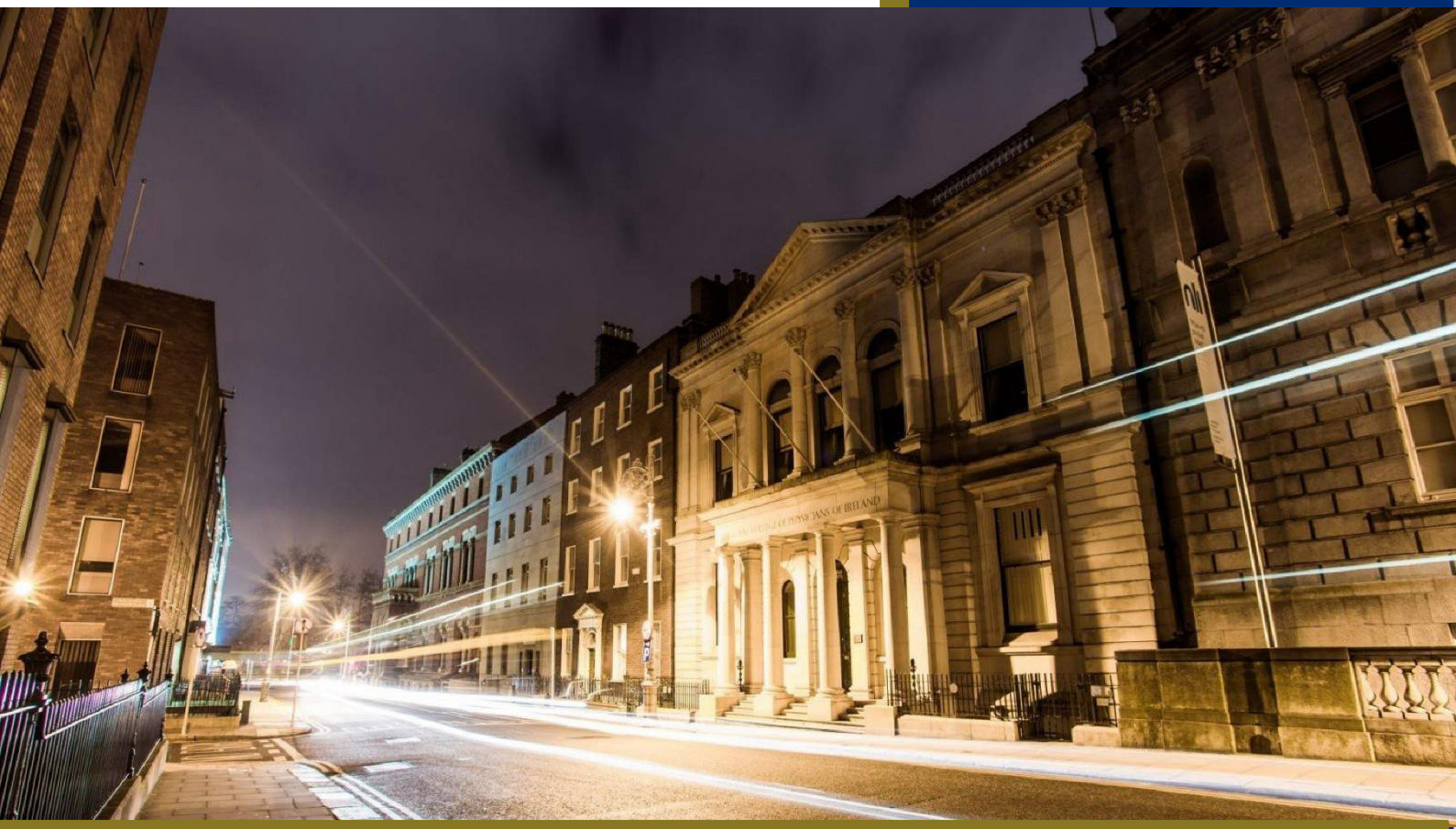
ROYAL COLLEGE OF PHYSICIANS OF IRELAND



Proposed Restructuring of Internal Medicine Training
Assessment of Proportionality

July 2026

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Executive Summary

Purpose of this Assessment

This report has been prepared in accordance with Directive (EU) 2018/958 on a proportionality test before adoption of new regulation of professions. It assesses whether the proposed introduction of a three-year Internal Medicine Training (IMT) programme is justified by legitimate public-interest objectives, supported by objective evidence and proportionate to the aims pursued.

The assessment does not seek to determine the overall position of Irish physician training under Annex V of Directive 2005/36/EC, except insofar as Annex V considerations are relevant to understanding the regulatory implications of the proposed reform.

The Proposed Reform

The proposal introduces a three-year Core Internal Medicine Training programme in place of the existing two-year Basic Specialist Training programme in General Internal Medicine. The reform forms the first stage of physician specialist training and is intended to provide broader clinical exposure, strengthen preparedness for registrar-level practice, improve curriculum delivery and enhance the consistency and quality of training across sites. The reform does not alter specialist registration, recognised specialties, CSCST, Higher Specialist Training or the Medical Council's regulatory functions.

Evidence Supporting Reform

The proposed reform originated from Medical Council accreditation requirements which required a formal review of BST delivery and trainee exposure to the full breadth of the curriculum. The subsequent *OPTIMISE* Review concluded that the traditional BST/HST structure had become increasingly challenged by changing working patterns, increasing service complexity and evolving patient needs.

Particularly significant evidence is related to preparedness for registrar-level practice. The *OPTIMISE* Review reported that 94% of surveyed BST trainees did not believe current BST teaching had prepared them to work as registrars. These findings were reinforced through a national stakeholder consultation involving 129 trainers and clinical stakeholders, in which preparedness for registrar-level practice was identified as the highest-priority area requiring reform.

The assessment also identified evidence of widespread reliance on informal registrar-level transition posts between BST and Higher Specialist Training. It also identified changing working patterns associated with implementation of the Working Time Directive, increasing patient complexity and growing demands on Internal Medicine services.

Workforce planning reports further highlighted future consultant workforce requirements, challenges in non-training scheme doctor dependency and the importance of maintaining high-quality physician training pathways.

Consideration of Alternative Options

The assessment considered four potential options:

Option	Feature	Consideration
1	Retention of the existing BST/HST model.	Would not address the deficiencies identified by the Medical Council, *OPTIMISE* Review, trainees, trainers and workforce planning evidence.
2	Enhancement of BST without structural reform.	Enhancement of BST without structural reform was considered carefully but was judged unlikely to address the underlying structural issues relating to clinical exposure, preparedness for registrar practice and the informal transition period between BST and HST.
3	Development of a standalone General Internal Medicine pathway	A standalone General Internal Medicine pathway was not considered proportionate to the issues identified and would require broader workforce and service redesign.
4	Introduction of the proposed three-year Internal Medicine Training model.	Recommended approach. The assessment concluded that the proposed three-year IMT model is suitable, necessary and proportionate.

Proportionality Assessment

The reform directly addresses the principal deficiencies identified through accreditation, stakeholder consultation and workforce evidence. It provides a structured and quality-assured mechanism for preparing trainees for registrar-level practice, strengthens supervision and educational governance arrangements, improves curriculum exposure and supports delivery of safe acute medical services.

The principal burden associated with the proposal is the extension of the first stage physician training from two years to three years. However, evidence indicates that a majority of trainees already undertake registrar-level transition posts before entering Higher Specialist Training. The proposed reform formalises this period within a recognised and educationally governed training programme. The anticipated benefits are therefore considered proportionate to the additional requirements imposed.

Annex V Considerations

The assessment acknowledges that questions relating to Directive 2005/36/EC and Annex V remain under active consideration by relevant stakeholders. The report does not seek to determine the outcome of that process.

However, the proposed reform increases the volume of structured Internal Medicine training delivered within the physician training pathway and cannot reasonably be regarded as increasing

potential Annex V-related risk. The proportionality conclusions reached in this assessment are therefore considered robust irrespective of the final outcome of any future Annex V review process.

Conclusion of Proportionality

Having considered the evidence available, the proposed three-year Internal Medicine Training model is considered:

- justified by legitimate public-interest objectives;
- supported by objective evidence of need;
- suitable for achieving its stated objectives;
- more effective than the alternative options considered; and
- proportionate in accordance with the requirements of Directive (EU) 2018/958.

Accordingly, the proposed reform represents the least extensive intervention reasonably capable of addressing the training, education, supervision, workforce and service challenges identified through Medical Council accreditation findings, the *OPTIMISE* Review and wider national workforce planning evidence.

Evidence Base

The proportionality assessment draws upon a range of regulatory, workforce, service-planning, educational and stakeholder evidence sources.

The principal sources are summarised below.

Evidence Source	Author / Organisation
Report on the Accreditation of the Institute of Medicine and Seven Programmes of Higher Specialist Training (2022)	Medical Council
OPTIMISE Interim Report (2023)	RCPI Institute of Medicine
Medical Workforce Report 2025–2026	HSE National Doctors Training & Planning (NDTP)
Dual Training Specialties of Medicine Medical Workforce in Ireland 2024–2038	HSE National Doctors Training & Planning (NDTP)
Model 3 Hospitals Consultant Recruitment and Retention Report (2023) and Implementation Group Report (2026)	HSE National Doctors Training & Planning (NDTP)
National Taskforce on the NCHD Workforce (2024)	Department of Health
Changing Horizons: Framing Physician Training to 2030 and Beyond	Royal College of Physicians of Ireland
Ireland's Future Health and Social Care Workforce	Department of Health
Medical Workforce Intelligence Report (2024)	Medical Council
IMT Stakeholder Expectations Survey (2025)	RCPI Institute of Medicine
IMT Stakeholder Consultation Record and Engagement Log	RCPI Institute of Medicine

Legal and Regulatory Sources

The assessment has also been prepared with reference to the following European legislative framework:

Source	Description
Directive 2005/36/EC	Recognition of Professional Qualifications
Directive 2013/55/EU	Amendment of Directive 2005/36/EC
Directive (EU) 2018/958	Proportionality Test Before Adoption of New Regulation of Professions
Directive 2003/88/EC	Working Time Directive
Directive 2000/78/EC	Employment Equality Directive
Directive (EU) 2019/1152	Transparent and Predictable Working Conditions Directive
Directive 2014/54/EU	Free Movement of Workers Directive

1. Background and Context

Internal Medicine sits at the heart of Ireland's acute hospital system. In 2023 more than 170,000 emergency episodes were discharged under General Medicine, while Medicine represented the largest consultant discipline within the publicly funded health service, comprising 1,373 consultants in 2025.

The assessment of proportionality examines the proposed restructuring of Internal Medicine Training (IMT) which has arisen from a range of regulatory, educational, workforce and service-delivery considerations and forms part of a broader effort to ensure that postgraduate medical training remains aligned with the needs of patients, the health service and the medical profession.

Regulatory Drivers

A key driver for reform was the Medical Council Report on the Accreditation of The Institute of Medicine and seven programmes of higher specialist training (including basic specialist training) which received Ministerial Approval in December 2022. Within this report, the Medical Council required that:

> *"The IOM must undertake a formal review of the delivery of (BST) education and training and provide a report to the IMC."*
>
> and
>
> *"The IOM must review the BST programme and rotations to ensure that all trainees are exposed to the full breadth of the curriculum."*

These requirements highlighted concerns regarding the structure and delivery of Basic Specialist Training (BST) in General Internal Medicine and directly informed the establishment of the *OPTIMISE* Review of Internal Medicine Training, commissioned by the Institute of Medicine to undertake a comprehensive review of the training pathway and develop recommendations for future reform.

The resulting *OPTIMISE* Interim Report (2023) concluded that the traditional BST/HST model was increasingly challenged by changing work patterns, increasing service pressures, evolving patient needs and the growing complexity of modern Internal Medicine practice.

The report recommended the development of an integrated Internal Medicine Training pathway, including a structured three-year Stage 1 Internal Medicine Training programme designed to provide broader and more consistent exposure to the core competencies required for contemporary physician practice.

Population Demographics

The educational rationale for reform is reinforced by wider national policy and population health trends. RCPI's Changing Horizons: Framing Physician Training to 2030 and Beyond (2024) identified increasing multimorbidity, chronic disease and population ageing as defining challenges for the future physician workforce and highlighted the need to strengthen Internal Medicine capability to meet these demands. The report specifically recognised the importance of enhancing training pathways that prepare physicians to manage increasingly complex patients with multiple co-

existing conditions while supporting integrated models of care across hospital and community settings.

A similar conclusion is reached in the Department of Health's Ireland's Future Health and Social Care Workforce (2025), which identifies population growth, demographic ageing, increasing chronic disease burden and service reform as major drivers of future workforce demand. The report emphasises that workforce planning must be aligned to the changing health needs of the population and that future workforce development will require greater flexibility, integration and responsiveness to emerging models of care.

Workforce Planning

Workforce planning evidence further highlights the strategic importance of Internal Medicine. The HSE National Doctors Training and Planning report Dual Training Specialties of Medicine Medical Workforce in Ireland 2024–2038 notes that consultants across the dual-accredited medical specialties are overwhelmingly trained in both their specialty and General Internal Medicine and play a central role in delivering acute medical care, staffing Acute Medical Units and managing increasingly complex inpatient populations. The report projects substantial future growth in consultant demand and identifies the need for a sustainable training pipeline capable of supplying sufficient numbers of appropriately trained physicians into the 2030s.

The Medical Workforce Report 2025–2026 records 286 first-year Medicine BST entrants and 147 first-year entrants to Higher Specialist Training across 19 medical specialities.

Across the dual-accredited Internal Medicine specialties, substantial training cohorts are now in place, including 117 trainees in Geriatric Medicine, 75 in Respiratory Medicine, 73 in Cardiology, 56 in Gastroenterology and 53 in Endocrinology and Diabetes Mellitus. This demonstrates both the scale of the Internal Medicine training pathway and its central role in supplying the future consultant workforce required to deliver acute and general medical services.

At the same time, the report notes that non-training scheme doctor posts remain concentrated in a number of specialties, particularly Emergency Medicine and General Internal Medicine, highlighting continuing challenges in workforce configuration and the importance of maintaining attractive, structured training pathways in Internal Medicine.

Model 3 Hospitals

The need to strengthen Internal Medicine capability is particularly evident within regional acute hospital services. The Model 3 Hospitals Consultant Recruitment and Retention Report identified significant challenges in consultant recruitment and retention throughout the Model 3 network and highlighted a growing requirement for generalist physicians capable of delivering acute medical care outside major tertiary centres. The report noted that many hospitals increasingly depend upon consultants with broad Internal Medicine expertise to support emergency and unscheduled care and concluded that strengthening the generalist physician workforce is essential to sustaining safe and effective services across the hospital network.

Broader workforce analyses point to similar concerns. The Medical Council's Medical Workforce Intelligence Report (2024) identified workforce sustainability, recruitment and retention, excessive working hours and growing service demands as major challenges facing the medical workforce.

Likewise, the National Taskforce on the NCHD Workforce (2024) concluded that education and training must play a central role in addressing workforce sustainability, emphasising the need for enhanced educational supports, improved training environments, stronger governance arrangements and increased access to structured postgraduate training opportunities.

Summary Context

These reports demonstrate that the proposed reform represents a coordinated response to explicit Medical Council accreditation requirements, recommendations arising from the *OPTIMISE* review, changing population health needs, national workforce planning evidence and recognised challenges in the delivery of Internal Medicine services.

The proposed Internal Medicine Training pathway is intended to ensure that future physicians are exposed to the full breadth of the Internal Medicine curriculum, acquire the competencies required for increasingly complex patient populations and are prepared to meet the future workforce needs of the Irish health system.

2. Legal and Regulatory Framework

2.1 European Union Professional Qualifications Framework

The recognition of specialist medical qualifications within the European Union is governed principally by Directive 2005/36/EC on the Recognition of Professional Qualifications, as subsequently amended by Directive 2013/55/EU. The Directive establishes the framework through which professional qualifications obtained in one Member State are recognised in another, facilitating the free movement of professionals across the European Union.

For the medical profession, the Directive provides for automatic recognition of qualifications in specified circumstances and sets out minimum training requirements for medical specialties. These requirements are contained within Annex V, which specifies recognised specialist qualifications and the minimum duration of training applicable to each specialty.

Directive 2013/55/EU introduced a number of amendments to the Professional Qualifications Directive, including measures intended to modernise professional qualification frameworks, enhance mobility and strengthen transparency. While the fundamental structure of automatic recognition remains based upon the provisions of Directive 2005/36/EC and Annex V, the amendments provide important context regarding the modernisation, and ongoing development of professional education and training frameworks.

Accordingly, any reform of Internal Medicine Training must be considered within the context of Ireland's obligations under Directive 2005/36/EC, as amended, and with regard to the requirements contained in Annex V relating to specialist medical qualifications

2.2 Directive (EU) 2018/958 Proportionality Framework

Directive (EU) 2018/958 on a proportionality test before adoption of new regulation of professions establishes a framework requiring Member States to assess the proportionality of measures that

may affect access to, or pursuit of, regulated professions. The Directive seeks to ensure that any regulatory measures are justified, evidence-based and proportionate to the objectives pursued.

The Directive requires that proposed regulatory measures be assessed against a number of key principles, including:

- whether the measure is justified by a legitimate public interest objective;
- whether the measure is suitable for achieving that objective;
- whether the measure is necessary;
- whether the objective could reasonably be achieved through less restrictive means; and
- whether the benefits arising from the measure are proportionate to any restrictions imposed.

The methodology adopted throughout this assessment follows the requirements contained within Articles 5–7 of Directive 2018/958. The purpose of the assessment is therefore not to determine whether the proposed Internal Medicine Training model is desirable in principle, but rather to determine whether any regulatory consequences arising from the reform are justified, necessary and proportionate when considered against the legitimate public interest objectives being pursued.

2.3 Irish Regulatory Framework

The regulation of postgraduate medical education and specialist medical registration in Ireland is governed through a combination of statutory responsibilities exercised by the Irish Medical Council and the training and education functions delivered by accredited postgraduate medical training bodies, such as the Institute of Medicine as a faculty of the Royal College of Physicians of Ireland.

The Medical Council is responsible for maintaining the Register of Medical Practitioners, accrediting postgraduate medical training bodies and training programmes, and assuring the quality of postgraduate medical education and training.

Successful completion of an approved specialist training programme results in the award of a Certificate of Satisfactory Completion of Specialist Training (CSCST). Possession of a CSCST allows a doctor to apply for entry onto the Specialist Division of the Medical Council Register in the relevant specialty and subsequently to apply for consultant appointments.

As the proposed Internal Medicine Training pathway forms part of the recognised postgraduate medical training system, any changes to programme structure, progression arrangements, certification pathways or their relationship to specialist registration must be considered within this wider regulatory framework.

2.4 Medical Council Accreditation Requirements

The afore-mentioned Medical Council Report on the Accreditation of the Institute of Medicine highlighted concerns regarding trainee exposure to the full curriculum, the structure of programme delivery and the adequacy of rotations within the existing Basic Specialist Training pathway.

In response to these requirements, the Institute of Medicine established the *OPTIMISE* Review of Internal Medicine Training, led by Professor Anthony O'Connor, to undertake a comprehensive assessment of Internal Medicine Training in Ireland and to develop recommendations for future programme design. The review subsequently recommended the development of an integrated

Internal Medicine Training pathway and a structured three-year Stage 1 Internal Medicine Training programme intended to strengthen curriculum exposure, improve consistency of training experience and better align physician training with future healthcare requirements.

The proposed Internal Medicine Training reform considered in this assessment therefore represents both a response to identified accreditation requirements and a broader programme of training and workforce reform arising from the findings of the *OPTIMISE* Review.

2.5 Scope of this Assessment

This proportionality assessment is concerned with the proposed introduction of a three-year Core Internal Medicine Training programme as the common entry route to Higher Specialist Training in Internal Medicine specialties. It assesses the proportionality of the proposed reform insofar as it may have regulatory consequences for access to, progression within, or completion of recognised specialist medical training.

In particular, the assessment considers whether the proposed measure is justified by legitimate public interest objectives, whether it is suitable and necessary to achieve those objectives, and whether the same objectives could reasonably be achieved through less restrictive means, in keeping with the requirements of Directive (EU) 2018/958.

The assessment of proportionality does not seek to determine, in itself, Ireland's overall position under Annex V of Directive 2005/36/EC in respect of dual-specialty training, dual-speciality service delivery or automatic recognition of specialist qualifications. Those issues are addressed only to the extent that they are relevant to understanding whether the proposed IMT reform affects the relationship between recognised training, CSCST, Specialist Registration and EU recognition of specialist medical qualifications.

While this assessment draws on workforce data, training priorities, training distribution and anticipated service delivery impacts, evidence relating to these areas is considered only insofar as it is relevant to determining whether the proposed measure is justified, necessary and proportionate in accordance with Directive (EU) 2018/958.

3. Definition of the Regulatory Measure

This assessment concerns the proposed reform of the existing Basic Specialist Training programme to a structured three-year Core Internal Medicine Training (IMT) programme which will continue to function as a common, but not exclusive, entry route to Higher Specialist Training in Internal Medicine specialties.

The reform does not alter the status of specialist registration, the award of a Certificate of Satisfactory Completion of Specialist Training (CSCST), or the role of the Medical Council in maintaining the Specialist Division of the Register. Its purpose is to provide broader and more consistent exposure to General Internal Medicine, improve curriculum delivery and ensure trainees acquire the competencies required to meet future patient, workforce and health service needs.

The principal features of the reform are:

3.1 Establishment of a Three-Year Core Internal Medicine Training Programme

A new three-year Internal Medicine Training programme as the initial stage of physician specialist training. The programme will place particular emphasis on acute medical care, multimorbidity, frailty, integrated care, critical care exposure and other areas identified through the *OPTIMISE* Review as essential components of contemporary physician training.

3.2 Revised Curriculum and Assessment Framework

The reform introduces revised curriculum requirements, learning outcomes, clinical exposures and assessment arrangements designed to ensure that trainees are exposed to the full breadth of the Internal Medicine curriculum. The programme seeks to provide a more consistent and structured educational experience across training sites while strengthening alignment between training outcomes, patient needs and service requirements.

3.3 Scope of Regulatory Impact

The proposal does not alter the legal status of specialist recognition, specialist registration, the Medical Council Register, or the requirement for successful completion of recognised specialist training leading to CSCST. Similarly, it does not introduce an additional point of regulatory approval, registration or professional licensing.

The principal regulatory effect of the proposal is therefore limited to the introduction of a three-year Core Internal Medicine Training programme in place of the existing two-year Basic Specialist Training programme in General Internal Medicine.

Accordingly, this assessment focuses on the proportionality of changes to training structure, curriculum and progression arrangements rather than the broader legal framework governing specialist medical qualifications. Issues relating to Annex V and automatic recognition are considered separately in Section 9 insofar as they may be affected by the proposed reform.

4. Legitimate Public Interest Objectives

Under Article 6 of Directive (EU) 2018/958, Member States may regulate professions where justified by recognised public interest objectives. The objectives below represent the legitimate public interest objectives which the proposed IMT reform seeks to advance and which form the basis for the proportionality assessment that follows.

4.1 Protection of Public Health and Patient Safety

The principal objective of the proposed Internal Medicine Training reform is the protection of public health and patient safety through the development of a medical workforce appropriately trained to meet the health needs of the Irish population. This objective is consistent with the public interest objectives recognised by Directive (EU) 2018/958 and reflects the statutory responsibilities of the Medical Council, HSE National Doctors Training and Planning (NDTP) and accredited postgraduate medical training bodies

The need for reform is reinforced by changing population demographics and patterns of disease. The Department of Health Report on *Ireland's Future Health and Social Care Workforce* identifies population growth, demographic ageing, increasing chronic disease prevalence and increasing service complexity as major drivers of future workforce requirements. The report emphasises that

workforce planning and education must respond to current and future population health needs and support emerging models of integrated care.

The RCPI *OPTIMISE Interim Report* similarly identifies Internal Medicine as the core business of Irish hospitals and highlights increasing multimorbidity, frailty, polypharmacy and clinical complexity as key challenges facing future physicians. The report concludes that Internal Medicine training must evolve to ensure doctors possess the knowledge, skills and experience necessary to meet these changing healthcare needs.

In a national stakeholder consultation involving 129 trainers and clinical stakeholders from all Health Regions and both Model 3 and Model 4 hospitals, preparedness for registrar-level practice was identified as the highest-priority area for reform. 76% of respondents rated preparedness to be the registrar on-call as either an "Absolute Must Change" or "High Priority" issue, with remarkably consistent findings across Model 3 and Model 4 environments (75% and 78% respectively). This supports the conclusion that the concerns identified through *OPTIMISE* are not confined to trainees alone but are shared by those responsible for training and supervising future registrars.

Accordingly, the proposed reform seeks to ensure that future physicians commencing registrar posts, or entering Higher Specialist Training are equipped to provide safe, effective and high-quality care within increasingly complex healthcare environments.

4.2 Quality of Specialist Medical Education and Training

The Medical Council accreditation of the Institute of Medicine identified concerns regarding the delivery of Basic Specialist Training and trainee exposure to the full breadth of the curriculum. The Council required that the Institute of Medicine undertake a formal review of the delivery of BST education and training and review programme rotations to ensure appropriate curriculum exposure. These findings directly led to the establishment of the *OPTIMISE* review.

The resulting *OPTIMISE* review concluded that the existing BST/HST model was increasingly challenged by changing work patterns, service pressures and evolving patient needs. It recommended an integrated Internal Medicine Training model intended to provide broader and more consistent educational exposure and strengthen acquisition of core Internal Medicine competencies.

The reform therefore seeks to deliver a higher quality, more consistent and more comprehensive training experience capable of meeting accreditation requirements and future service needs

4.3 Alignment of Training with Contemporary Healthcare Needs

RCPI's *Changing Horizons: Framing Physician Training to 2030 and Beyond* report identified multimorbidity, chronic disease and population ageing as defining issues for the future physician workforce and highlighted the need to support wider generalist capability within Internal Medicine. The report recognised that future physicians will increasingly be required to manage patients with multiple concurrent conditions across organisational boundaries and care settings.

The HSE / NDTP *Medical Workforce Report 2025-2026* records continuing expansion of physician specialty training programmes, including 565 trainees in Medicine BST and 670 trainees across Higher Specialist Training programmes in Medicine. The report also notes continuing challenges

relating to workforce configuration and concentration of non-training posts in specialties such as Emergency Medicine and General Internal Medicine.

The proposed IMT structure seeks to better align early physician training with these contemporary patient, workforce and service realities by strengthening exposure to acute medicine, multimorbidity, frailty, integrated care and related core competencies.

4.4 Maintenance of Safe Acute Medical Services

The *Dual Training Specialties of Medicine Medical Workforce in Ireland 2024-2038* report notes that consultants across the dual-accredited physician specialties are overwhelmingly trained in both their specialty and General Internal Medicine and are central to the delivery of acute medical care, Acute Medical Units and management of complex inpatients. The report projects substantial future consultant demand across these specialties.

The *Model 3 Hospitals Consultant Recruitment and Retention Report* highlights the increasing dependence of regional hospitals on physicians with broad Internal Medicine expertise and identifies significant consultant recruitment and retention challenges across the Model 3 network. The report concludes that strengthening the generalist physician workforce is essential to sustaining safe and effective services across regional hospitals.

The strategic importance of Model 3 hospitals has been further reinforced through the 2026 Model 3 Hospitals Consultant Recruitment and Retention Implementation Group Report, which describes these hospitals as providing care to over 50% of the Irish population and identifies consultant workforce sustainability, postgraduate training opportunities and workforce planning as continuing priorities. The report highlights the importance of strengthening training pathways and exposure to Model 3 environments as part of longer-term workforce sustainability planning.

The proposed IMT model provides a framework through which accredited training activity can be expanded across a broader range of clinical settings, including hospitals outside major tertiary centres. This aligns with wider workforce planning objectives that seek to ensure that training opportunities, education resources and future workforce supply are distributed in a manner that reflects population need and service demand. In doing so, the reform has the potential to contribute both to the maintenance of safe acute medical services and to greater regional equity in access to recognised postgraduate medical training.

4.5 Workforce Sustainability and Medical Workforce Planning

The *Dual Training Specialties of Medicine Medical Workforce in Ireland 2024-2038* report projects significant future growth in consultant requirements across physician specialties and highlights the importance of a sustainable training pipeline capable of meeting future workforce requirements.

The *National Taskforce on the NCHD Workforce* and the Medical Council's *Medical Workforce Intelligence Report* both identify recruitment, retention, educational quality, training opportunities and workforce sustainability as significant challenges facing the Irish medical workforce. Both reports emphasise the importance of maintaining attractive, high-quality training pathways as part of wider workforce planning and retention strategies.

While workforce sustainability is not the primary justification for the proposed reform, it is a legitimate secondary objective insofar as workforce shortages, recruitment difficulties or inadequately structured training pathways may adversely affect the health system's capacity to provide safe and effective patient care.

5. Evidence of the Problem

EU Directive 2018/958 requires objective evidence that the status quo is insufficient. In this case, it is incumbent on RCPI and the Institute of Medicine to demonstrate that the existing BST programme is no longer fully capable of achieving the public interest objectives identified in Section 4.

Accordingly, this section examines the evidence relating to the current Basic Specialist Training (BST) pathway in Internal Medicine. The evidence base for reform indicates that the current two-year Basic Specialist Training (BST) pathway in General Internal Medicine is no longer consistently sufficient to prepare trainees for the transition to registrar-level Internal Medicine practice.

This conclusion is supported by the Medical Council accreditation findings already referenced in this assessment, the *OPTIMISE* Review of Internal Medicine Training, trainee feedback, evidence of changed working patterns, the growth of informal "gap year" registrar posts, and continuing reliance on non-training scheme doctor posts in areas closely associated with acute and general medical care.

The issue is therefore not simply whether a three-year Internal Medicine Training programme would be preferable, but whether the existing BST structure is sufficient to deliver the public health, patient safety, educational and workforce objectives identified in Section 4.

5.1 Medical Council Accreditation and the Requirement to Review BST

The immediate regulatory trigger for reform was the 2022 Medical Council accreditation requirement that the Institute of Medicine undertake a formal review of the delivery of BST education and training and review BST rotations to ensure that trainees are exposed to the full breadth of the curriculum. These requirements identified concerns regarding the structure, delivery and consistency of the existing BST pathway and provided the basis for the subsequent *OPTIMISE* Review of Internal Medicine Training.

The Medical Council requirements and the *OPTIMISE Interim Report* analysis identify the current BST pathway as both large in scale (c.560 doctors) and central to the future physician workforce, but also as requiring formal review in relation to delivery, rotations and curriculum exposure.

5.2 Preparedness for Registrar-Level Practice

The most direct evidence of the problem relates to trainee preparedness for the transition from SHO-level practice to registrar-level Internal Medicine practice. The *OPTIMISE Interim Report* states that trainees themselves felt ill-prepared for the demands of the medical registrar role at the end of BST.

In consultation with trainees, the review was presented with an unpublished survey of BST trainees in two large Dublin academic teaching hospitals in which 94% of trainees reported that current BST teaching had not prepared them to work as registrars.

This is a particularly important finding for the purposes of proportionality. The existing two-year BST pathway appears, at least on the evidence presented to *OPTIMISE*, to leave a substantial proportion of trainees feeling insufficiently prepared for the next major clinical transition in their training pathway and the delivery of safe patient care.

OPTIMISE further notes that trainees in Internal Medicine frequently undertake a "gap year" working at registrar level in a chosen subspecialty between the end of BST and the start of HST. The report states that almost half of successful applicants for HST had undertaken such a post, with this figure rising to 80–90% in certain specialties such as Gastroenterology.

These findings are reinforced by the aforementioned national survey of 129 trainers and clinical stakeholders, where preparedness for registrar-level practice emerged as the highest-priority area requiring change within the BST programme. Feedback consistently highlighted concerns regarding preparedness for registrar on-call responsibilities and the need for more structured progression towards registrar-level duties.

Trainee and trainer feedback, alongside workforce data suggests that the system has already developed an informal, non-accredited transition period between BST and HST. From a proportionality perspective, this is highly relevant.

Viewed through this lens, the proposed third year of Internal Medicine Training may be understood not as the creation of an entirely new burden, but as an attempt to bring an existing de facto transition period into a structured, supervised and educationally governed training programme.

5.3 Changed Working Patterns and Reduced Experiential Learning

OPTIMISE identifies a clear explanation for why a two-year BST model that may previously have been sufficient is now under pressure. The report notes that when BST in Internal Medicine was first established in Ireland in the mid-2000s, the average working hours of an NCHD were approximately 75–77 hours per week, whereas in line with EU Directive 2003/88/EC (Working time), average weekly hours had subsequently reduced to approximately 53 hours per week. *OPTIMISE* concludes that it can therefore be reasonably assumed that direct clinical contact and experience of acute medicine, unselected take and outpatient activity have decreased proportionately.

This is an important structural change whereby the environment in which clinical learning occurs has changed. Working time compliance is necessary and appropriate for the safety of doctors and patients, but training programmes must adapt if reduced hours and altered work patterns mean that trainees have fewer opportunities to acquire equivalent experience within the same programme duration.

OPTIMISE also states more broadly that the former training model, based around doctors embedded in the same clinical environment and a master-apprentice model, has been significantly disrupted by changes in work patterns, clinical demand and patient factors. The report concludes that training programmes must therefore adapt how learning, both on and off the job, is delivered.

The proposed reform is intended to address these training consequences within the framework of contemporary working-time protections rather than through any increase in working hours or reduction in employee protections.

5.4 Informal Transition Posts and Non-Training Scheme Doctor Dependency

The reliance on informal "gap year" registrar posts is also linked by *OPTIMISE* to the growth of non-training scheme doctor posts. The report states that these posts have contributed to the expansion in the proportion of NCHDs occupying unaccredited, non-training scheme doctor posts, which were reported at that time to account for 38.8% of all NCHD posts in the system. It further states that the number of such posts increased from 1,447 to 3,081 between 2012 and 2021, despite policy objectives to reduce reliance on non-training scheme posts.

More recent workforce evidence confirms that reliance on non-training scheme doctor posts has persisted. The HSE NDTP *Medical Workforce Report 2025-2026* records that a large proportion of NCHDs remain in non-training scheme posts and states that such roles are concentrated in particular specialties, including Emergency Medicine and General Internal Medicine. It records an increase in non-training scheme doctors in the public health sector from 2,801 in 2021 to 4,018 in 2025.

Similarly, the 2026 HSE NDTP Model 3 Hospitals -Consultant Recruitment & Retention Implementation Group Report demonstrates that expansion of recognised training opportunities continues to be viewed nationally as an important workforce strategy, reflecting an ongoing need to strengthen formal training pathways in settings where non-training posts remain prevalent.

For this assessment, the significance of these data is that the proposed IMT reform will reduce reliance on unstructured transition arrangements by incorporating a supervised early registrar year within an accredited training pathway. This supports the view that the proposed reform is directed at a real feature of the current training system rather than an abstract educational preference.

5.5 Breadth of Curriculum and Contemporary Clinical Need

The *OPTIMISE Interim Report* identifies that the healthcare environment in which Internal Medicine trainees practice has changed substantially. It states that demographic factors and advances in medical science and technology will continue to change clinical practice and that training should increasingly emphasise cross-subspecialty work, the acutely unwell patient, multimorbidity, frailty and polypharmacy.

This aligns directly with the Medical Council requirement that BST rotations be reviewed to ensure exposure to the full breadth of the curriculum. *OPTIMISE* describes the current and future practice of Internal Medicine as requiring broader and more integrated capability than mastery of individual disciplines alone. It also proposes that the initial stage of IMT include structured experience in acute internal medicine, cardiology, acute respiratory care, stroke, integrated care, critical care or high-dependency care, procedural skills, Point of Care Ultrasound, and human factors including communication, teamwork and care of the dying patient.
The current evidence therefore indicates that the problem is not simply one of programme length. It concerns whether the existing structure allows sufficiently consistent exposure to the breadth of experience now required for safe Internal Medicine practice.

5.6 Scale and Complexity of Acute Medical Activity

The challenge facing contemporary Internal Medicine training must also be considered within the context of the scale and complexity of activity undertaken within Irish hospitals.

The *OPTIMISE* Review describes Internal Medicine as the "core business" of Irish hospitals and notes that consultants trained in Internal Medicine are responsible for the assessment and management of a substantial proportion of acute and unscheduled care activity. The report highlights that acute medical presentations account for more than 250,000 hospital bed days annually and notes that the overwhelming majority of the most common causes of bed occupancy relate to acute medical conditions, including cardiovascular disease, respiratory disease, neurological illness, infection, frailty and multimorbidity.

The report further notes that nine of the ten most common causes of hospital bed occupancy are attributable to acute medical presentations, underlining the central role of Internal Medicine in the operation of the Irish hospital system.

These data are consistent with broader national hospital activity figures demonstrating that more than 170,000 emergency episodes were discharged under General Medicine in 2023.

As patient activity increases in volume and complexity, the responsibilities of medical registrars expand correspondingly. Registrars are expected to assess acutely unwell patients, manage diagnostic uncertainty, coordinate multidisciplinary decision-making, supervise more junior doctors and contribute to the safe operation of acute medical services.

The findings of *OPTIMISE* suggesting that 94% of surveyed BST trainees did not feel prepared for registrar practice must therefore be interpreted against the backdrop of the scale, intensity and complexity of the clinical environment in which those doctors will subsequently work.

In this context, the question is not simply whether trainees complete the existing curriculum, but whether the structure of the current BST pathway provides sufficient clinical exposure, supervised responsibility and experiential learning to prepare doctors for the realities of contemporary registrar-level Internal Medicine practice.

5.7 Supervision, Feedback and the Trainer–Trainee Relationship

OPTIMISE identifies weaknesses in the traditional trainer–trainee relationship under contemporary service conditions. The report states that trainees no longer experience the master-apprentice model as practised historically and that a new method is required to ensure trainers have the time, resources and skills needed to provide continuity of support, guidance and supervision.

The report further states that trainers face multiple competing obligations, including responsibilities for medical students, BST trainees, HST trainees, non-physician healthcare professionals and wider clinical and public-facing commitments. Based on feedback from trainees and trainers, *OPTIMISE* concludes that it is the BST supervision relationship that is most likely to suffer in this environment.

In response, *OPTIMISE* recommends that each IMT trainee should have a named educational supervisor providing continuity over the three-year period of training, working alongside clinical

supervisors who change from post to post. It also recommends quarterly review of trainee progress, annual professional development planning, trainee feedback on training and supervisors, and site-level quality review.

Stakeholder consultation undertaken during the IMT review provides further support for these findings. 63% of respondents identified supervision and trainer structures as a high-priority area for change. Trainers frequently reported difficulties in identifying assigned trainees, inconsistent engagement during rotations and insufficient governance of supervision arrangements. Many stakeholders supported more structured educational oversight, formalised review processes and greater accountability for trainer and trainee engagement.

This evidence supports the conclusion that reform is required not only to increase duration, but to strengthen the educational infrastructure around the early years of physician training.

5.8 Training Site Quality and Consistency

The *OPTIMISE Interim Report* also identifies a need for stronger site-level educational governance. It recommends that sites offering IMT undergo 360-degree feedback review every two years, incorporating trainee feedback, adherence to training recommendations, provision of clinical teaching and examination pass rates. It proposes that sites be categorised as green, amber or red, with improvement planning or suspension of IM training where required.

The report also recommends protected, defined, bleep-free clinical teaching for trainees preparing for registrar-level duties, focused on common medical presentations in unselected take. It states that no trainee in the third IMT year should undertake overnight rostered on-call until signed off by an educational supervisor as safe and competent to do so.

These recommendations indicate that the proposed reform is intended to address variability in training experience and to ensure that progression towards registrar-level practice occurs in a safe, monitored and educationally supported manner.

5.9 Summary of the Problem Statement

The evidence reviewed in this section supports the following conclusions:

- The Medical Council required a formal review of BST delivery and rotations, including exposure to the full breadth of the curriculum.

- *OPTIMISE* identified that the traditional BST model has been disrupted by changed working patterns, reduced clinical exposure, increased service complexity and altered trainer–trainee relationships.

- Trainee feedback indicated a serious concern regarding preparedness for registrar practice, with 94% of trainees in one survey reporting that current BST teaching had not prepared them to work as registrars.
- The frequent use of informal “gap year” registrar posts between BST and HST suggests that a transition period is already operating within the system, but outside formal accredited training and quality structures.

- The continued concentration of non-training scheme doctor posts in areas such as Emergency Medicine and General Internal Medicine reinforces the need to strengthen accredited training pathways in areas central to acute care.

- *OPTIMISE* identifies the need for structured supervision, protected teaching, defined progression to registrar-level practice, simulation, POCUS, Model 3 exposure, critical care exposure and stronger site-level educational governance.

Taken together, the evidence indicates that maintaining the current two-year BST structure without reform would be unlikely to fully address the public health, patient safety, educational quality and workforce objectives identified in Section 4.

The proposed three-year IMT model is therefore being considered as a structured response to a demonstrable problem: the need to ensure that doctors progressing into higher specialist training and registrar-level Internal Medicine practice have acquired the breadth of experience, clinical exposure, supervision and competence required for contemporary Irish healthcare.

6. Assessment of Alternative Options

Directive (EU) 2018/958 requires consideration of whether the objectives pursued can be achieved through less restrictive means. Accordingly, a range of alternative approaches were considered. These included maintaining existing arrangements, introducing non-structural programme improvements, establishing a standalone General Internal Medicine pathway, and implementation of the proposed three-year Internal Medicine Training model. Each option was assessed against the public interest objectives identified in Section 4 and the evidence of limitations in the current system outlined in Section 5.

6.1 Option 1 – Retain the Existing BST/HST Structure

The first option considered was retention of the existing two-year Basic Specialist Training pathway and subsequent Higher Specialist Training structure without material reform.

This option would minimise regulatory intervention and maintain the existing training pathway. However, it would fail to address the concerns identified through Medical Council accreditation, including the requirement to review BST delivery and ensure trainee exposure to the full breadth of the curriculum.

Retention of the status quo would also leave unresolved the issues identified through the *OPTIMISE* Review, including concerns regarding trainee preparedness for registrar-level practice, reduced experiential learning opportunities, reliance on informal transition posts between BST and HST, inconsistencies in curriculum exposure and pressures on supervision arrangements.

As outlined in Section 5, evidence presented to *OPTIMISE* indicated that 94% of surveyed trainees did not feel current BST teaching had prepared them to work as registrars. Maintaining existing arrangements would not provide a mechanism to address this finding.

Accordingly, the option of retaining the existing BST/HST structure was not considered capable of achieving the identified public health, patient safety, educational quality and workforce objectives.

6.2 Option 2 – Enhance BST Without Structural Reform

A second option considered was the retention of the existing two-year BST structure while introducing targeted educational improvements, including curriculum revision, enhanced teaching, increased simulation, improved supervision arrangements and strengthened assessment processes.

This option would represent a less restrictive intervention than introduction of a revised three-year programme and was therefore given particular consideration.

However, the evidence reviewed in Section 5 strongly suggests that the limitations of the current model are not solely attributable to curriculum design or educational quality. *OPTIMISE* identified structural challenges arising from reduced clinical contact time, altered working patterns, increasing patient complexity and reduced exposure opportunities within the current two-year timeframe.

The review further identified widespread use of informal registrar-level transition posts between BST and HST, suggesting that additional experiential learning is already being sought outside the formal training programme. Almost half of successful HST applicants had undertaken such posts, increasing to 80–90% in some specialties.

The stakeholder consultation undertaken during the IMT review similarly demonstrated that concerns extended beyond individual training or education interventions. Respondents identified preparedness for registrar practice, regional equity of allocation, supervision, governance, consistency of exposure and trainee progression as areas requiring substantial change. The breadth of these findings suggests that educational enhancement alone would be unlikely to address the full range of issues identified.

While educational enhancements could improve aspects of the current BST programme, the considered view is that it would be unlikely to fully address the need for increased supervised responsibility, greater clinical exposure and structured preparation for registrar practice within the constraints of the existing two-year model.

For this reason, this option was considered unlikely to achieve the identified objectives to the same extent as the proposed reform.

6.3 Option 3 – Standalone General Internal Medicine Pathway

Consideration was also given to the development of a standalone General Internal Medicine training pathway.

This option could potentially increase exposure to General Internal Medicine and strengthen preparation for acute medical practice. However, it would represent a significantly more extensive regulatory intervention than the proposed IMT model and would require substantial changes to existing HSE workforce structures.

Current service delivery and workforce planning arrangements in Ireland are based largely on dual-accredited physician specialties incorporating both specialty-specific expertise and General Internal Medicine capability. The *Dual Training Specialties of Medicine Medical Workforce in Ireland 2024-2038* report notes that physicians across the dual-accredited specialties play a central role in the delivery of acute medical care and inpatient services.

There is currently limited evidence of demand for large numbers of consultants practising exclusively as General Internal Medicine specialists within the existing Irish consultant workforce model. Implementation of such a pathway would need to be considered following a comprehensive review of workforce planning and service design extending beyond the scope of the current proposal.

Accordingly, while RCPI is very open to further consideration of standalone General Internal Medicine training that may form part of future workforce and training discussions, it was not considered a proportionate response to the specific issues identified through the Medical Council review and *OPTIMISE* process.

6.4 Option 4 – Three-Year Internal Medicine Training Model (Preferred Option)

The preferred option is the introduction of a three-year Internal Medicine Training programme incorporating revised curriculum requirements, structured supervision arrangements, enhanced assessment processes and defined preparation for registrar-level practice.

This option directly addresses the concerns identified by the Medical Council regarding curriculum exposure and BST delivery and aligns with the recommendations arising from the *OPTIMISE* Review. It provides an accredited and educationally governed mechanism to address the preparedness gap identified among trainees while reducing reliance on informal transition posts outside recognised training structures.

Unlike Option 1, it responds directly to identified deficiencies. Unlike Option 2, it addresses both educational and structural limitations of the current model. Unlike Option 3, it achieves the required objectives without requiring fundamental redesign of Ireland's physician specialty training framework.

The proposed IMT model was therefore considered the option most capable of achieving the identified public interest objectives while representing the least extensive reform necessary to address the evidence reviewed in Section 5.

In addition to addressing the training and accreditation issues identified in Section 5, the proposed three-year Internal Medicine Training model is expected to support wider workforce and service objectives identified in national workforce planning reports.

By creating a structured training year at registrar level, the model increases opportunities to expand recognised training capacity across a broader range of training environments, including substantial uplift of training numbers in Model 3 hospitals. This supports greater regional equity in access to training, increases exposure to the acute medical environments in which many future consultants will ultimately practise, and aligns with recommendations within the HSE / NDTP *Model 3 Hospitals Consultant Recruitment and Retention Report* regarding the need to strengthen the pipeline of

broadly trained physicians capable of supporting acute and unscheduled care services outside major tertiary centres.

The model also responds to concerns identified by the *National Taskforce on the NCHD Workforce* regarding training quality, structured career progression, access to recognised training opportunities and workforce sustainability.

The 2026 HSE NDTP Model 3 Hospitals Consultant Recruitment and Retention Implementation Group Report concluded that strengthening postgraduate training opportunities within Model 3 hospitals is a key strategy for improving long-term consultant recruitment and workforce sustainability, and specifically identified the RCPI Internal Medicine Training project as having the potential to significantly strengthen the training pipeline for General Internal Medicine in Model 3 hospitals in the longer term

Unlike the other options considered, the proposed IMT structure is capable of simultaneously addressing registrar preparedness, workforce development, regional training distribution and service sustainability within a single accredited training pathway.

For these reasons, the proposed IMT model was considered the option most capable of achieving the identified public interest objectives while representing the least extensive reform necessary to address the evidence reviewed in Section 5. It delivers training, workforce and service benefits that cannot be fully realised through retention of the current BST model or through education enhancement alone.

7. Proportionality Analysis

Article 7 of Directive (EU) 2018/958 requires assessment of whether the proposed measure is suitable, necessary and proportionate to the public-interest objectives pursued, and whether those objectives could reasonably be achieved through less restrictive means. This section considers the proposed Internal Medicine Training reform against those tests, drawing on the evidence reviewed in Sections 4, 5 and 6.

7.1 Suitability of the Proposed Measure

A measure is suitable where it is capable of contributing to the achievement of the objectives pursued.

The evidence reviewed in Section 5 identified concerns regarding trainee preparedness for registrar-level practice, curriculum exposure, reduced experiential learning opportunities, increasing clinical complexity, supervision arrangements and reliance on informal transition posts between BST and HST.

The proposed three-year IMT model directly addresses each of these issues through an additional structured year of training, enhanced curriculum requirements, increased supervised clinical exposure, strengthened educational governance and defined preparation for registrar-level practice. The reform also responds directly to the Medical Council requirement to review BST delivery and ensure exposure to the full breadth of the curriculum.

The proposed measure is therefore considered suitable for achieving the objectives of protecting public health and patient safety, improving educational quality, strengthening alignment between

training and healthcare needs, supporting safe acute medical services and contributing to workforce sustainability.

7.2 Necessity of the Proposed Measure

A measure is necessary where the identified objectives cannot reasonably be achieved by maintaining existing arrangements.

The evidence reviewed in Section 5 indicates that the current BST model is no longer fully capable of delivering the intended outcomes. Medical Council accreditation findings required a formal review of BST delivery and rotations, while the *OPTIMISE* Review identified education, structural and workforce issues that were not addressed within the existing programme design.

Particularly significant is the evidence that 94% of surveyed trainees did not feel that BST had prepared them to work as registrars and that many trainees subsequently seek registrar-level experience through informal transition posts before entering HST.

The evidence therefore supports the conclusion that maintaining the current BST structure would not adequately address the identified deficiencies.

7.3 Consideration of Less Restrictive Means

Directive (EU) 2018/958 requires consideration of whether the same objectives could reasonably be achieved through a less restrictive intervention.

The principal less restrictive alternative identified was enhancement of the existing BST programme without structural reform. This option was examined in detail in Section 6.2 and would have retained the existing two-year programme while introducing curriculum enhancements, additional educational supports and revised supervision arrangements.

While such measures may improve elements of the current training experience, they would not address the underlying structural issues identified through *OPTIMISE*, including reduced clinical exposure, altered working patterns, increasing patient complexity and widespread reliance on informal registrar-level transition posts. Nor would they provide additional supervised responsibility and experiential learning opportunities within the recognised training pathway itself.

Accordingly, less restrictive alternatives were considered but were not judged capable of achieving the identified objectives to the same extent as the proposed IMT model.

7.4 Extent of the Regulatory Impact

The proportionality of a measure must also be assessed by considering the extent of the restriction it imposes.

The proposed reform does not alter specialist registration, CSCST, the Specialist Division of the Medical Council Register, access to Higher Specialist Training, or the legal framework governing specialist recognition.

It does not create a new regulated profession, a new licensing requirement or an additional regulatory approval process.

The regulatory impact is limited to the structure, curriculum and duration of the first stage of physician specialist training which represents a common, but not exclusive pathway towards specialism.

The reform therefore represents a targeted modification of an existing training pathway rather than a fundamental restructuring of the specialist registration system.

7.5 Balance Between Benefits and Burdens

The principal burden arising from the proposal is the extension of training from two years to three years. However, the evidence reviewed in Sections 5 and 6 indicates that an additional transition year is already operating informally for many trainees through non-training registrar appointments prior to entry into HST.

The proposed reform converts this informal and variable experience into a structured, supervised and quality-assured component of recognised training. In doing so, it is expected to improve preparedness for registrar practice, strengthen governance, support regional training distribution, increase recognised training capacity and reduce reliance on unstructured transition arrangements.

The benefits arising from the proposal are therefore considered proportionate to the additional requirements imposed.

7.6 Overall Proportionality Conclusion

Having considered the evidence available, the proposed three-year Internal Medicine Training model is considered:

- justified by legitimate public-interest objectives;
- suitable for achieving those objectives;
- necessary in light of the identified deficiencies in the existing system;
- more effective than the less restrictive alternatives considered; and
- proportionate to the objectives pursued.

Accordingly, the proposed reform is considered consistent with the requirements of Directive (EU) 2018/958 and represents the least extensive intervention reasonably capable of addressing the training, workforce and service issues identified through Medical Council accreditation findings, the *OPTIMISE* Review and broader national workforce evidence.

8. Impact Assessment

Directive (EU) 2018/958 requires consideration of the likely impacts of the proposed measure on those affected by it. This includes both the benefits and burdens associated with reform. The assessment below considers the likely effects of the proposed Internal Medicine Training model on trainees, healthcare providers, patients, regulators and the wider specialist training system.

8.1 Impact on Trainees

The most direct impact of the proposal falls on trainees entering the first stage of physician training. The reform extends the duration of training from two years to three years and therefore represents

an additional time commitment before progression to Higher Specialist Training. This is the principal burden associated with the proposed measure.

However, the evidence reviewed in Sections 5 and 6 indicates that most trainees already acquire additional registrar-level experience outside recognised training structures before entry to Higher Specialist Training. The proposed IMT model formalises this transition within an accredited training programme, providing structured supervision, defined educational outcomes and quality assurance mechanisms.

The reform is expected to improve preparedness for registrar-level practice through increased clinical exposure, enhanced supervision, greater continuity of educational oversight and more consistent attainment of core Internal Medicine competencies. These benefits are directly related to the public-health and patient-safety objectives identified in Section 4.

8.2 Impact on Health Service Delivery

The proposed reform is expected to have a positive impact on healthcare providers through the development of a workforce better prepared for registrar-level responsibilities and progression into Higher Specialist Training.

The model is also expected to support delivery of acute medical services by increasing opportunities for supervised registrar-level experience within recognised training. As outlined in Sections 4 and 5, acute medical services account for a substantial proportion of hospital activity and rely heavily on physicians trained in both General Internal Medicine and specialty practice. Strengthening preparation for these roles is therefore expected to support the safe and effective delivery of acute care.

The broader health service context also demonstrates increasing emphasis on strengthening workforce capacity within regional hospitals. The 2026 HSE NDTP Model 3 Hospitals Consultant Recruitment and Retention Implementation Group Report documents a 37% increase in consultant workforce numbers across Model 3 hospitals between January 2022 and February 2026, alongside continuing efforts to expand postgraduate training opportunities and improve consultant recruitment and retention.

The proposed IMT model aligns with these broader objectives by supporting expansion of recognised Internal Medicine training opportunities within regional clinical environments. While this is not a primary objective of the reform, it represents a positive secondary benefit insofar as it supports broader access to accredited training and aligns training locations more closely with service need.

8.3 Impact on Workforce Progression and Training Pathways

The available workforce evidence suggests that the proposed reform should also be considered in the context of progression through the Irish medical training system.

In line with EU Directive 2019/1152 (Predictable Working Conditions), the revised programme structure provides greater clarity regarding training duration, curriculum expectations, geographical rotations, assessment requirements and progression arrangements than currently exists in the Basic Specialist Training programme or through informal transition pathways between BST and HST.

Consultation carried out as part of this reform identified strong support for a more structured transition between BST and Higher Specialist Training, with preparedness for registrar-level practice emerging as the highest-ranked area requiring change. This suggests that stakeholders perceive benefits not only in educational quality but also in the coherence and transparency of progression through the physician training pathway

NDTP workforce analysis indicates that 80% of doctors awarded CSCST between 2017 and 2021 were retained in Ireland by 2025. While no direct causal relationship can be inferred, these findings suggest that progression through recognised specialist training pathways is an important component of long-term workforce development.

The proposed IMT structure is not intended as a retention measure. However, by providing a clearer and more structured transition between early specialist training and registrar-level practice, it may support more efficient progression through the training pathway and reduce reliance on informal transition arrangements.

8.4 Impact on Patients and Public Health

The principal anticipated benefit of the reform is enhanced protection of public health and patient safety.

The proposed IMT model seeks to ensure that doctors progressing to registrar-level practice have gained additional experience in acute medicine, multimorbidity, frailty, care of complex medical patients and supervised clinical decision-making. The reform also strengthens educational governance and progression standards through structured supervision and assessment arrangements.

Although the impact on patient outcomes cannot be quantified in advance, the proposal is directly targeted at areas identified by the Medical Council and the *OPTIMISE* Review as requiring improvement.

8.5 Impact on Regulation and Professional Mobility

In line with EU Directive 2000/78/EC (Employment Equality), the proposed reform applies equally to all trainees entering Internal Medicine Training and does not alter existing selection arrangements, eligibility criteria, reasonable accommodation policies or less-than-full-time training arrangements. The proposal is therefore not considered to create differential access to specialist training pathways on grounds protected under employment equality legislation.

Similarly the reform does not introduce additional nationality-based requirements or barriers to access and is not intended to restrict professional mobility within the framework established by Directive 2005/36/EC or Directive 2014/54/EU (Free Movement of Workers).

The proposal therefore does not create new barriers to access, progression or mobility within specialist medical training.

The proposal has limited regulatory implications. It does not alter the Specialist Division of the Medical Council Register, CSCST requirements, specialist recognition, access to Higher Specialist

Training or the legal framework governing specialist registration. It does not create a new regulated profession, a new licensing requirement or a new regulatory approval process.

The principal regulatory effect is confined to the structure, duration and delivery of the first stage of a common, but not exclusive pathway within existing specialist training framework.

Consideration of implications for automatic recognition under Directive 2005/36/EC and Annex V is addressed separately in Section 9.

8.6 Overall Impact Assessment

The principal burden associated with the proposal is the extension of the initial period of training from two years to three years. Against this, the reform is expected to deliver benefits in training and education quality, preparedness for registrar-level practice, consistency of training experience and structured progression through the early stages of physician specialist training.

The proposal will likely also provide secondary benefits by supporting workforce development, reducing reliance on informal transition arrangements and enabling expansion of recognised training opportunities across a broader range of hospital settings. However, these effects are supplementary to the primary objectives of protecting public health, patient safety and educational quality.

Having considered the likely impacts on trainees, service providers, patients, regulators and workforce pathways, the anticipated benefits of the proposed reform are considered proportionate to the additional requirements imposed

9. Directive 2005/36/EC Annex V Considerations

9.1 Annex V – Context and Scope

Directive 2005/36/EC and Annex V establish the framework for the mutual recognition of specialist medical qualifications within the European Union. Annex V identifies recognised specialist qualifications and specifies minimum training durations applicable to individual specialties.

As Internal Medicine Training forms part of the pathway leading towards Higher Specialist Training, award of a Certificate of Satisfactory Completion of Specialist Training (CSCST) and subsequent specialist registration; the relationship between the proposed reform and Annex V has been considered as part of this assessment.

Questions relating to the application of Annex V to Irish physician training pathways, including the treatment of dual-specialty training and recognition arrangements, are currently the subject of ongoing consideration by relevant stakeholders. This assessment does not seek to determine or pre-empt the outcome of that process.

For the purposes of this proportionality assessment, the existence of Annex V considerations does not alter the evidence reviewed in Sections 4 to 8. The identified issues relating to curriculum exposure, preparedness for registrar practice, supervision, experiential learning, acute medical

service delivery and workforce sustainability remain relevant irrespective of the approach taken in relation to Annex V compliance.

9.2 Relationship of IMT to Annex V

The proposed reform concerns the replacement of the existing two-year Basic Specialist Training programme with a three-year Internal Medicine Training programme. It does not alter specialist registration, CSCST, the Specialist Division of the Medical Council Register, recognised specialties or the overall legal framework governing specialist recognition.

Irrespective of any future review of Annex V considerations, the introduction of an additional year of structured Internal Medicine Training increases the volume of General Internal Medicine training delivered within the overall physician training pathway.

Consequently, the reform does not reduce the amount of Internal Medicine training available for recognition and may increase flexibility in how future training pathways are considered, mapped or aligned within the framework established by Directive 2005/36/EC and Annex V.

From the perspective of this proportionality assessment, the proposed reform therefore cannot reasonably be regarded as increasing any potential Annex V-related risk. Rather, it increases structured and accredited exposure to General Internal Medicine while addressing the education, workforce and patient-safety issues identified elsewhere in this report.

The proportionality conclusions reached in Sections 4 to 8 are therefore considered robust irrespective of the final outcome of any future Annex V review process.

10. Stakeholder Consultation

10.1 Consultation Approach

The development of the proposed Internal Medicine Training (IMT) model has been informed by extensive consultation undertaken over a multi-year period. Engagement has been conducted in a phased manner, beginning with consideration through Institute of Medicine governance structures before expanding to trainers, trainees, Regional Programme Directors, training sites, hospital management, Medical Manpower teams, HSE National Doctors Training and Planning (NDTP), the Department of Health and the Medical Council as well as presentations at several college-wide meetings and conferences.

The objective of consultation was not only to communicate a proposed reform, but to test its rationale, operational feasibility, workforce implications and potential impact on service delivery. Consultation therefore formed an integral part of the development process and informed successive iterations of the proposal over 2025 and 2026.

10.2 Stakeholders Consulted

Consultation activities included:

- engagement through Institute of Medicine governance and steering group structures;
- repeated discussion through the Regional Programme Directors Forum
- workshops and structured engagement with training sites throughout all Health Regions

- meetings with trainers, trainees and local programme leadership
- consultation with Medical Manpower teams and hospital management
- briefing and engagement with NDTP and Department of Health stakeholders
- regulatory engagement with the Medical Council regarding programme redesign and accreditation requirements

Detailed records of workshops, site visits, stakeholder feedback sessions and consultation activities are included in Appendix 11. A summary of key consultation findings is provided in the table below:

Consultation Feedback	Key Finding
Registrar preparedness	Highest ranked priority for change
Supervision & trainer structures	63% high priority
Teaching & learning	Strong support
Regional equity	Strong support, especially Model 3 sites
Clinical exposure	Broad support for increased GIM exposure
Governance	More accountability and structured oversight

10.3 Themes Emerging from Consultation

Stakeholder consultation demonstrated a high degree of consistency regarding the areas considered most in need of reform within the current Basic Specialist Training pathway. A structured stakeholder expectations exercise undertaken in 2025 generated 129 completed responses from trainers, consultants, trainees and programme stakeholders representing all Health Regions, including both Model 3 and Model 4 hospitals.

Preparedness for registrar-level practice emerged as the clearest priority for change and attracted the highest level of consensus across all stakeholder groups. Respondents consistently identified concerns regarding readiness for registrar-level clinical responsibility, particularly in relation to acute medical take, decision-making, supervision of junior colleagues and management of increasingly complex patients. These findings closely mirrored the conclusions of the *OPTIMISE* Review and reinforced concerns previously identified through trainee feedback.

The consultation also highlighted a number of related themes:

- Stakeholders identified supervision and trainer structures as a key area requiring improvement, emphasising the importance of continuity of educational supervision, structured feedback and clearer accountability for educational outcomes.

- Teaching and learning opportunities, technical skills development, exposure to General Internal Medicine and consistency of training experience across sites were also identified as important priorities.

- Regional equity emerged as a recurring theme throughout consultation. Stakeholders highlighted the educational value of training in regional settings and identified opportunities to strengthen the role of Model 3 hospitals within the physician training pathway.

Respondents noted that broader distribution of training activity could support both educational objectives and wider workforce sustainability goals while ensuring trainees are exposed to a diverse range of acute medical environments.

Finally, stakeholders emphasised the importance of governance, programme administration and trainee progression. Feedback highlighted the need for greater transparency regarding rotations, improved coordination between training sites, clearer progression pathways and a more structured transition from Basic Specialist Training to registrar-level practice and Higher Specialist Training.

The consultation findings therefore demonstrate broad stakeholder agreement regarding both the need for reform and the principal areas requiring attention. Importantly, the areas identified through consultation aligned closely with the issues identified through Medical Council accreditation findings, the *OPTIMISE* Review and wider workforce planning evidence, providing additional support for the proportionality of the proposed reform.

10.4 Influence of Consultation on the Proposed Reform

Consultation findings aligned closely with the conclusions of the *OPTIMISE Interim Report* and reinforced the view that reform should focus on preparedness for registrar-level practice, strengthening education supervision, improving quality and consistency of training experiences, increasing exposure to General Internal Medicine and acute care, and addressing perceived inequities in training distribution across training sites.

Clinical stakeholders consistently highlighted concerns regarding preparedness for registrar on-call responsibilities, the need for more structured supervision and feedback, and the importance of ensuring greater consistency in the delivery of training across sites. Feedback also emphasised protected teaching time, simulation-based education, broader clinical exposure, stronger trainer–trainee engagement and more formal governance arrangements. These themes directly informed the development of the proposed three-year Internal Medicine Training model and its associated supervision, curriculum and quality-assurance structures.

10.5 Regional Equity

A notable finding from consultation was the importance attached to regional equity of training allocation. Stakeholders from Model 3 hospitals expressed concern that training sites outside major tertiary centres were not always perceived as attractive training locations and highlighted the advantages available through broader General Internal Medicine exposure in regional settings.

Stakeholders also identified opportunities to increase trainee presence in Model 3 hospitals and improve the distribution of training experiences across the system. These findings informed consideration of regional training capacity and support the broader objective of aligning training opportunities with service need across the health system.

10.6 Consultation Summary

Importantly, consultation did not identify opposition to the need for reform. While stakeholders expressed differing views regarding particular implementation approaches, there was broad consensus that the current BST model requires modernisation to better prepare trainees for registrar-level practice, strengthen supervision and governance arrangements, improve consistency of training experience and respond to evolving service requirements.

The consultation findings therefore provide additional evidence supporting the proportionality of the proposed reform and reinforce the conclusions reached in Sections 5–8 of this assessment.

Supporting Evidence

Ref	Appendix	Author
1	Report on the Accreditation of The Institute of Medicine	Medical Council
2	*OPTIMISE* report	RCPI
3	Medical Workforce Report 2025–2026	HSE / NDTP
4	Dual Training Specialties of Medicine Medical Workforce in Ireland 2024–2038	HSE/NDTP
5	Model 3 Hospitals Consultant Recruitment and Retention Report (2023) and Implementation Group Report (2026)	HSE/NDTP
6	National Taskforce on the NCHD Workforce (2024)	Department of Health
7	Changing Horizons: Framing Physician Training to 2030 and Beyond	RCPI
8	Ireland's Future Health and Social Care Workforce	Department of Health
9	Medical Workforce Intelligence Report, 2024	Medical Council
10	IMT Stakeholder Expectations Survey (2025)	RCPI
11	IMT Stakeholder consultation record and engagement log	RCPI

The documents listed above are available through the accompanying SharePoint evidence repository and provide the primary evidence base referenced throughout this proportionality assessment.

Legal and Regulatory Sources

1. Directive 2005/36/EC on the Recognition of Professional Qualifications
2. Directive 2013/55/EU (amending 2005/36/EC)
3. Directive (EU) 2018/958 on a Proportionality Test Before Adoption of New Regulation of Professions
4. Directive 2003/88/EC (Working Time Directive)
5. Directive 2000/78/EC (Employment Equality Directive)
6. Directive 2019/1152 (Transparent and Predictable Working Conditions)
7. Directive 2014/54/EU (Free Movement of Workers)