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.