to report by end of March 2024.
	• Scoping exercise on how NTSD posts can be repurposed as Lynn Trainee posts.	• Factfinding	• Briefing document to be prepared on the location and nature of NTSD posts by end August 2023.
	• Engagement with HSE/ CCO and Clinical Advisory Groups on Internal Medicine Workforce.	• Several meetings where objectives were outlined and aligned.	• Formal meeting arranged for June 2023.
Governance Review	• Develop terms of reference (ToR) for integrated IMT speciality training committee (STC).	• Ongoing comprehensive review of current training governance • International benchmarking exercise.	• ToR to be put in place by end of January 202

Workstream	Tasks/Subtasks	Work to Date	Timelines
Governance Review *(continued)*	• Invite Expressions of Interest for IMT STC.	• Project to date has found a number of Trainees and Trainers with significant interest in IMT training.	• Advertise for expressions of interest June 2024
	• Engage with IoM and RCPI board on appointment of DIMT.	• Informal discussion with IoM board.	• Ongoing engagement with RCPI board and management team
Training Resources Review	• Following on from the curriculum review, outline of a final number of posts required (Trainee, Trainer and administrative) to implement OPTIMISE recommendations.	• Issuance of recommendations in this document.	• Report on Trainer, Trainee and administrative posts needs to be issued end March 2024 along with workforce implications report.
	• Outline resources required for POCUS, and the location, funding and network of Trainers required to implement.	• Issuance of recommendations in this document	• Report by November 2023
	• Outline resources required for Simulation, and the location, funding and network of Trainers required to implement.	• Issuance of recommendations in this document.	• Report by November 2023
	• Review ICT structures in place that currently support BST and HST in GIM, both in hospitals and for personal learning	• Engagement with Trainees.	• Invite CMC to conduct a survey/review on this topic to report by May 2024.

Workstream	Tasks/Subtasks	Work to Date	Timelines
Training Structures Review	• Invite STCs in Medicine specialities not currently engaged in dual training to be briefed on OPTIMISE work and to consider whether they would like to undertake dual training.	• Stakeholder meetings	• Hold an online briefing for NSDs in October 2023.
	• Develop guidance on the role of educational supervisors.	• International benchmarking review	• Issue a document on the role of the Educational Supervisor by April 2024
	• Develop a feedback mechanism for Trainees	• Working group discussion	• Following further Trainee engagement, to be included in OPTIMISE final report in July 2024.
	• Establish working group to promote the role of the internal medicine (GIM) in Ireland, who can also address the prospect of single-speciality training in IM.	• Working group discussion	• Seek meeting with IoM board. RCPI EMT on this before October 2023.
	• Develop a model for 360 feedback reviews for sites	• Recommendations outlined in this report	• Proposed mechanism be included in OPTIMISE final report July 2024, for consideration of IMT STC when commissioned

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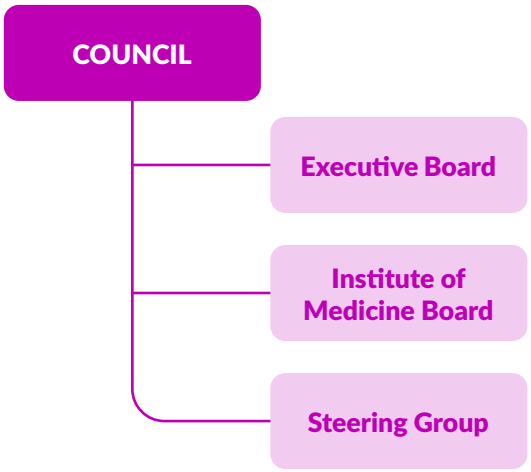
6.0 Appendices

6.1 Optimise Steering Group Terms of Reference

PURPOSE
The role of the Steering Group for the review of General Internal Medicine Training is to provide oversight and direction on the following areas:

- *To strategically and operationally review General Internal Medicine training programmes at both basic and higher specialty training level.*
- *To develop and agree a set of recommendations for improvement / change to General Internal Medicine training.*

SCOPE
Reporting in the College
This Committee reports to the Board of the Institute of Medicine, which in turn sits under the Council. The Committee may present to Council / Executive directly after having passed items through the Board of the Institute of Medicine first.



OVERSIGHT
From time to time the Steering Group may be required to form 'working groups' to address specific issues and workstreams. Working group leads may be appointed to lead out on specific workstreams / projects.

RESPONSIBILITIES

The Steering Group will regularly review and report to the Board of the Institute of Medicine on relevant metrics.

The Committee may from time to time present to the RCPI Executive and Council on certain topics.

Individual Steering Committee members have the following responsibilities:

- *Understand the goals, objectives, and desired outcomes of the project*
- *Understand and represent the interests of project stakeholders*
- *Take a genuine interest in the project's outcomes and overall success*
- *Act on opportunities to communicate positively about the project*
- *Actively participate in meetings through attendance, discussion, and review of minutes, papers and other Steering Committee documents*
- *Support open discussion and debate, and encourage fellow Steering Committee members to voice their insights*

MEMBERSHIP

Chair: Clinical Lead for the Review of General Internal Medicine Training
Executive Support: Project Manager

The Steering Group for the review of General Internal Medicine Training shall comprise of between 8 and 16 members:

1. Dean, Institute of Medicine
2. Associate Director BST
3. Associate Director HST
4. National Speciality Director HST GIM x2
5. Regional Programme Director BST x2
6. Fellow on Council
7. Trainee representative HST x2 (domestic programme)
8. Trainee representative BST (domestic programme)
9. Trainee representative international
10. Lay Member x2
11. External expert in Internal Medicine

Alternates may be nominated by the Dean of the Institute of Medicine / Clinical Lead.

Staff of the RCPI will also be in attendance, namely members of the Training and Faculties Function and members of the Education Function.

FREQUENCY AND NATURE OF MEETINGS

The Steering Group will meet quarterly, at a minimum, during the training year which runs from July to June. Committee members are required to fully prepare for each meeting, read the documentation in advance, and make every reasonable effort to attend each meeting. Meetings are held face-to-face, by videoconference or other electronic means.

The Quorum for a meeting is 50% of the membership of the committee rounded up to the nearest whole number.

RESPONSIBILITIES

Review internal medicine in its entirety and relevance to a structured formative training programme, that relates to Irish Healthcare needs and aligns with international (including European) Standards.

1) Structure and Organisation of the Training Programmes

a. Review the organisational structure of the internal medicine training programmes both BST and HST, with recommendations on best practice for an integrated governance model.

b. Consider and make recommendations on the duration of training and relevant outcomes to ensure training is competency-based and internationally benchmarked.

c. Recommendation on how outcomes can be measured and assessed.

d. What resources are required to organise and quality improve an integrated programme?

e. Consideration should be given to a longitudinal study of Trainees and Trainers for prospective data analysis and assessments of training pathways and career progression.

f. Consider recognition of prior learning, equality and diversity, and integration with international training programmes.

2) Mandatory Skills and Education

a. Best model for clinical experiential learning on sites. This would include rotations in general medicine, specialties, and across healthcare domains (service level of hospital, community).

   i. *What is the optimal duration of rotations for learners?*
   ii. *How should internal medicine and specialty experience be delivered?*
   iii. *Are there gaps in experience – ICU, geriatric medicine?*
   iv. *What are the core exposures and skills required in practice and how to we pragmatically measure and report on competency?*
   v. *How to integrate 'elective time' for specialty experience where required?*

b. Learning Opportunities: Formal and informal

   i. *A core requirement will be learning from post-call ward-rounds and in service education such as morning report.*
   ii. *Review and make recommendations on critical procedural and non-procedural skills relevant to the present workforce. What skills are mandatory for competency and what skills just require experience?*

iii. *A key area of potential development is Point of Care Ultrasound (POCUS). What the clinical need is, and how it will be trained and integrated into clinical practice. The need for faculty development and on-site training across training sites requires development.*

iv. *Recommend on mandatory courses relating to professionalism, leadership etc. How these courses are structured and integrated across training is essential. With simulation, it is important to consider how it can be utilised to support training on site and what requires more formal course work. It would be useful to consider practical experiences such as service reviews and committee membership. This should also link with the workstream reviewing mandatory training activities in RCPI.*

v. *The role of simulated learning in training and lifelong patient care delivery needs to be considered. How should this be best integrated into site educational facilities? This should be developed in conjunction with the RCPI simulation strategy.*

3) Alignment to Healthcare needs

a. How can training be structured to allow flexibility in careers according to future workforce demands is important – this may include hospitalists, acute physicians, or less than full-time clinicians.

b. How does this align with present and future healthcare models including Slaintecare and the development of less dependence on doctors not on training schemes?

c. Ensure there is training in audit and quality improvement to equip Trainees with skills for service improvement and quality of care into the future.

6.2 BST specialty Standards for GIM

1. SUPERVISION	
1.1	Each Trainee must have an assigned Trainer that has been approved by RCPI and is available to supervise clinical activities. Supervision should be commensurate with the Trainee's level of experience.
1.2	Quarterly assessments must take place and be recorded on the Trainee's ePortfolio.
1.3	Formal training meetings between the Trainer and Trainee must occur during each 3-month rotation. The Trainer should meet with the Trainee for goal setting at the beginning of the rotation and again at the end of rotation, with at least one Workplace Based Assessment (WBA) during the rotation.
1.4	A local training lead / Regional Programme Director will be assigned and available to Trainees for guidance and mentoring.
2. CASE LOAD	
2.1	Trainees must gain adequate experience in procedures and skills throughout their training programme. The quantity and variety of the workload available to BST GIM Trainees must be sufficient to meet the requirements detailed in the current RCPI BST GIM curriculum.
2.2	For accreditation to provide General Medicine training, each Trainee must rotate through three of the following five specialties: Cardiology, Respiratory Medicine, Geriatric Medicine, Endocrinology and Gastroenterology.
2.3	It is essential that there be adequate numbers and variations of patients attending the services provided. Each rotation must be three months in duration and the programme must be 24 months in total. A full programme must include: – A minimum of 6 months spent outside of the metropolitan area – Time in a model 4 hospital and a model 3 or 2 hospital Trainees must have the opportunity to partake in supervised ward rounds and consultations. Trainees should participate in the on-call rota for a minimum of 18 months, as per local hospital and individual rotation requirements. This should involve a minimum of 12 months General Medical unselected call. Formal consultant-led clinical handover of all patients admitted on-call must occur.

3. RESOURCES	
3.1	Trainees must have access to appropriate learning resources and facilities, including up-to-date medical literature and online journal access appropriate for General Medicine training.
3.2	Each Trainee must have access to a designated workspace including a desk, telephone and IT facilities. There must be facilities to support educational activities such as study areas and tutorial rooms.
4. EDUCATIONAL ACTIVITIES	
4.1	The training site should provide access to formal training including lectures, tutorials, grand rounds, and exam-preparatory courses
4.2	Trainees should be provided with the opportunity to teach junior colleagues and undergraduates.
4.3	The site should provide opportunities for Trainees to develop quality improvement/research interests on site or through affiliation with appropriate research institutions

6.3 HST Speciality Standards for GIM

1. SUPERVISION	
1.1	There must be a minimum WTE General Internal Medicine (GIM) Consultant to supervise Trainees and provide training in and supervision of GIM procedures. At a minimum, there is twice weekly contact between the consultant(s) and the Trainee working in the hospital, community or inpatient units to review new and complex patients.
1.2	A lead Trainer will be assigned and available to Trainees for clinical activities and meet with the Trainees for informal teaching. This Trainer must be RCPI registered.
1.3	Meetings between the Trainer and Trainee must occur on a minimum 3-monthly basis. Monthly meetings are strongly recommended.
1.4	Trainers are supported by the training site and RCPI to be given the time and resources to meet their supervision requirements

2. CASE LOAD	
2.1	Trainees must gain adequate experience in diagnostic procedures, experience and skills throughout their training programme. The quantity and variety of the workload available to General Internal Medicine Trainees must be sufficient to meet the requirements detailed in the current RCPI GIM curriculum.
2.2	It is essential that there be adequate numbers and variations of patients that participate in the services provided. Trainees must experience adequate and supervised consultations.
2.3	Trainees must have the opportunity to partake in ward rounds, consultations and MDT Meetings. Effective support for the management of the general medicine caseload is available across the various sites including clinical nurse specialists, social work and allied health professionals.
3. RESOURCES	
3.1	Trainees must have access to appropriate learning resources and facilities, including up-to-date medical literature and online journal access appropriate for General Internal Medicine specialist training.
3.2	Trainees must have access to the infrastructure required for confidential and educational activities which allow telephone calls, emailing and reviewing of work online
4. EDUCATIONAL ACTIVITIES	
4.1	The training site should provide access to formal training including lectures, tutorials, grand rounds, and journal clubs
4.2	Trainees should be provided with the opportunity to teach junior colleagues, undergraduates and allied health professionals
4.3	The site should provide opportunities for Trainees to develop research interests on site or through affiliation with appropriate research institutions
4.4	Trainees should have job plans which facilitate attendance at mandatory study days, local and regional days, this may include half a day per week or the equivalent of protected, bleep-free study time to peruse learning opportunities and participate in activities relevant to completing their curricula.

6.4 Workshop attendees

Clinicians	Role
Prof. Anthony O'Connor	Clinical Lead, OPTIMISE
Dr. Ed McKone	Director of Training, Institute of Medicine
Dr. Lucy Ann Behan	Director of Exams, RCPI
Prof. Mike Watts	Associate Director, HST
Dr. Emer Kelly	Fellow on Council
Dr. Catherine Mc Gorrian	Acute Medicine Cardiology, GIM Speciality Training Committee
Dr. John Stack	Consultant Rheumatology, GIM Speciality Training Committee
Dr. Sean Fleming	National Speciality Director, HST GIM
Dr. Alanna Allen	Trainee Representative
Dr. Michael Strader	Trainee Representative, IMG
Dr. Orlaith Kelly	National Specialty Director for Training in Gastroenterology
Dr. Clodagh O 'Dwyer	Geriatric Medicine
Dr. Barry Ryan	Representative
Prof. Anthony O'Regan	Dean, Institute of Medicine
Dr. Diarmuid O'Shea	Consultant Physician in Geriatric Medicine
Dr. Emily Buckley	Trainee Representative
Dr. Paul Carroll	Palliative Medicine
Dr. Dearbhla Doherty	Trainee Representative
Dr. Evelyn Lynn	Trainee Representative
Dr. James Murphy	Trainee Representative
Dr. Clifford Kiat	Regional Programme Director, South
Dr. Lucy Power	Trainee Representative
Dr. Marie Talty	Trainee Representative
Ms. Mary Ryan	Programme Manager, Acute Medicine Programme

Clinicians	Role
Dr. Wan Lin Ng	Trainee Representative
Dr. Frances O'Mahony	Trainee Representative
Dr. Anne Fennessy	Trainee Representative
Dr. Nicole Cosgrave	Trainee Representative
Dr. Naoimi Davey	Trainee Representative
Dr. John Garvey	Regional Programme Director, SVUH
Dr. Eimear Connolly	Trainee Representative
Dr. Marcia Bell	Department of Endocrinology
Dr. John McManus	Regional Programme Director, Mid West
Dr. Avril Beirne	GIM, Speciality Training Committee
Dr. Brian Kent	Regional Programme Director, St. James Hospital
Dr. Ronan Canavan	Department of Endocrinology
Dr. Denise Sadlier	Regional Programme Director, Mater
Prof. Garry Courtney	BST GIM Training Lead

Staff	Role
Dr. Ann O'Shaughnessy	Head of Education
Mr. Colm Small	Head of Training and Examinations
Mr. Barry Quinlan	Finance Manager
Ms. Sheila Gallagher	Chief Financial Officer
Dr. Trevor Duffy	Head of Healthcare Leadership
Ms. Georgina Farr	Manager, Quality Enhancement Office
Ms. Cliona McHugh	Manager, Training and Faculties
Ms. Jessica Dowling	Manager, Accreditation and Quality Improvement
Ms. Aisling Smith	Education Manager, Education Development

Staff	Role
Ms. Janet O'Farrell	Manager, Research
Ms. Roisin Craven	Project Manager, OPTIMISE
Mr. Ken Carmody	Project Manager, Accreditation and Quality Improvement
Mr. Eoin Donnelly	Strategy Programme Manager, Executive Office
Mr. Stephen Capper	Education Specialist, Education Development
Ms. Anjitha Radhamoney	Project Manager, OPTIMISE
Ms. Sophia Kilcullen	Research Fellow