National Committee on Medical Education and Training

Report of the Intern Sub-Committee

As adopted by the National Committee on Medical Education & Training July 2008

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Addendum to Report of the Intern Sub-Committee of the National Committee on Medical Education and Training

The Report of the Intern Sub-Committee of the National Committee on Medical Education & Training (NCMET) was adopted by the National Committee at its meeting in July 2008.

Following its endorsement by NCMET, the Report was presented to the Interdepartmental Policy Steering Group on Medical Education and Training, which includes representation from the Department of Health & Children, Department of Education & Science, Department of Finance, Higher Education Authority and Health Service Executive.

It was subsequently established that additional funding for the implementation of the recommendations, the cost of which was estimated in the report, would not be available. In the circumstances, the HSE developed an approach to progress the relevant recommendations and, in particular,

- The creation and funding of additional intern posts when required
- The establishment of Intern Training Networks and the appointment of Intern Coordinators
- The development of accredited intern education programmes
- The introduction of a single, national application and matching system for intern posts
- The expansion of intern training into new specialty areas
- European Working Time Directive compliance for all intern posts

An Intern Implementation Group, including representation from the Medical Council, Medical Schools, Postgraduate Medical Training Bodies, pilot clinical sites and medical manpower managers was established by the HSE to oversee achievement of these objectives.

Progress on the implementation of the report in its totality continues to be monitored on a regular basis by the National Committee on Medical Education & Training.

Medical Education & Training Unit
Health Service Executive
February 2010

On behalf of the National Committee on Medical Education & Training

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Summary of the Sub-Committee's Recommendations

Structure

1. Note the Medical Council's recommendation that the intern year should be the first year of postgraduate medical training.

2. Appointments to intern posts should be for one year's duration; all interns should receive a one-year fixed term specified purpose contract.

3. The intern year should be a 3 x 4 month modular structure of 4 months medicine, 4 months surgery and 4 months selective (which may consist of another module in medicine or surgery) and this structure should apply to all existing and new posts.

   Or

   The intern year should have a flexible structure and should incorporate 3-4 modules with a minimum of 3 months medicine, 3 months surgery and 1-2 selectives (which may consist of another module in medicine and/or surgery) and this structure should apply to all existing and new posts.

4. The selective specialties previously approved by the Medical Council should be introduced on a phased basis as part of a pilot approach. This expansion should be informed by service priorities, capacity, availability of resources and student preferences.

5. General practice should be prioritised for inclusion as a selective specialty owing to the shifting emphasis of health services to primary care.

6. We understand that a core curriculum for the intern year will be prepared by the Medical Council. It is recommended that this be developed in consultation with the Forum of Irish Postgraduate Medical Training Bodies, the medical schools, the HSE and the National MET Committee and that generic skills e.g. leadership, communication skills, clinical governance and team working would be included.

7. The Postgraduate Medical Training Bodies and medical schools should be involved with the Medical Council in drawing up the specialty-specific curriculum and learning outcomes for medicine, surgery and the selective modules. However, it is recognised that a decision on such an arrangement is a matter for the Medical Council itself under new legislation.

8. All intern posts, new and existing, should be EWTD compliant.

9. On-call duties (training at night and at weekends) should be retained for interns but should be significantly reformed. Night-time and weekend working must be scheduled in the context of appropriate rostering arrangements which will ensure EWTD compliance. Appropriate supervision should be provided by a designated supervisor at all times, including while on call.

10. Interns should have access to flexible training, in line with guidelines developed by the Postgraduate Medical & Dental Board for SpR/SR posts.

Numbers

11. The Sub-Committee welcomes the establishment of the joint DoHC/HSE/FÁS group which will develop a tool which will allow for the assessment of supply and demand factors affecting healthcare staffing. The recommendations of this group should inform future developments of the intern year.

12. The intern year is a pre-registration year and should only be open to those that require to undertake it for the purposes of registration. Graduates who are otherwise entitled to full registration with the Medical Council should not have access to intern posts.

13. The recommendations of the Fottrell Report with respect to numbers of undergraduates should be kept under review.

14. The Intern Subcommittee's concerns regarding the implications of the increase in medical graduates should be taken into account by the joint DoHC/HSE Workforce Planning Group and by the Postgraduate Subcommittee in their deliberations. The Sub-Committee recommends that the Interdepartmental Policy Steering Group should consider the implications of the medical workforce planning model produced by FÁS for the Workforce Planning Group when it becomes available later in 2008

15. A sufficient number of intern posts should be available to meet the number of qualifying EEA graduates from Irish medical schools. Some access to intern posts should also be available to non-EEA students of Irish medical schools, and EEA graduates of foreign medical schools. An overall total of 800 intern places is recommended on the basis of a national medical school intake of 725. This includes approximately 10% to address the requirements of non-EEA graduates of Irish medical schools and EEA graduates of foreign medical schools.

16. The number of posts should be sufficient to meet service requirements, ensure EWTD compliance, facilitate graduate retention and ensure the protection of the State's investment in undergraduate medical education.

17. The intern year structure must be sufficiently flexible to react to adjustments resulting from medical workforce requirements and service configuration.

18. A pilot of the Sub-Committee's recommendations should be undertaken to further inform recommendations on numbers of posts.

Access and Appointment

19. A standardised central application system for intern posts should be developed.

20. A single national matching scheme managed centrally, delivered regionally should be introduced and organised around the six medical schools.

21. Rotations should be on a regional/network basis e.g. a single intern post with rotations in medicine, surgery and general practice could take place on different clinical sites but these should be within a single network.

22. Existing intern posts and any new posts created should be distributed in a transparent and equitable fashion between the intern networks, to ensure an efficient and fair system of allocation, training and supervision and reflecting the numbers of EEA students in each region.

23. Each intern post should be given a reference number, which can be used in the compilation of a database of intern posts and will be compatible with databases being developed for other medical posts.

24. An intern coordinator should be appointed to each intern network.

25. Policies around the appointment of interns should be developed by the HSE collaboratively on a national basis to ensure a consistent and transparent approach and in concordance with the HSE's recruitment licence.

Management and Supervision

26. The Medical Council recommendations that Intern Tutors have a dedicated session or number of sessions each week to allow them time to fulfil the role properly should be implemented, resourced at a minimum rate of:

- two sessions for the first eight interns, designated in the practice plan of the tutors' contract
- one extra session for each additional eight interns, designated in the practice plan of the tutors' contract

27. The relevant training body should devise an intern-specific curriculum and competencies in consultation with the Medical Council.

28. The Sub-Committee acknowledges the statutory role of the Medical Council for the sign-off of the intern year and recommends that there should be a single common pathway for the final assessment of the intern year and its modules; which could assist the Medical Council in fulfilling its statutory role in this regard.

29. The role of intern tutors, particularly in monitoring the performance of interns should be clearly defined.

30. A database of intern posts should be maintained, in line with the database of SHO and Registrar posts currently being developed.

31. The Sub-Committee notes the feedback from interns arising from the survey undertaken and recommends that the intern year should incorporate structured and protected training sessions and fixed teaching sessions.

32. Other areas identified by the survey on interns should be explored and addressed by the relevant partner organisations as appropriate e.g. supervision of interns.

33. The Medical Council's recommendations with regard to induction should be implemented on a collaborative and consistent basis.

34. The intern contract should reflect the modular structure of the year, training needs, rotations and should include reference to completion of modules, remedial action etc.

35. The Training Principles to be incorporated into New Working Arrangements for Doctors in Training (appendix D Buttimer Report) include a set of General Principles for application to NCHDs and a set of specific principles for each specialty. As the intern year is now the first year of postgraduate training the subcommittee recommends that the general principles should also apply to interns and that specific principles should be developed and agreed by the stakeholders.

Resourcing

36. Additional, ring-fenced, funding should be provided by Government to fund the costs identified.

37. Any new consultant posts should include defined and protected time for medical education and training, at undergraduate, intern and postgraduate levels.

Implementation

38. The Sub-Committee suggests that its recommendations should be implemented on a pilot basis. The pilot should allow different options to be introduced and assessed.

39. While acknowledging the statutory role of the Medical Council and without detracting from this role, the Sub-Committee recommends that the Health Service Executive should take the lead in the initial convening of a working group to progress the implementation of the recommendations set out in this report.

1. Introduction

1.1 Establishment of the Sub-Committee

The National Committee on Medical Education and Training was established by the Interdepartmental Steering Group on Medical Education and Training. The National Committee held its inaugural meeting on March 13th 2007. At that meeting, it was decided to establish three sub-committees, to examine (i) undergraduate medical education and training, (ii) the intern year and (iii) postgraduate medical education and training.

This is the report of the Intern Sub-Committee and was submitted for initial consideration to the National Committee on Medical Education & Training in April 2008. The Report was adopted by the National Committee at its meeting in July 2008.

1.2 Terms of Reference

The following terms of reference were specified for the Sub-Committee on the Intern Year:

> "The purpose of the Sub-Committee is to examine issues regarding the Intern Year arising from the implementation of the recommendations set out in the Fottrell & Buttimer reports as adopted by Government and having due regard to the issues raised in the Irish Medical Council's report of December 2006 reviewing the Intern Year and make recommendations to the National Committee".
>
> In submitting its report the Sub-Committee will consider:
>
> - The current structure of the intern year and issues arising in the implementation of the recommendations of the Fottrell and Buttimer Reports.
> - Number and location of intern positions having regard to the projected development of undergraduate and graduate entry training.
> - Arrangements for access and appointment to intern positions.
> - Management and supervision of intern appointments.
> - Resourcing and in particular estimates of costs and options for resourcing proposed developments.
> - Clarify the roles and responsibilities of the various bodies involved in the intern year.
>
> In considering the above the Committee shall recognise and give due cognisance to the programme of work currently underway by the Irish Medical Council in relation to structure of the Intern year, approval of Intern positions, accreditation of sites, assessment etc. in its role under the Medical Practitioners legislation."

1.3 Membership

The membership of the Sub-Committee comprised members of the National Committee, representing the key stakeholders involved in the intern year, each of whom was nominated by their respective representative bodies. The membership of the Sub-Committee is provided at Appendix B.

1.4 Context

Recent legislation, published Government policy and other relevant documents provided the backdrop to the discussions of the Intern Sub-Committee, in line with the Sub-Committee's terms of reference as specified by the National Committee. The Fottrell Report, "*Medical Education in Ireland: A New Direction*" (2006) and the Buttimer Report, "*Preparing Ireland's Doctors to meet the Health Needs of the 21st Century"* (2006), in particular, provided the focus for the Sub-Committee's deliberations and allowed the Sub-Committee to examine in greater detail some of the issues raised in these reports with respect to interns. In addition, the Sub-Committee has been mindful of the global standards in postgraduate medical education, as set out by the World Federation of Medical Education.

Other key developments include the health system reform and the reform of medical education and training now underway, the proposed expansion in undergraduate numbers, the commencement of the graduate entry programme in medicine, and the requirement to become EWTD-compliant.

Health Act 2004
The Health Act 2004 provides a statutory framework for education and training across the spectrum of the health and social services, including intern training. Section 7(4) of the Act charges the Health Service Executive with the responsibility for the provision of education and training, as follows:

> "(The HSE shall) *to the extent practicable and necessary to enable the Executive to perform its functions, facilitate the education and training of (i) students training to be registered medical practitioners, nurses or other health professionals and (ii) its employees and the employees of service providers."*

Buttimer & Fottrell Reports (2006)
The Fottrell Report (undergraduate), and the Buttimer Report (postgraduate), recommended sweeping changes to the organisation and delivery of undergraduate and postgraduate medical education and training. The endorsement by Government of key recommendations of the reports signalled the most significant reform of medical education and training in Ireland. These include an increase in the numbers of EU medical students and consequently interns and the redesignation of the intern year as the first year of postgraduate training.

Medical Council Report – Intern Coordinator and Tutor Network Project Report – A Review of the Intern Year (2006)
The Medical Council's Report was considered by the Sub-Committee at the outset of its deliberations, in line with its terms of reference. The report contained much useful information on intern numbers, locations etc. The opinions and concerns of interns consulted during the course of the Council's project were particularly informative to the Sub-Committee's discussions. The recommendations of the Report have been taken into account by the Sub-Committee in the drafting of this report.

Medical Practitioners Act 2007
The Medical Practitioners Act 2007 (not commenced at the time of writing) sets out wide-ranging reforms to the system of regulation of medical practitioners and heralds the introduction of a new era in Irish medical education and training. While the Act deals with the wider medical arena, the Act does make specific references to the intern year. The relevant sections are 7(4), 49, 87 and 88. Details of these are provided at Appendix C.

Under the provisions of the Act, specific responsibilities are assigned to the Medical Council and to the HSE with respect to the intern year. In particular, the Medical Council is charged with specifying and publishing the standards for training and experience required for the certificate of experience, the approval of posts suitable for intern training, the registration of intern trainees, the granting of the certificate of experience and the specification of the number of intern training posts on foot of proposals from the HSE.

As well as facilitating intern training on its clinical sites and clinical sites funded by it, the HSE is responsible for assessing on an annual basis the required number of intern training posts and making proposals to the Medical Council arising from this assessment.

1.5 Modus Operandi

The Sub-Committee immediately set about identifying the key issues for consideration and drawing up a work plan to guide the Sub-Committee's discussions. The work plan was divided in line with the terms of reference and individual Sub-Committee members took responsibility for individual sections. Papers were prepared in respect of each section for discussion and these have formed the basis of this report to the National Committee.

The Sub-Committee met 11 times between May 2007 and April 2008.

1.6 Summary of Survey of Interns

The Sub-Committee was interested in gaining the opinions of young doctors on their experiences of the intern year. The Sub-Committee undertook a survey of a group of SHOs who had recently completed the intern year, in order to obtain their views on a range of issues regarding the intern year, experience gained, preparedness before and after the intern year, working and teaching arrangements during the year, views on future changes etc.

A total of 100 surveys were circulated and there was a response rate of 66%. The findings of the survey are provided at Appendix D.

The SHOs who completed the survey included some that had undertaken their intern year at (i) a university teaching hospital, (ii) a university teaching hospital and general hospital and (iii) a general hospital.

Many aspects of the findings of the survey were positive, however there were a number of areas which raised particular concern. Some of the main findings of the survey are outlined below.

The level of preparedness of graduates on completion of medical school was rated poorly with 53% indicating that they felt unprepared or not well prepared. A majority favoured an internship which rotated through both a university teaching hospital and a general hospital.

The opinions of interns on the inclusion of selective specialties were useful to the Sub-Committee's discussions on the reform of the intern year. 37% would have selected an Emergency Medicine module if it had been available; 21% would have chosen a module in anaesthesia and 18% of interns would have chosen a GP module if it had been available.

The intended career paths of interns showed some interesting statistics with almost half (48%) of those surveyed intending to proceed with a career in general internal medicine, 22% in surgery, 14% in general practice, 5% in radiology, 3% in emergency medicine, 2% in obstetrics and gynaecology and 2% in pathology. None indicated an intention to pursue a career in anaesthesia, paediatrics, psychiatry, ophthalmology, sports and exercise medicine, public health medicine or occupational health medicine. Though this may be clearly influenced by the size of the sample surveyed it is however possible that the relatively high desire expressed for experience in areas such as emergency medicine and anaesthesia for example but the conversely low intent to pursue careers in these specialties may indicate that current exposure during the intern year is not sufficient to encourage careers in these areas and could therefore support the case for the expansion of selective modules.

Currently, it appears that most interns are satisfied with the overall experience gained during the intern year. In the survey, the vast majority (92%) felt at least moderately prepared for SHO training. The survey shows that the majority were satisfied with the clinical experience gained during the year on medical and surgical rotations in relation to assessment and diagnosis of patients, patient management, and interpreting investigations and prescribing.

However, the findings of the survey were not as positive in relation to the exposure of interns to non-clinical areas such as time management, communication skills, clinical governance and management. Infection control and hygiene were highlighted as the areas in which most interns had received direct training, with 63% and 56%, respectively, of interns receiving specific training in these areas. However, this is still far below the optimum. All other areas of

non-clinical training identified in the survey showed poorer levels of dedicated training: time management (12%), communication skills (21%), breaking bad news (29%), ethical decision making (16%), record keeping (21%), career guidance (40%), feedback on clinical decisions made while on call (16%), consent (33%), clinical governance (11%), audit (20%), leadership (11%), teamworking (15%), management/administration (5%) and IT skills (35%). Notwithstanding these data, only around 20% indicated dissatisfaction with the experience received in relation to dealing with patients, around 25% were dissatisfied with experience of breaking bad news and around 10% were dissatisfied with experience related to patient dignity and compassion and overall, most were satisfied with the experience gained in non-clinical areas, which may indicate that interns feel they are receiving sufficient training in these areas albeit outside of dedicated training.

Most of the interns surveyed indicated their satisfaction with their overall level of personal responsibility and decision making while on call in both medical and surgical rotations, although it is noteworthy that around 20% indicated that they were dissatisfied in the case of surgical rotations. As regards the support received while on call, a significant majority (77%) were satisfied with the support received from colleagues while on medical rotations in university teaching hospitals, though this was lower (64%) in general hospitals. Approximately 55% were satisfied with the support received while on surgical call in both university teaching and general hospitals though around 20% were dissatisfied with support received while on surgical call.

The survey undertaken by the Sub-Committee found that over half of the interns surveyed were either satisfied or very satisfied with the level of dedicated intern training available during their intern year. However, a further 32% indicated that they were either moderately dissatisfied or very dissatisfied with the level of dedicated training available.

Interns were asked to indicate the number of hours of education and training activity per week, such as teaching rounds, journal clubs, out-patient clinics etc. 35% received up to three hours per week of dedicated education and training activities, a further 40% received between four and six hours per week, 11% received between seven and ten hours while 14% received in excess of 10 hours per week. As regards actual dedicated teaching time received, a majority (61%) indicated that they received 1-2 hours per week. 24% received 3-4 hours per week and 1% received in excess of 5 hours per week. Most worryingly, 14% of those surveyed received less than one hour per week of dedicated teaching time during their intern year.

In the survey, interns were asked whether there was a bleep policy in use in the hospitals where they trained and whether formal intern teaching sessions were understood to be bleep free. While 61% indicated that there was a bleep policy in place, 78% indicated that the policy is either rarely or never adhered to; worryingly some 77% indicated that formal teaching sessions were not bleep free.

The survey showed variation between the assignment of intern tutors and the amount of interaction between interns and their tutors. 80% of the interns surveyed had an intern tutor. However, only 32% stated that they had formal meetings with their intern tutor and these meetings varied from weekly to six monthly.

As regards their logbook, only 68% of the interns that submitted questionnaires had completed a logbook. 67% of those surveyed indicated that they had received direct feedback from consultants.

The findings of the survey have informed the discussions and recommendations of the Sub-Committee. The Sub-Committee suggests that these findings should be further explored and addressed by the relevant partner organisations involved in the intern year.

1.7 Note on the Structure of report

The report is set out in line with the terms of reference, with chapters setting out the main considerations and recommendations relating to each term of reference.

2. Structure of the Intern Year

2.1 Introduction

All students who graduate from Irish medical schools must complete an intern year to enable them to be fully registered with the Irish Medical Council and thus registered to practise independently. Interns are salaried employees whose role combines both service and training.

The intern year is currently structured broadly as six months medicine and six months surgery. While there has been some expansion in the range of specialties offered (e.g. a three month module in general practice), this has been limited.

2.2 Definition & objectives of the Intern Year

The members of the Sub-Committee agreed that the intern year requires a robust structure, allowing aspiring doctors the opportunity to experience a range of situations in a clinical setting, in a structured and supported environment. A key concern of the Sub-Committee in examining the structure of the intern year was ensuring that interns are given the appropriate level of responsibility for their level of experience, that they undertake appropriate tasks and that they are afforded the opportunity to attain the competencies that will allow them to progress to general and specialist training by ensuring an appropriate balance between service and learning components.

The Sub-Committee adopted the objectives of the intern year provided in the Medical Council Report (2006).

> *The overall aim of the intern year is to provide an educationally sound experience for the new doctor in terms of skills and attitudes together with personal development. The objective of the intern year is to apply the knowledge and skills learned in undergraduate education and to develop competencies in basic clinical skills, medical procedures and patient management.*

The Medical Practitioners Act 2007 makes provision for the intern year to become the first year of postgraduate training. This will commence when the Medical Council is ready to grant certificates of experience and gives notice to the Minister for Health & Children (Section 49(5)). The intern year bridges the transition between the undergraduate curriculum and postgraduate medical education and training. The intern year should instil the need for continuous professional development and life long learning. Successful completion of the intern year will indicate that the doctor is professionally accountable for patient safety and ready to commence general professional training. The philosophy of the intern year is that education and training will be provided in the work place.

To this extent the intern year should have clear objectives and outcomes. These should be communicated on a consistent basis to all medical students throughout the six medical schools. Intern learning opportunities should provide for:

- hospital ward based experiential learning
- supervised consultation in outpatient clinics, day care hospitals, community visits
- small group case presentations and discussion
- appropriate life support courses and other external courses
- personal study – electronic and distance learning

2.3 Structure of the Intern Year

2.3.1 Current structure of the Intern Year

The current structure of the intern year generally allows exposure to only two specialties – medicine and surgery - albeit with exposure to sub specialities within these. This model has remained largely unchanged over the past decades.

In its favour this model has broadly served the interns well in that it has facilitated interns access to

- supervised experience and teaching in the clinical environment
- work experiences in the key specialties and sub specialities of medicine and surgery;
- working with other members of the multidisciplinary team;
- working environs extending from large teaching to general and local service delivery systems through the core working day to evening, night and weekend working.

This broad experience is reflected in the feedback received in our survey discussed in Chapter 1 where 92% of those responding felt at least moderately prepared for SHO training.

Furthermore with 2 X 6 month appointments in the intern year the administrative structure of appointments, rotation etc. were easily managed and where intern appointees remained within a particular team or department their experience suggested that their contribution to service and continuity of care increases with time.

Notwithstanding this, the Sub Committee, in its discussions, identified particular problems and weaknesses in the current structure of the intern year. These were

1. The current structure does not reflect the diversification of medicine which has occurred over the past 10 – 20 years in particular and the need to provide interns with the opportunity to access intern appointments in these new specialty areas. Extending the range of specialties and indeed subspecialties, to which interns will have structured access will greatly facilitate opportunities for experience in these areas and will assist interns in their decisions on future career choice etc.

2. While it is considered that the majority of an intern's learning occurs at an early stage in their appointment and the value of an intern to service increases with time, there is real concern that service commitments and demands far outweigh the structured learning/teaching components in current posts. The Sub Committee considers this to be inappropriate having regard to the overall objectives of the intern year from a training perspective and the experience and decision making capacity of interns at this stage of their medical training.

3. Interns currently undertake considerable duties in relation to ECGs; phlebotomy etc. and routine administrative support duties as part of their work. While experience in these areas is essential, the requirement to undertake these duties on a frequent repetitive basis is of little training value.

4. Interns must currently secure 2 X 6 month assignments, and in certain cases appointments, in medicine and surgery and their sub specialties to complete the 12 month requirement. At present there is an imbalance between the numbers of medicine and surgery posts available and interns in certain cases have the twin difficulties of not knowing that they will be able to complete their intern year or where they will be appointed to complete their intern year when they commence their internship. This creates uncertainty for interns, medical schools and hospitals in managing the intern appointment process. Furthermore two separate 6 month posts do not facilitate a continuum of structured training and experience as required for the intern year.

In addition to the above the Sub Committee recognised that there were a number of other drivers for change to the current structure. These include

- The increase in the number of medical graduates will make it increasingly difficult to cater for all graduates on the basis of the current 6 months medicine, 6 months surgery, given the imbalance between the numbers of medical and surgical posts, requirements of the EWTD and reconfiguration of service delivery systems underway.

- General practice is the career choice of the largest number of doctors and this trend is likely to increase in light of the general move towards community provided health services.

- Flexible training (i.e. the ability to train in posts that are less than fulltime) should be facilitated. Flexible training is defined as working less than full-time but at least 50% of full-time hours.

- The current configuration does not allow interns the opportunity to consider future career choices beyond medicine and surgery.

2.3.2 Future Structure for the Intern Year

A significant proportion of the Sub Committee's discussions centred on how to restructure the intern year. In this regard the Sub Committee agreed that

- Intern posts should be of one year's duration and all intern appointees should receive a one year fixed term, specified purpose contract at the commencement of internship to cover their full intern programme

- Intern appointments should accommodate flexible training as currently defined by the Post Graduate Medical & Dental Board

- While it is not always possible to structure an intern post such that the post includes assignments to general medicine and surgery in the same hospital every effort should be made when structuring posts that the post holder can be located in one geographic area

- There should be a sufficient number of intern posts available to allow the flexibility necessary for graduates to commence their intern post at a time other than July 1st each year in order to accommodate students who fail their first sitting of final medicine exams, cannot take up their intern positions directly after graduation for reasons such as illness, maternity leave etc. The flexibility will also accommodate any interns who fail to pass, and are required to repeat a module.

The Committee gave detailed consideration as to how the intern year would be structured across the different specialties to which it is proposed to provide supervised structured teaching and experience and in particular whether or not the intern year should comprise

A – 3 X 4 month module assignments – 4 months medicine, 4 months surgery; and 4 months selective which may consist of another module in medicine or surgery (discussed par 2.4) and that this structure should apply to all existing and new posts

B - 3 to 4 modules with a core of at least 3 months medicine, 3 months surgery and 1-2 selectives which may consist of another module in medicine and/or surgery and that this structure should apply to all existing and new posts

Following discussions there was not unanimous agreement amongst the Sub Committee members as to the preferred option.

In relation to 3 month modules there was concern by the members that this option would not support the objectives of continuity of care and exposure to an increased range of specialties especially when an assignment to a specialty coincided with an intern's study, annual or other leave period.

Option A: 3 modules of 4 months' duration

The Sub Committee recognises that Option A provides for

1. a structured framework – 3 X 4 month specified modules in specified sequence – to all posts thereby creating a pool of nationally agreed posts
2. all posts can be restructured to include assignments to selective specialties as approved by the Medical Council and this range of specialties can be expanded as they are approved by the Medical Council
3. a profile of the structure of all intern posts is available to graduates when seeking an intern post and they can have regard to career choice etc. in applying for an intern post
4. posts can be developed to ensure EWTD compliance as selective modules can be provided on a core working day basis only
5. the 4 month module contributes to continuity of care and reduces the difficulties in balancing leave requirements with gaining experience across each speciality in a particular post.

The Sub Committee does recognise that this new structured 3 modular post will require additional administrative resources to develop and manage and that a move to this structure will require a restructuring and redistribution of all existing and new posts to this format.

Option B: 3-4 modules

Option B provides flexibility to develop a pool of posts taking account of existing post structure while at the same time facilitating the development and attachment of selectives of posts. This structure would allow flexibility in the introduction of selectives as they can be brought in on an incremental basis. EWTD compliance would be facilitated as would a greater visibility of choice to intern applicants.

Consideration of options

The Medical Council rules set out in Statutory Instrument no. 285 of 2003,state;

> "*For the purpose of section 28(2), a prescribed period of employment is a period of not less that 12 months, which should be consecutive, of which at least 3 months must be spent in medicine in general and 3 months in surgery in general. As part of this 12 month period, a person may also be employed for not less than 2 months and not more than 3 months in the following specialities: Emergency Medicine, Obstetrics and Gynaecology, Paediatrics and Psychiatry*"

The proposed options for reformed structure of intern posts meet the requirements of the Council in relation to time spent in medicine and surgery. The Medical Council currently recognises a minimum of two months and a maximum of three months in designated specialties including general practice, obstetrics and gynaecology, paediatrics, psychiatry, emergency medicine and perioperative medicine (anaesthesia). The proposed reform of the structure of the intern year will require the consideration of the Medical Council.

Representatives of the Sub Committee discussed the provision that not more than 3 months be spent in certain specialties which are being recommended as 4 month selectives by the Sub Committee with representatives of the Council. From these discussions it is understood that an amendment to accommodate the structure proposed could be recommended to the Council for its consideration.

The Sub-Committee recommended that in the case of both options, intern networks should provide a reasonable spread of posts which would facilitate access to a range of selective modules. Within each network and/or institution, a single option should be implemented and this should be informed by the pilot being recommended by the Sub-Committee.

While the prevailing view arising from the discussions of the Sub-Committee was in favour of Option A i.e. 3 x 4 month modules, it was agreed that both options should be subject to a pilot.

Given the considerable change proposed, the Sub-Committee is aware of the need to road test the new arrangements. For this reason, **it is recommended that the new structures be**

piloted (e.g. in two intern networks) in order to assess the impact on training, the integration of new specialties, the experience from the perspective of the patients, trainees, the consultant-led team and the training body, the implications of the changes on service provision and the administrative requirements to support same. Any future roll out of the proposed changes will be dependent on the outcome of this pilot.

2.4 Options for Selectives

A number of additional specialties have previously been approved by the Medical Council for intern rotations. These specialties are emergency medicine, obstetrics & gynaecology, paediatrics, psychiatry, general practice and perioperative medicine. However, only a small number of posts had been created in these specialties.

The Sub-Committee felt that available specialties for selective modules could be expanded over time, on a phased basis, as part of a pilot approach. The appropriate order for the expansion of selective specialties should be informed by capacity, service priorities, the availability of resources, student preferences and should be through consultation between the Medical Council, the HSE, Forum of Irish Postgraduate Medical Training Bodies*, the medical schools and students.

While the Sub-Committee did not seek submissions, representations supporting internship rotations in their respective specialties were received from the College of Anaesthetists, the Faculty of Radiologists and the Irish Association for Emergency Medicine. These submissions were considered by the Sub-Committee and helped to inform the Sub-Committee's discussions in relation to the appropriate expansion of rotational specialties for inclusion in the intern year in the future.

Interns will be able to select from a list of specified posts. The phased restructuring of the intern year and the introduction of new selective specialties should be mindful of potential impact on patient services.

General practice is identified as a priority area, given the move towards more community-based health services. The Sub-Committee considered a study undertaken in NUI Galway to assess the lessons learned from intern rotations in general practice. The study compared the experiences of a small number of interns in hospital and general practice settings and found that a general practice setting encouraged greater learner autonomy and was more motivating for interns. It found that the interns' sense of being responsible for their own actions was the key contributing factor to their greater sense of motivation. The survey conducted by the Sub-Committee indicated that 18% of interns would have chosen a GP module if it had been available.

The survey of interns also showed that 37% would have selected an Emergency Medicine module if it had been available. The Sub-Committee is aware that the Medical Council has recognised emergency medicine as a specialty for inclusion in the intern year. The Sub-Committee was mindful that Emergency Medicine is often a patient's first point of contact with the health service. The assignment of interns in emergency departments should therefore be in the best interest of interns.

Other preferences for additional modules as highlighted in the survey of interns were anaesthesia (21% of those surveyed would have chosen it as an optional module), paediatrics (13%), obstetrics/gynaecology (7%) and psychiatry (3%).

The Sub-Committee suggests that the findings of the survey in relation to intern choices of selective modules and likely career paths should be taken into account in the future introduction of new selective modules in the overall context of medical workforce and service planning.

* The Forum of Irish Medical Postgraduate Training Bodies was established to promote common strategies and enhance universal efficiencies of the accredited postgraduate medical training bodies. The Forum consists of the 13 postgraduate training bodies recognised by the Medical Council plus the Advisory Committee in Emergency Medicine, RCSI & RCPI. The ICHMT and ISPTC are represented separately to their parent training bodies, the RCPI and RCSI. The Forum meets at least four times each calendar year. The Chairperson and Secretary are elected from the members. An annual report will be published by the Forum and may also publish policy papers. The Forum unites individual training bodies by enhancing the standardisation of practices, coordination of responses to third parties and generation and implementation of common strategy. However, each training body reserves the right to independently pursue the same or other activities. The Forum does not have a statutory basis. Funding for the administrative support to the Forum is provided by the HSE.

Arrangements for the phased expansion in selectives available to interns should be discussed at training body and local hospital and community level. The training bodies should suggest the appropriate locations for intern training in their specialties in the first instance. The determination of the appropriate locations for intern training posts is ultimately the responsibility of the Medical Council in consultation with the HSE.

A worked example of a modular intern post, showing details of possible rotations is provided at Appendix E.

2.5 Core Training

In its 2006 report, the Medical Council recommended that a national consensus should be reached on curriculum content for intern training. The intern curriculum should focus on clinical skills required to manage acutely ill patients and care of patients with chronic disease in hospital and community settings.

Under the Medical Practitioners Act 2007, the Medical Council has a statutory obligation to prepare and publish a syllabus or curriculum including the core knowledge, skills and personal attributes to be acquired during the intern year. It is noted that a core curriculum is already in place through individual medical schools. It is recommended that future developments of this should be undertaken in consultation with the National Committee on Medical Education & Training, the Forum of Irish Medical Training Bodies and the medical schools.

As highlighted in Chapter 1, the survey undertaken for the Sub-Committee showed a low exposure of interns in a number of non-clinical areas. In the light of the proposed development of clinical directorates and the recommendations in the Buttimer report for generic training modules the Sub-Committee recommends that the Medical Council consider including leadership, communications skills, clinical governance and team working in the list of core competencies.

The Medical Council has determined that at the end of their one year internship, interns should be able to demonstrate awareness of and ability to manage acutely ill patients in different settings and sometimes against a background of chronic illness. The Medical Council has advised that assessment of clinical scenarios could include:

- Airway problems
- Breathing problems
- Circulation problems
- Neurological problems
- Psychiatric / behaviour problems
- Pain

Details of the core competencies specified by the Medical Council have been provided to the Sub-Committee. These should be addressed in the intern year through formal teaching sessions with an emphasis on patient safety and clinical governance. These core competencies are grouped under the headings overleaf. Details are provided at Appendix F.

- History taking, examination and record keeping
- Diagnosis using sound clinical judgement and decision making and establishing a differential diagnosis.
- Therapeutics & safe prescribing
- Medical data & information management
- Infection control
- Medical Ethics & relevant legal consideration.
- Consent
- Legal framework for medical practice
- Practical skills
- Management of acutely ill patients.
- Clinical accountability in risk management.
- Effective team management and organisation skills.

The intern year therefore provides the opportunity for training in core diagnostic skills. It is envisaged that interns would have the opportunity to undertake additional courses and/or gain certification in relevant areas such as ACLS, ATLS, basic surgical skills, relevant certification in selective specialties etc. during their intern year.

In the development of the curriculum the Sub-Committee recommends that the recognised training bodies should be involved in drawing up the curriculum and learning outcomes for each selective module and that the intern be measured against these stated competencies on completion of the module. The assessment of modules and sign-off of the intern year is discussed further in Chapter 5.

Career Information

Section 88(9) of the Medical Practitioners Act 2007 provides that the Medical Council "shall in consultation with the Dental Council, the HSE and other such appropriate bodies as the Council thinks fit, arrange for the provision of career information to registered medical practitioners and registered dentists." This responsibility is currently being undertaken to varying degrees by the Medical Schools by individual training bodies and through the Postgraduate Medical and Dental Board.

2.6 On-call commitment

In the context of the intern year, "on-call" commitment refers to the particular training experience gained by dealing with clinical situations at night and at other times, such as at weekends. It has historically been a feature of all levels of the medical profession. It is envisaged that the rollout of the EWTD and the implementation of a shift system will result in significant reform of the traditional "on-call" commitment.

The issue of intern involvement in on-call cover led to considerable debate by the Sub-Committee. Overall, it was felt that on-call commitment offered a valuable learning experience to interns. However, it was agreed that there was a need to move away from the traditional structure of long hours and onerous on-call commitments of interns. The Committee agreed that interns should have appropriate supervision at all times, including while they are on call.

In considering the current on call commitments of interns and possible reform of these duties, the Sub-Committee agreed the following:

- On-call duties provide a valuable learning experience for interns and that on-call duties should be retained for interns.
- The current working hours of interns (average 65 hours per week) have to be addressed in the context of the EWTD. The on-call commitment of interns should be restructured in line with the provisions of the EWTD and the need to maintain a training focus for the posts. The EWTD allows for appropriate restructuring of the on-call commitments of interns. A flexible approach to on-call commitments will maximise exposure while maintaining the EWTD compliance of posts.

2.7 Flexible training

The Sub-Committee is aware of the general demand for flexible medical training (i.e. the ability to train in posts that are less than fulltime). The modular structure of the intern year, as well as moves towards EWTD compliance will facilitate a greater degree of flexibility in intern training.

The Sub-Committee was informed that guidelines on flexible training have been prepared by the Postgraduate Medical and Dental Board. It is noted that the PgMDB has agreed that these guidelines should initially be applied at specialist / senior registrar level only. However, the Sub-Committee feels that there is scope to apply flexible training to the intern year. This will have obvious consequences in terms of the number of posts required.

It is acknowledged that the implementation of flexible training in the context of a modular structure will require planning. The practicalities of this should be considered at the stage of implementation and should be informed by the pilot process.

It is further acknowledged that the availability of flexible training for interns would require discussion with the Medical Council in the context of the statutory description of the intern year as being a consecutive period of not less than 12 months.

Summary of Recommendations - Structure

1. Note the Medical Council's recommendation that the intern year should be the first year of postgraduate medical training.

2. Appointments to intern posts should be for one year's duration; all interns should receive a one-year fixed term specified purpose contract.

3. The intern year should be a 3 x 4 month modular structure of 4 months medicine, 4 months surgery and 4 months selective (which may consist of another module in medicine or surgery) and that this structure should apply to all existing and new posts.

   Or

   The intern year should have a flexible structure and should incorporate 3-4 modules with a minimum of 3 months medicine, 3 months surgery and 1-2 selectives (which may consist of another module in medicine and/or surgery) and that this structure should apply to all existing and new posts.

4. The selective specialties previously approved by the Medical Council should be introduced on a phased basis as part of a pilot approach. This expansion should be informed by service priorities, capacity, availability of resources and student preferences.

5. General practice should be prioritised for inclusion as a selective specialty owing to the shifting emphasis of health services to primary care.

6. We understand that a core curriculum for the intern year will be prepared by the Medical Council. It is recommended that this be developed in consultation with the Forum of Irish Postgraduate Medical Training Bodies, the medical schools, the HSE and the National MET Committee and that generic skills e.g. leadership, communication skills, clinical governance and team working would be included.

7. The Postgraduate Medical Training Bodies and medical schools should be involved with the Medical Council in drawing up the specialty-specific curriculum and learning outcomes for medicine, surgery and the selective modules. However, it is recognised that a decision of such an arrangement is a matter for the Medical Council itself under new legislation.

8. All intern posts, new and existing, should be EWTD compliant.

9. On-call duties (training at night and at weekends) should be retained for interns but should be significantly reformed. Night-time and weekend working must be scheduled in the context of appropriate rostering arrangements which will ensure EWTD compliance. Appropriate supervision should be provided by a designated supervisor at all times, including while on call.

10. Interns should have access to flexible training, in line with guidelines developed by the Postgraduate Medical & Dental Board for SpR/SR posts.

3. Numbers

3.1 Introduction

Current policy relating to the future of the intern year is based on the Buttimer and Fottrell Reports, the broad thrust of whose recommendations were adopted by Government in February 2006. Workforce planning policy issues relevant to the intern year were also identified in the *Report of the National Task Force on Medical Staffing,* 2003 ("Hanly Report").

The key features of current policy include (references in brackets):

- the numbers of doctors in training at each level should be aligned with future consultant and specialist staffing requirements *(Hanly, p 106 and Buttimer, Recommendation 21);*
- HSE should ensure that there are sufficient intern places to meet service needs and facilitate graduate retention, and continue to provide funding and resources to develop appropriate information systems *(Buttimer, p 67);*
- additional intern positions should be provided by the HSE/health service in line with need *(Fottrell, pp 41, 98-99)*;
- HSE should establish a matching scheme for all NCHDs and interns, based on transparent, published criteria, and ensure transparency in recruitment and in the allocation of intern positions *(Buttimer, Recommendation 17);*
- The intern year should be redesignated as the first year of postgraduate training in line with international best practice *(Buttimer, Recommendation 55).*

The Buttimer Report recommended that the HSE should review workforce planning requirements regularly, reflecting the clinical capacity within the service in consultation with primary, public and community care stakeholders. This role has been placed on a statutory basis through the Medical Practitioners Act 2007. These annual reviews will assist in identifying the appropriate number of doctors required to be trained for each specialty and subspecialty.

It will be necessary, therefore, to build sufficient flexibility into the intern year structure to allow adjustments resulting from medical workforce requirements and service configuration, in order to allow the appropriate increase and decrease in intern numbers. The Medical Council recommended that funding for intern posts should follow the intern. This would facilitate the necessary flexibility and allow the system to react to any necessary changes rather than continuously providing funding to a hospital for an intern post which might not be necessary or appropriate.

The Fottrell Report recommendation for 725 medical entrants has been adopted by Government. The planned increase approved by Government requires an expansion of intern posts from 2011 to accommodate an eventual 240 EU graduates from the new graduate entry stream as well as an additional 180 EU graduates from the undergraduate stream arising from the substitution of 180 non-EU places for EU places if an intern post is to be available for each EEA graduate of Irish Medical Schools on completion of his or her medical degree.

The recruitment procedure for interns is a matter for the HSE having due regard to Government and HR policies, including policy on employment ceilings. There are currently sufficient numbers of intern posts (505) in the health service to place any Irish/EU students graduating in the next 3 years. In relation to intern places for non-EU graduates, there is a need to ensure that provision of such places should be compatible with national medical education and training priorities.

It will be a challenge to provide sufficient posts in the medium to longer term in light of the recently proposed expansion in undergraduate numbers and the commencement of the graduate entry programme in medicine, to be EWTD compliant and to expose interns to a sufficiently wide range of training experiences.

Discussions within the committee have highlighted a number of issues which impact on the recommendations of the committee and which are discussed in this section. These include

- the current lack of a comprehensive workforce plan and indeed workforce planning function, through which the number and location of intern posts is clearly determined on the basis of service need within an overall framework of established relationships between student intake, interns, basic specialist training posts, higher specialist training posts and consultant appointments. It is noted that a joint HSE/DoHC group has been established to examine the issue of workforce planning in the health service and this group is expected to report by the end of 2008.

- current distribution and structure of intern positions including the basis for existing established numbers and locations

- requirements to comply with EWTD requirements

- The provision of intern positions or at minimum access to such posts for EEA (including Irish) students studying medicine in other EU Medical Schools and private fee paying non-EEA students of Irish Medical Schools.

- The provision of a national framework for the creation, maintenance and development of intern positions while at the same time providing day to day management of intern positions at a local level including vesting authority at central level to decisions on the creation of new posts and/or the re-designation of existing intern positions to other posts within the service

- The overall capacity of the health system to accommodate an increase in the number of intern positions having regard to current and projected service demands and educational/training capacity.

- the capacity of the education and health sectors to adjust medical student intake numbers, and hence intern numbers, in a timely manner to reflect changes in service need, market supply factors etc.

It was recognised that any decision reached in relation to the restructuring of the intern year and increasing the number of intern positions should be introduced on a pilot basis in the first instance and after review of the pilot programme rolled out to the wider sector on a phased basis having regard to the phased increase in the numbers of medical students graduating from our medical schools as part of the overall reform programme. It was also appreciated that the implementation of a revised programme including additional numbers of interns would have to take account of service needs / training capacity and the requirement to ensure continuity of patient care services during any changes to the internship programme.

3.2 Workforce Planning

The Subcommittee notes the workforce planning functions assigned to the Health Service Executive in the Medical Practitioners Act 2007 and in particular those relating to assessment of intern numbers (see Appendix C). Section 86 3(d) of the Medical Practitioners Act 2007 provides that the HSE shall have the following responsibility

> "to assess on an annual basis the number of intern training posts and the number and type of specialist medical training posts required by the health service and pursuant to that assessment, to put proposals to the Council in relation to the Council's function under Section 88 (3)(a) and (4)(a)".

In this regard it is recognised that the "assessment" and putting of "proposals" cannot and should not be done in isolation from an overall comprehensive medical workforce strategy.

The development by HSE of its statutory role in providing a comprehensive framework for workforce planning will be crucial in ensuring the proper planning of the intern year in the future. The Subcommittee acknowledges that workforce planning in medicine, due to the long lag time (up to 15 years before independent specialty practice) is very difficult. The Subcommittee therefore recommends that training place requirements be updated on an annual basis by the HSE in the light of emerging health service strategies and in line with its statutory obligations.

The need for a medical manpower plan has been highlighted through a number of reports. Examples include the *Report of the Forum on Medical Manpower* (2001), the Tierney Report (*Medical Manpower in Acute Hospitals,* 1993), the Hanly Report (*National Task Force on Medical Staffing*, 2003) and the *Healthcare Skills Monitoring Report* (FÁS, 2005).

The development of a medical workforce plan should also take into account Irish students studying medicine abroad.

The Sub-Committee welcomes, and considers timely, the workforce planning exercise commenced at the end of 2007 by FÁS. FÁS has been commissioned by the DoHC and HSE to review its 2005 report with a view to updating it and developing a framework for the future timely analysis of the supply and demand of healthcare skills. This work is focussing on eleven specific occupations spanning both the public and private sectors and will include medical consultants and general practitioners. The objective is to develop a tool which would enable policy makers to assess, in quantitative terms, alternative supply scenarios. The aim is to model the flow of supply from potential to actual by tracing medicine training cohorts through different stages of training; undergraduate, intern, general professional training and higher professional training. The work is being overseen by a liaison group consisting of representatives from the DoHC, the HSE, the Department of Education and Science, the Department of Finance and FÁS.

The Subcommittee has been advised that it is expected that this study will be completed during 2008 and will include a comprehensive review of supply and demand factors affecting medical staffing at all levels including medical student and intern level.

The Sub-Committee believes that it is crucial that medical workforce planning is sufficiently sensitive to react to changes in health service provision and configuration. Furthermore, it is imperative that a mechanism be in place whereby the workforce requirements identified annually by the HSE and in the medium to longer term will be reflected throughout the training pathway i.e. intake at medical school, intern, BST, HST and consultant levels are proportionate to clinical and service needs and capacity.

3.3 Expansion of undergraduate medical school places

From an international viewpoint the increase in output from medical schools is a world wide phenomenon. Increased output from both existing and new medical schools is occurring in the US, UK and Canada, traditional destinations for Irish graduates; thus employment opportunities for Irish graduates in these destinations are decreasing. In Australia, the number of domestic graduates from Australian medical schools is set to increase by 81% in 7 years from 1348 in 2005 to 2442 by 2012. Including international students, medical school graduates will total almost 3,000 in Australia by 2012[*]. Increased numbers from existing schools and new medical schools are also the pattern in the US, UK and Canada. In Australia, there is recognition that a lack of intern posts represents a potential bottleneck in the system. The states and territories have agreed, as part of the Council of Australian Governments (COAG) Health Workforce initiative, to provide sufficient intern-level positions. They are now addressing the need to increase positions for subsequent postgraduate years.

Based on a projected output of approximately 725 EEA medical entrants per annum and on the basis of an estimated minimum training pathway in most specialties of seven years after internship, it is estimated that approximately 4,500 NCHD places would be required. Projecting through the training pathway to specialist registrar level, this figure of 4,500 NCHD posts would

[*] Riding the wave: Current and emerging trends in graduates from Australian university medical schools. MJA 2007; 186(6): 309-312

include over 300 specialist registrars completing their specialist training per annum. The typical annual new increase in consultant posts per annum has been approximately 100 since 2000.

The Sub-Committee recommends that the Fottrell recommendations in respect of medical student numbers should be kept under review in the context of the DoHC/HSE workforce planning exercise and the consideration of the introduction of new health service grades.

3.4 Irish students studying medicine abroad

It remains to be seen whether the expansion in medical places will impact on the number of Irish choosing to study medicine abroad. It appears that the number of Irish students studying medicine abroad (principally in the UK and the Czech Republic) could be significant. The Sub-Committee is informed that in some countries, graduation and registration is simultaneous, thereby negating the requirement to undertake an intern year. However, the Sub-Committee is conscious that such students may find themselves at a disadvantage when applying for SHO posts owing to their overall lack of practical experience and that these students may seek to undertake an intern year in Ireland to gain experience for this reason despite their entitlement to registration with the Irish Medical Council without this. However it is the view of the Sub-Committee that the intern year is a pre-registration year and should only be open to those that require to undertake it for the purposes of registration. **The Sub-Committee recommends that graduates who are otherwise entitled to full registration with the Medical Council should not have access to intern places.**

3.5 Internationalisation of Irish Education Services and the Application of Community Preference

In discussions on whether or not intern positions should be provided for private fee paying non-EEA students of Irish Medical Schools key issues which have arisen are the application of Community Preference, the policy on 'Internationalisation of Medical Education' and the costing/funding models to be applied in relation to such posts.

The need to support the Government policy objective of developing and consolidating a leading position for Ireland in the knowledge economy through strong research and educational links with other countries is recognised. Furthermore it is also important to recognise the value of the additional income streams from these links to the medical schools in meeting their overall school costs, including contributing to the costs of training Irish/EU medical undergraduates. However, as reported by Fottrell, "*it is highly unusual, among developed countries, for non-national students to comprise more than 10% of the total medical school student body. In the U.K., for example, non-EU students comprise less than 10% of medical school intake, which contrasts with a non-EU student intake of 61% in Ireland in 2003/04. The main adverse consequence of such imbalance in the proportion of non-EU students is that it limits the number of clinical training placements available to expanded numbers of EU medical students*". The issue of costing/funding models for intern posts is discussed in Chapter 6.

Community Preference is provided for by Council Resolution of 20 June 1994 and article 19 of EC Regulation 1612/68 on the Freedom of Movement for Workers within the Community. Most EU Member States operate this Community Preference through a work permits system which obliges employers to seek (and to prove that they have sought) to fill vacancies in the first instance from within the EEA.

In Irish legislation the Employment Permits Acts 2003 and 2006 set out the provisions governing the employment of non-nationals in the State. Section 10 of the Employment Permits Act 2006 sets out the circumstances under which a permit may be granted. The Act requires employers to fill vacancies from within the EEA before offering the position to non-EEA nationals.

Intern positions fall within the scope of the work permit scheme as the duration of internship training is 12 months and they do not meet the two year job offer criteria for a green card. The advice provided by the Health Service Employers Agency is that in situations where a work permit is required, the community preference rules should be applied and all EEA candidates and non-EEA candidates who do not require a work permit should be ranked in preference to

non-EEA candidates who require a work permit. This approach is in line with advice from the Department of Enterprise, Trade and Employment.

There has been no formal mechanism for discussion between the medical schools who admit non-EEA students and the health service which has to accommodate these students both during student clinical placements and internship. The majority of non-EEA students who study here choose to return to their own countries after graduation. However, some students choose to stay in Ireland, for a variety of reasons, such as professional development, personal reasons etc. While community preference is currently applied there has not been difficulty to date in accommodating most of the non EEA graduates of Irish Medical Schools who apply for intern positions as there have ordinarily been a sufficient number of intern places to meet both the needs of EEA graduates and those non-EEA students that chose to stay. However, this situation will change with the proposed increase in (EEA) student numbers.

The Equality Act 2004 affords legislative protection to employers against possible claims of discrimination in the event that they apply the community preference rules. Section 10 of the Equality Act 2004 amends s17 of the Employment Equality Act 1998 by substituting the following for subsection (2) of s17 of the 1998 Act:-

"In relation to discrimination on the basis of nationality, nothing in this Act shall render unlawful any action taken in accordance with the Employment Permits Act 2003".

Therefore, the practice, as described should not give rise to claims under the Employment Equality Act 1998 and 2004.

The Sub-Committee is aware that it is current practice in Irish medical schools that all non-EEA students are informed on entry to medical school that they are not guaranteed access to an intern post in Ireland upon graduation. The Sub-Committee supports this approach.

3.6 Number of intern posts

The Fottrell and Buttimer Reports both highlighted the need for sufficient intern posts to facilitate registration, graduate retention, service needs and to realise the benefit of increased student intake.

The subcommittee is satisfied that as a minimum, sufficient intern positions must be provided to allow EEA graduates of Irish Medical Schools to remain in Ireland until registration. Having regard to the most recent advice from the HSEEA on the application of community preference to intern appointments (see section 3.5) this will require the provision of a minimum of 725 intern positions and represents an overall increase of 220 intern positions to be funded in the sector.

This additional requirement is based on the understanding that all existing intern posts and new posts are restructured as recommended by the sub committee and that existing and new posts are managed within a matching/appointment system to ensure access by all qualifying EEA graduates of Irish medical schools.

In its consideration of the impact of increased intake of students to medical schools the Fottrell report considered four scenarios including changes to the non EEA intake. In this regard the Fottrell Report noted that it was unlikely that a decision would apply that all intern positions would be allocated to EEA students only and if that provision was to be made for access to non EU students, about 300 additional intern positions will be required.

Given a non-EEA medical student intake in Irish medical schools of 25%-29%, it is likely that many of these students will choose to return home directly after graduation to continue their careers. However, the Sub-Committee considers that it is important that appropriate allowance is made for access to intern places by non-EEA graduates of Irish medical schools and EEA graduates of foreign medical schools.

Thus the Sub-Committee recommends that a total of approximately 800 intern posts will be required on the basis of 725 EEA medical school entrants and allowing an additional 10% to allow access to intern places in Ireland by EEA graduates from foreign medical schools in line

with employment legislation as well as allowing some access by non-EEA students to intern places. It should be noted that the intern year is a pre-registration year and should only be available to those that require the experience and supervision afforded by the intern year to achieve registration with the Irish Medical Council.

As stated in Section 3.5, the Fottrell Report indicated that a non-national medical student population of around 10% is representative of international norms. The Sub-Committee would see the provision of an additional 10% of intern posts (approximately 75-80 posts) for non-EEA students as being a reasonable target in the context of Government policy on the internationalisation of Irish education to provide reasonable access to EEA graduates of foreign Medical Schools access to Intern positions.

3.7 Location of Intern Posts & Capacity

The Sub-Committee's survey of interns showed that a majority of interns (64%) indicated that their preference for a rotating internship would be through both a university teaching hospital and a general hospital.

As noted in Fottrell, the practice has grown that individual universities have long-standing affiliations with specific hospitals for the placement of interns notwithstanding that intern positions are funded posts in the HSE funded agencies. The distribution of affiliated intern posts is provided in Table 3.2 below.

The number of intern positions funded and filled by the HSE/HSE funded agencies is between 505 – 517 posts. The range of 12 posts reflects the fact that all posts are not filled on a continuous basis due to short term vacancies, withdrawal of approval for certain posts etc. and the creation of new posts in certain circumstances. For the purpose of this report a conservative approach in terms of numbers of posts approved and funded, 505 is taken. This number compares with 534 posts approved by the Irish Medical Council, reflecting the fact that there are a number of posts approved by the Council, but not approved by the HSE for funding and filling within its current employment control ceiling.

Table 3.1 – Distribution of available intern posts (summer 2007) by existing medical school affiliation

Medical School	Affiliated Interns	EEA Graduates	Posts available to Non-EEA Graduates
TCD	94	70	24
UCC	100	64	36
UCD	115	123	0*
NUIG	79	64	15
RCSI	117	44	73
UL	-	-	-
	505	**365**	**140***

* UCD were short 8 places in 2007. This was particular to that year's graduation class and is above the normal EEA graduate number for that school.

Details of the distribution of intern places by hospital as at July 2007 are provided at Appendix G.

Table 3.2 below provides details of the proposed distribution of EEA medical student intake places at the full rollout of the undergraduate and graduate entry programmes.

Table 3.2 – Proposed distribution of EEA medical intake

Medical School	Planned EEA Intake	Current Intern Affiliation	Balance
TCD	132	94	38
UCC	130	100	30
UCD	171	115	56
RCSI	69	117	(48)
NUIG	128	79	49
UL	95	-	95
	725		**220**

It will be necessary to address the current affiliations. This issue is particularly urgent given the proposed increase in Irish / EEA numbers (as distinct from non-EEA) and legal situation arising from Community Preference legislation, HSE employment control and HSE recruitment licence requirements.

Existing intern posts and any new posts created should be distributed in a transparent and equitable fashion between the regional networks which are discussed in the next chapter, to ensure an efficient system of allocation, training and supervision and reflecting the numbers of EEA medical students per region.

The appropriate allocation of intern places in the context of the move of the intern year to the first year of postgraduate training should be planned carefully in line with workforce planning, service planning and any changes in service configuration.

A key issue arising in discussions on the number of interns is whether there is capacity within the sector to accommodate the additional intern posts proposed. Details of the distribution of intern positions in 2007 by bed complement are provided at Appendix G.

In addition, the Report of the Medical Council, October 2006, indicates that

- there was regional inequality in distribution of intern positions with 254 of 505 posts in the Dublin ATHs
- Only 23 (4.6%) of intern posts are in newly recognised specialties –

Medicine		Surgery	
Emergency	3	Emergency	5
General Practice	1	Obstetrics	12
	4	Paediatrics	2
			19

- Of 40 hospitals approved for intern training positions only 35 hospitals have intern positions.

3.8 EWTD Compliance

By August 2009 the work patterns for doctors, including interns, is legislated to be 48 hours/week over a 17 week period (This may be extended to 52 hours for a further 3 years in exceptional circumstances). The EWTD also stipulates a maximum period of continuous duty of 13 hours.

The current average weekly working hours of interns nationally is 65.39 hours. Details of intern average working hours by speciality by hospital are given at appendix H. These details clearly show the extent of non compliance with EWTD requirements.

Having regard to variance in regional distribution; opportunities to develop posts in recently approved specialties and the requirement to ensure EWTD compliance in existing and any newly approved posts the sub committee is satisfied that there is capacity in the sector to accommodate the additional intern positions recommended.

3.9 Impact of selective options on number of posts required

The Sub-Committee recommends in Chapter 2 of this report that the intern year should be restructured to provide for a three module structure with core and selective modules. Core modules will be in the specialities of medicine and surgery and will be of 4 months duration each. Selective modules will initially be in the specialties recognised by the Medical Council for inclusion in the intern year.

The decision on the structure of the intern post will have a direct influence on the extent to which new posts developed will be available for allocation to sites which currently have a low number of intern positions i.e. regional and general hospitals, general practice etc.

For example if existing intern positions are to be restructured to provide for a 4 month selective in each post and at the same time maintain the core intern hours to the substantive post the number of post equivalents to facilitate same will be 168. This means that only 52 of the new posts to be created within a ceiling of 725 posts will be available for allocation as new core posts.

This approach and projection is based on the assumption that there is full pooling of all posts from an access viewpoint and that there will be rotation between medical and surgical departments both within and between hospitals in certain cases to accommodate the rotations required to maintain core specialty hours within the ceiling of posts approved.

Summary of recommendations – Numbers

11. The Sub-Committee welcomes the establishment of the joint DoHC/HSE/FÁS group which will develop a tool which will allow for the assessment of supply and demand factors affecting healthcare staffing. The recommendations of this group should inform future developments of the intern year.

12. The intern year is a pre-registration year and should only be open to those that require to undertake it for the purposes of registration. Graduates who are otherwise entitled to full registration with the Medical Council should not have access to intern posts.

13. The recommendations of the Fottrell Report with respect to numbers of undergraduates should be kept under review.

14. The Intern Sub-committee's concerns regarding the implications of the increase in medical graduates should be taken into account by the joint DoHC/HSE Workforce Planning Group and by the Postgraduate Subcommittee in their deliberations. The Sub-Committee recommends that the Interdepartmental Policy Steering Group should consider the implications of the medical workforce planning model produced by FÁS for the Workforce Planning Group when it becomes available later in 2008

15. A sufficient number of intern posts should be available to meet the number of qualifying EEA graduates from Irish medical schools. Some access to intern posts should also be available to non-EEA students of Irish medical schools, and EEA graduates of foreign medical schools. An overall total of 800 intern places is recommended on the basis of a national medical school intake of 725. This includes approximately 10% to address the requirements of non-EEA graduates of Irish medical schools and EEA graduates of foreign medical schools.

16. The number of posts should be sufficient to meet service requirements, ensure EWTD compliance, facilitate graduate retention and ensure the protection of the State's investment in undergraduate medical education.

17. The intern year structure must be sufficiently flexible to react to adjustments resulting from medical workforce requirements and service configuration.

18. A pilot of the Sub-Committee's recommendations should be undertaken to further inform recommendations on numbers of posts.

4. Access and Appointment

4.1 Introduction

Intern posts are salaried posts in HSE funded agencies. The current system of access and appointment to intern places is based on long-standing arrangements between medical schools and hospitals on an affiliation basis. The current system is confined and calls into question the extent to which the system complies with the HSE's recruitment licence.

As a single national employer the HSE needs to be assured that there is a fair, transparent applications process in place, in compliance with employment legislation and HSE recruitment licence, and that all EU students qualifying from Irish universities will have the opportunity to complete the necessary pre-registration year.

4.1.1 Current Arrangements

Each Medical School has a network of intern posts at the main teaching, affiliated hospitals, and other hospitals with informal links. In most cases Medical Schools have arrangements with these hospitals for clinical teaching. In a few cases, hospitals have interns from more than one medical school. The Medical School liaises with medical manpower at the hospitals and clinicians regarding the filling of the intern posts. Student applications are invited early in the year, and when the results of the Final Medical Examination are to hand in late May a matching process is implemented, taking account of student preferences, academic ranking and, in some instances, clinicians preferences. When the match is complete, there is a further liaison with other medical schools in the event that posts are unfilled or EU graduates have not secured a post. Each Medical School has appointed an overall Intern Co-ordinator and Intern Tutors are appointed by HSE or Medical Schools to cover individual Hospitals. In teaching hospitals these individuals are often university employees. There is an intern committee at each Medical School which meets regularly to review operations. Arrangements for the remuneration of intern tutors at Affiliated Hospital sites vary, with funded HSE sessions in some places, and a voluntary arrangement in others.

4.1.2 Education Programme

An Intern Induction programme is run in late June for all interns. This typically runs for 5-7 days, and involves a period of shadowing with the team to which the intern has been assigned. Throughout the intern year there are regular scheduled intern teaching sessions. These activities are arranged by the Tutors and Co-ordinators. Interns and clinicians are actively reminded of the scheduled 3-monthly reviews and the necessity of completion of certificates of satisfactory experience. At the end of year these certificates are collected by the Medical School, certified by the Dean and sent on to the Medical Council to allow full registration before starting SHO posts.

4.1.3 Problem Solving

Over the course of the year there may be complaints about interns and also from interns. These are generally dealt with through the Medical School office in consultation with the clinical sites. Where interns become ill this is dealt with through the intern tutors, co-ordinator and medical management at the HSE sites. Where unsatisfactory performance has been documented, and persisted despite adequate feedback, the Medical School may become involved in counselling and, on occasion, facilitating remedial placements for interns.

4.1.4 Issues with current arrangements

Although the current system works in a fashion that satisfies the needs of most graduates, it has significant flaws:

- The distribution of intern posts between Medical Schools is variable
- Supervision is under-funded and as a consequence is variable
- The application process is not transparent and it is difficult for an intern applicant from outside an established pool to have equal access to positions, thereby raising questions on compliance with employment legislation and HSE recruitment licence
- Several universities have fewer positions in their network than they have graduates leading to uncertainty and stress among some graduates
- There is a mismatch between available medical and surgical posts leading to a small pool of interns unable to fulfil pre-registration requirements in a timely fashion.
- There is little opportunity to develop new positions in other specialities.

In addition to the above, new arrangements must recognise that:

- we now have a national programme for undergraduate medical training and, as a result, should move towards a national approach to intern places,
- the increase in the number of Irish / EEA medical school places,
- the establishment of a new medical school at Limerick and
- the shift of the intern year from the remit of undergraduate training to that of postgraduate training

In undergraduate nurse education there is a nationally agreed pro-forma contract that explicitly outlines the obligation on both the University and the employing hospital. The health service providers and third level institutions work closely in partnership to assign and monitor clinical placements. They are jointly responsible for managing effective partnership structures to support academic and clinical aspects of the programme and providing adequate support to clinical teaching staff in developing and maintaining an effective learning environment. This successful model should inform the development of new intern training models.

4.1.5 The Future

The Medical Practitioners' Act 2007 continues to assign statutory responsibility for the structure, content and quality of the intern year to the Medical Council. It is therefore incumbent on the HSE, post graduate training bodies and the Medical Schools to engage with the Medical Council in developing policy and procedures for access and appointments to Intern posts.

4.2 Proposed Appointment Process

Following extensive discussions by the Sub-Committee two proposals were presented in relation to arrangement for access and appointment to Intern positions.

It was agreed that the most favourable approach would be a **single national matching scheme** with standardised central application, delivered regionally and based on six intern networks organised around the six Medical Schools

4.2.1 National Matching Scheme

An area of particular discussion for the Sub-Committee was the viability of a matching scheme for intern posts. The initial discussion in this regard focussed on the feasibility of a national matching scheme. The Buttimer Report recommended that the HSE should harness research on matching schemes already carried out by the PgMDB and the RCPI and establish a matching scheme for all NCHDs and interns, based on transparent criteria, ensure transparency in the recruitment process and in the allocation of intern positions (Buttimer recommendation 17). The Sub-Committee considered the matching scheme in the RCPI for SHO posts, which is a matching scheme for SHO positions in various sub-specialties of medicine.

The discussion of a national matching scheme inevitably led to a discussion of the possible introduction of a common final exit exam. The introduction of a national matching scheme would be simpler if there was a common exit exam from medical school. However, the reality is that each medical school has its own exit exam. The consensus view of the Sub-Committee was that while a common exit exam would be helpful to the introduction of a national matching scheme, it was not a prerequisite. At this stage the development of a national consensus for the assessment of medical students would be a considerable undertaking and one which would require a significant amount of discussion and agreement among the six medical schools. It is envisaged that an agreed system (e.g. decile system) could be put in place at this time to facilitate the introduction of a national matching scheme.

The Sub-Committee recommends that there should be a standardised central application system for intern posts. Furthermore, a national matching system, delivered regionally, should be established with one standardised and integrated information system. The appropriate location for the centralised system could be the Forum of Irish Postgraduate Medical Training Bodies. Such a system would enable a database of intern posts to be maintained; with each post being assigned a distinct reference number. This should be developed in line with the implementation of the database of SHO and Registrar posts, arising from the *"National Audit of SHO & Registrar Posts"* (April 2008).

There should be six intern networks. Each network should be largely based around each of the six medical schools. Modules of the intern year should be on the basis of geographical proximity. The Sub-Committee is aware of other successful centralised application systems with regional organisation in place such as the RCPI SHO scheme and the ICGP programme.

Currently, intern coordinators are employed through the medical schools to organise the allocation and on-going organisation and administrative support of intern places and intern postholders. In the context of the move of the intern year from undergraduate training to postgraduate training, an intern coordinator should be appointed to each intern network, along with appropriate support, to ensure appropriate coordination throughout each intern network. Policies around the appointment of interns should be developed collaboratively by the HSE to ensure a consistent and transparent approach, in accordance with the provisions of its recruitment licence and reflect the continuum from internship to SHO.

An illustration of a model for such a system (based on the successful RCPI medical SHO matching process) is given at Appendix I.

Students of each School will apply centrally for a post, using a standardised application form listing their order of choices of linked one year posts within that network. The number of preferences that may be indicated will be determined during the pilot having regard to considerations, including administrative capacity. However, it is envisaged that a fixed number of preferences will be set. If a candidate exhausts their preferences, they may then select by network only. To facilitate comparison across medical schools ranking will be on the basis of percentile class ranking in the home Medical School.

Intern posts will be allocated in early February of final year on the basis of a matching scheme which takes account of academic credits obtained in the clinical subjects up to the end of semester 1, final year (December), when up to 80% of marks will have been allocated. Offers will be conditional on successful completion of the course. Knowledge of intern placement for the forthcoming July will enable students to undertake junior internship (shadowing) on the relevant clinical firms, enhancing preparedness for starting work.

Candidates will apply for particular posts with defined rotations. Modules will be grouped together into numbered posts. Interns will rank their choices of posts and intern networks will rank applicants and a match will then take place.

4.3 Current Application process

In parallel to the work of the Sub-Committee the HSE is in discussions with the Medical Schools and hospital medical manpower managers, to develop an agreed application procedure for intern positions in the short term. This work is at its early stages and involves the current intern coordinators associated with each of the medical schools, hospital workforce manpower

management representation and HSE input. It is hoped that a consensus can be reached on a common application system which can be communicated to students in all medical schools and implemented on an interim basis.

Summary of Recommendations – Access & Appointment

19. A standardised central application system for intern posts should be developed.

20. A single national matching scheme managed centrally, delivered regionally should be introduced and organised around the six medical schools.

21. Rotations should be on a regional/network basis e.g. a single intern post with rotations in medicine, surgery and general practice could take place on different clinical sites but these should be within a single network.

22. Existing intern posts and any new posts created should be distributed in a transparent and equitable fashion between the intern networks, to ensure an efficient and fair system of allocation, training and supervision and reflecting the numbers of EEA students in each region.

23. Each intern post should be given a reference number, which can be used in the compilation of a database of intern posts and will be compatible with databases being developed for other medical posts.

24. An intern coordinator should be appointed to each intern network.

25. Policies around the appointment of interns should be developed by the HSE collaboratively on a national basis to ensure a consistent and transparent approach and in concordance with the HSE's recruitment licence.

5. Management & Supervision

5.1 Role of the Employer

5.1.1 Protected training time

As discussed in Chapter 1, while the survey of interns undertaken on behalf of the Sub-Committee indicated a general satisfaction with the level of training during the intern year, the Sub-Committee was concerned by the sometimes low levels of dedicated intern training. Furthermore, the Sub-Committee was concerned by the low adherence to bleep free policies. The Sub-Committee sees the protection of training time as crucial and recommends that the findings of the survey, including those related to protected teaching time and supervision should be further examined and addressed.

5.1.2 Induction

The survey of interns indicated that a majority (53%) did not feel well prepared for the intern year. A consistent and nationally agreed induction programme could help to address this. In the survey, one suggestion which arose from a number of the interns was that a full working week of shadowing would be beneficial in advance of commencement of the intern year. It is envisaged that the reforms of the intern year proposed by the Sub-Committee and the timely allocation of attachments would help to facilitate this.

In its report (2006), the Medical Council recommended that national consensus should be reached on an induction programme and delivery thereof. The Sub-Committee is supportive of this recommendation and suggests that this should be developed jointly by the medical schools, the training bodies / trainers, the intern coordinators and hospital medical manpower managers. It is acknowledged that induction programmes are currently in place through individual medical schools. As mentioned in the previous chapter, work is already underway by HSE-METR, the Intern Coordinators and medical manpower managers to devise an agreed application system to intern positions. The development of a nationally agreed induction programme would be a natural extension of this.

5.1.3 Training Principles

The Training Principles to be incorporated into New Working Arrangements for Doctors in Training (appendix D Buttimer Report) include a set of General Principles for application to NCHDs and a set of specific principles for each specialty. Protected time for trainers and trainees are an integral part of these principles. As the intern year is now the first year of postgraduate training the subcommittee recommends that the general principles should also apply to interns and that specific principles should be developed and agreed by the stakeholders

5.1.4 Intern contract

The Sub-Committee is aware that the NCHD contract has been the subject of discussion for some time. The Sub-Committee believes that the contracts for interns should be consistent throughout the service and should reflect the one-year modular structure of the year, training needs, rotations, reference to completion of modules, remedial action etc.

The Sub-Committee is aware of work underway through the Forum of Irish Postgraduate Medical Training Bodies and the NCHD contract talks to develop a training agreement for NCHD posts which would reflect the training component of their posts as an integral part of the contract with the HSE. The Training Principles should be reflected in the NCHD contract.

5.2 The role of the Intern Tutor

Currently, coordination of the intern year is led by each medical school through a network of intern tutors and intern coordinators. The responsibilities of the intern tutor include running the intern training programme in the hospital and offering pastoral support and guidance to interns as they begin their medical career. The Medical Council highlighted in its report (2006) the importance of intern tutors having dedicated sessions, the role of the intern tutor being defined and the establishment of national standards for intern tutors.

As stated in Chapter 1, the survey of interns found that there was variation in the assignment of and interaction with intern tutors.

The Sub-Committee discussed the potential of non-consultant staff taking on the role of intern tutor. While the potential role of a cross-disciplinary postgraduate tutor on a single hospital site has merit, it was felt that given the particular significance of the intern year in career development and its status as a pre-registration year, all intern tutors should be consultant doctors.

In 2002, it was recommended by the Medical Council that Intern Tutors have a dedicated session or number of sessions each week to allow them time to fulfil the role properly and should be resourced at a minimum rate of:

- two sessions for the first eight interns, designated in the practice plan of the tutors' contract.
- one extra session for each additional eight interns, designated in the practice plan of the tutors' contract.

The Sub-Committee agrees with the Medical Council's minimum requirement and recommends that this be implemented and that protected time is provided for intern tutors, including allocating the appropriate funding to implement this recommendation. The role of intern tutors should be clearly defined and their role in the monitoring of interns clearly specified.

The Sub-Committee also recommends that the intern tutor responsibilities of consultants should form part of their contract rather than being additional to their clinical contract. However, it is acknowledged that some flexibility is required such as in the case of smaller hospitals where the sessional commitment of a consultant to intern tutor duties does not exceed two sessions per week.

The Sub-Committee recommends that all intern tutors should undertake these duties to a maximum of half-time and that appointments as Intern Tutors be for a fixed period of time.

The primary roles of the intern tutor should be:

- delivery of the intern core curriculum
- mentoring
- remedial issues
- competence assessment for the core curriculum

The Sub-Committee recommends the protection of teaching time for all consultants. However, the Sub-Committee recognises that the appropriate forum for the progression of this issue is through the negotiation of a new consultants' contract.

Career Mentoring

An important objective of the reform of the intern year is to establish a career mentoring programme to supplement the mentoring which should be provided to interns by trainers. A career mentoring programme could allow for a more formalised mentoring approach. During the application process, students should be assisted to identify a career mentor to advise on both their intern programme and future career development. For the duration of the programme the mentor will act as a role model and a resource assisting the student in fulfilling the obligations of their training and meeting the milestones required for timely completion. The first meeting should take place early in the first week of the placement and should involve the mentor and the student agreeing the domains of competence that will be achieved in the

placement. A learning plan should be designed and agreed. A midway meeting to discuss the student's progress should identify any problems and implement agreed action plans. A final or exit interview, during which the assessment is completed, should take place at the end of the clinical placement. Thereafter the lead mentor should continue to assist the candidate for the duration of their medical training. The teaching of pre-registration medical interns must be an integral part of professional medical practice. To ensure the success of this mentoring programme a panel of qualified and willing mentors needs to be developed.

Continuing professional development (CPD) is recognised as the best assurance to the provision of world class efficient medical service. The scope of medical education must extend from intern and higher specialist training, into continued in-service training. A mentoring programme will promote lifelong learning and will contribute to professional and personal development.

The Intern Programme

The intern training programme will be a sequentially graded competency-based model. The programme commences with a structured and facilitated student orientation programme, covering administrative, clinical and training aspects of the forthcoming year and appointment of a mentor. Competency evaluation begins during this orientation where each intern is provided the opportunity to demonstrate criteria-based competency in administration, basic therapy knowledge and skills of therapeutic interventions and is on going throughout the programme with year-end evaluations. Specific criteria for demonstrating competencies are provided in the training manual that each intern receives during orientation week. Criteria include demonstration of competencies in consultation and communication, assessment and diagnosis, intervention, professional and ethical behavior, research and scholarly inquiry. Demonstrated competency in these areas is required for successful completion of the internship.

During the internship year, students should be provided with a supportive, supervised environment in which they continue to develop competencies while assuming growing responsibility for patients in preparation for functioning independently. Seminars and skills training should be provided to work on and correct any entry-level deficits. The training programme emphasises the active involvement of the intern in choosing training assignments, participating in training seminars and workshops, and in providing input into the internship programme. Interns will be provided with ongoing evaluation/feedback to assist them with self-monitoring their own progress towards autonomy through the mentoring system. In addition to the rotation training courses will be provided by the Medical Schools in conjunction with the HSE and a candidate can choose to make up their own bespoke programme. For example, a candidate on a Beaumont and affiliated hospital rotation could apply to do a suitable course provided by any other of the hospitals participating in the scheme. Institutions will provide courses according to their particular expertise

5.3 Assessment & Sign-Off of the Intern Year

Currently, assessment of the intern year involves three monthly assessments by supervising consultants and sign-off by the appropriate trainer at six month intervals. The Dean of the medical school certifies the successful completion of the intern year based on the assessments provided by the supervising consultants.

Developments including the move of the intern year from undergraduate to postgraduate and the provisions of the Medical Practitioners Act 2007 necessitate the review of these arrangements. In light of these changes, it is envisaged that postgraduate training bodies should play a significant role in the assessment and sign-off of the modules of the intern year.

Under the Medical Practitioners Act 2007, the Medical Council is responsible for sign-off of the intern year. The Medical Council must prepare and publish criteria it will use to determine whether an individual intern has attained a satisfactory standard for awarding a certificate of experience. The Medical Council may establish a standard professional development portfolio to record progress through the programme and to keep records of assessments. The Medical Council must ensure that interns are provided with a structured assessment in the workplace. After successful completion of the intern programme, doctors can be approved for entry into the

Trainee Specialist Division, if they wish to undertake postgraduate training or the General Division of the Medical Council's Register.

While acknowledging the statutory role of the Medical Council, the Sub-Committee has considered two suggestions in relation to the assessment of the Intern year –

1. that the assessment will be undertaken by the Postgraduate Training Bodies on behalf of the Medical Council; or
2. the assessment will be undertaken by the Medical Schools on behalf of the Medical Council

The key considerations of the Sub-Committee in discussing these suggestions included:

- ensuring appropriate organisation and governance of the intern year,
- the important role of local trainers in the assessment of modules,
- ensuring that the assessment process is reflective of the intern year's status as the first year of postgraduate training,
- ensuring a common and consistent final pathway for assessments from all intern networks to Medical Council sign-off,
- ensuring that appropriate and timely advice is provided to the Medical Council to facilitate it in fulfilling its statutory responsibilities under the Medical Practitioners Act 2007 in relation to the issuing of certificates of experience.

The majority of the Sub Committee favoured the first option, i.e. that the assessment be undertaken by the Postgraduate Training Bodies as the intern year would be the first year of post graduate training. The arguments put forward in respect of each option are provided below.

5.3.1 Option 1: Assessment by the Postgraduate Medical Training Bodies

It is acknowledged that reform is necessary to address problems recognised within the intern year as highlighted by the findings of the survey of interns undertaken on behalf of the Sub-Committee. The statutory requirement for moving the intern year to the first postgraduate year provides the Sub-Committee with an opportunity to review current matching, curricula, rotations, assessment and certification processes. Issues have been identified with the current practices and it is considered that the postgraduate medical training bodies are well placed to manage the coordination of the intern year.

The Postgraduate Medical Training Bodies currently have structures which monitor, supervise and assess progression through Basic Specialty Training / Senior House Officer level (e.g. General Professional Training, Basic Surgical Training, etc.) to Specialist Registrar training. The Bodies provide Certification of Satisfactory Completion of Training and advise the Medical Council as to suitability for inclusion on the Specialist Register or otherwise. Likewise, the training bodies have established local remedial processes to support the trainee with any range of performance problems. Thus the precedent exists for the postgraduate training bodies to deliver national training programmes and to advise the Medical Council on outcome.

It is recommended that the relevant training body, in consultation with the Medical Council, should devise an intern-specific curriculum and competencies to form a continuum with Basic Specialist Training. Each training body should be responsible for sign-off for the relevant module. This should be centrally coordinated by the training body in the first instance but delegated to the appropriate hospital-based trainer in each case. In most instances, the same team of trainers will be responsible for an intern and a senior house officer.

Clearly comprehensive change is essential. Thirty-two percent of those who participated (n=66) in the Sub-Committee's survey reported dissatisfaction with the level of dedicated intern training available (a level similar to that recorded in other surveys of interns[*]). In part this may be the result of inadequate funding, the current positioning of the intern year following graduation from

[*] For example: Postgraduate Medical & Dental Board 1995 Survey of the views of House Officers and Registrars on Postgraduate Training and Career Counselling, The Career Plans of Irish Interns: Results of a National Study (Irish Medical Journal, 2004) and Career Tracking Study: Factors affecting career choices and retention of Irish medical graduates (2005).

medical school or may reflect the different challenges presented by under-graduate teaching and the training of clinicians, though supervising consultants engage in both. The present model of intern training has been found wanting; more of the same is unacceptable.

In 2008 there were 749 applications to the Basic Specialty Training programmes for which matching schemes are operated in RCPI and RCSI. 336 applicants were matched to posts available. A similar number of appointments are made on an annual basis to the 2 year programmes delivered by these Medical Training Bodies. In the same year 1226 doctors were enrolled in Higher Specialty Training programmes delivered by all the Medical Training Bodies. The proposed model draws on the extensive relevant experience of the Postgraduate Training Bodies. The best interests of the intern will be protected while progressing from medical school to a medical school area based intern network. There the trainees will be locally supported, supervised and assessed by the Postgraduate Training Body trainers using specially designed competence-based methodology and coordinated by the proposed Intern Committee of the Forum of Irish Postgraduate Medical Training Bodies (see below).

It is clear that responsibility for the intern year lies with the Medical Council. Should the Medical Council decide to be advised by the Postgraduate Training Bodies regarding training of interns it would affirm its preferred competency based assessment model. This will establish a continuum at postgraduate level extending from the beginning of clinical training through specialty training into professional assurance and will utilise the already proven practices of the Postgraduate Medical Training Bodies.

As stated in the previous chapter, it is recommended that the intern year should be organised through six intern networks, based largely around the six medical schools. Responsibility for the delivery of the intern year will be delegated to the networks. Each network will have an Intern Coordinator.

Without prejudice to any position the Medical Council might take, existing experience of the Forum of Postgraduate Training Bodies* and its constituent members could provide such a function. However, it is recognised that a decision on the detail of such an arrangement is a matter for the Medical Council itself under new legislation.

The process of assessment would involve local assessment, with centralised and consistent assessment of completion of training modules. An outline of the process is as follows:

1. The intern electronically records module specific training in their log book, including procedures observed, procedures performed and generic skills attained in the training schedule and trainer sign-off.

2. Approved trainers, approved by the Forum, will indicate the following at the end of the rotation:
   - Whether curricular requirements have been satisfactorily completed.
   - Whether overall satisfactory progress has been achieved.
   - Whether elements of generic curriculum have been achieved.
   - Any problem areas e.g. interest, absences, communication skills, interpersonal skills, ethical issues etc.

   The trainers' assessments will be forwarded to the Intern Coordinator, who will in turn forward the assessments to the Forum within two weeks of completion of the training schedule. If a trainee is assessed not to have made satisfactory progress, not having achieved all curricular requirements in more than one module, the Forum's Intern Training Committee (see below) will advise the Medical Council against registration and will pursue appropriate remedial action and investigate problems.

* The Forum of Irish Medical Postgraduate Training Bodies was established to promote common strategies and enhance universal efficiencies of the accredited postgraduate medical training bodies. The Forum consists of the 13 postgraduate training bodies recognised by the Medical Council plus the Advisory Committee in Emergency Medicine, RCSI & RCPI. The ICHMT and ISPTC are represented separately to their parent training bodies, the RCPI and RCSI. The Forum meets at least four times each calendar year. The Chairperson and Secretary are elected from the members. An annual report will be published by the Forum and may also publish policy papers. The Forum unites individual training bodies by enhancing the standardisation of practices, coordination of responses to third parties and generation and implementation of common strategy. However, each training body reserves the right to independently pursue the same or other activities. The Forum does not have a statutory basis. Funding for the administrative support to the Forum is provided by the HSE.

3. The relevant training body will make a recommendation on satisfactory completion of training module.

4. An Intern Training Committee will be formed as a sub-group of the Forum, comprising representatives of relevant training bodies. Membership will include those training bodies currently involved and likely to become involved in intern training. The Committee may make recommendations on the appropriate curriculum and competencies in line with health service needs and in accordance with the Medical Council's statutory role.

   The Intern Training Committee will also consider the assessments made by local trainers and provided by local intern coordinators and will deal with any remedial matters required. The Sub-Committee acknowledges the importance of addressing remedial issues and feels this issue should be further explored at implementation and pilot stage.

   The Intern Training Committee may also make recommendations on intern training needs based on surveys undertaken from time to time.

5. The Forum, on the advice of the Intern Training Committee, will advise the Medical Council whether or not each occupant of an intern post has achieved the curricular requirements and performed to an acceptable standard. Where registration is not recommended, the Committee will submit a detailed report outlining specific deficiencies and/or problem areas, specify action taken including remedial processes and recommend advice for the trainee.

6. It is the statutory responsibility of the Medical Council to issue certificates of experience for intern training, as set out in the Medical Practitioners Act.

The proposed process is outlined in Figure 1 on page 32.

5.3.2 Option 2: Assessment by the Medical Schools

Over the past 50 years the intern year has been the responsibility of the Medical Council. However, the organisation and management of the year has been delegated to the Medical Schools. Interns do not pay a university fee, nor is there any clear income stream to support the process. The Medical Schools have supported the appointment and monitoring process since inception.

Each Medical School has appointed an overall Intern Co-ordinator and Intern Tutors are appointed by HSE or Medical Schools to cover individual hospitals. In teaching hospitals these individuals are often university employees. There is an intern committee at each Medical School which meets regularly to review operations. Arrangements for the remuneration of intern tutors at affiliated hospital sites vary, with funded HSE sessions in some places, and a voluntary arrangement in others.

The Intern year is now designated by the Medical Council as the first year of post-graduate education, in accordance with the recommendation of WFME, necessitating a review of process. In doing so, it is prudent to take account of the experience, expertise and valuable working relationships that have been developed in the intern networks over many years.

It is proposed that an enhanced process would be as follows:

1. The intern records module specific training in their log book, including procedures observed, procedures performed and generic skills attained in the training schedule and will present this to the supervising consultant/ trainer sign-off.

2. In certifying satisfactory completion of the Module, the trainer will indicate the following objectives have been achieved:
   - Curricular requirements determined by the Medical Council have been satisfactorily completed.
   - Satisfactory patient service has been delivered.

- Any problem areas e.g. interest, absences, communication skills, interpersonal skills, ethical issues etc.

The trainers' assessments will be forwarded to the Intern Coordinator and Medical School Dean within two weeks of completion of the training schedule. If a trainee is assessed not to have made satisfactory progress the Intern Committee of the Medical School will investigate the problems, and make remedial recommendations.

3. The Medical School will make a recommendation of satisfactory completion of intern training to the Medical Council when, and only when, certificates of satisfactory completion have been submitted for all the constituent modules of the year.

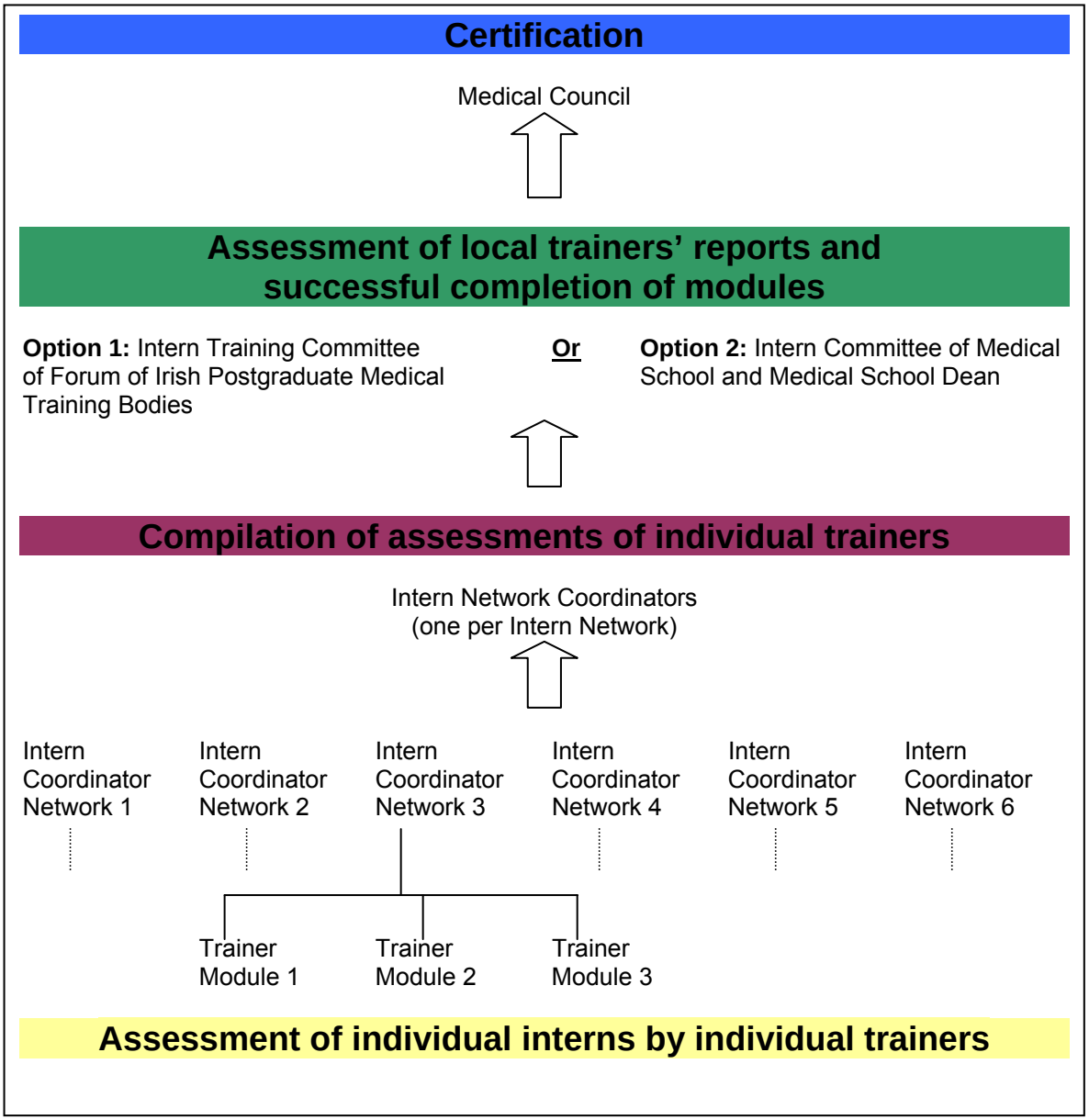
4. The Intern Training Committee of each Medical School will have representatives of each specialty .The committee will consider reports and recommendations from local trainers, intern tutors and coordinators regarding the organisation and delivery of the educational programme; and also feedback from interns in post. The Committee may also undertake surveys on intern training to inform education and service planning.

This proposal provides that the Medical Schools will continue to have responsibility for the quality of the intern's educational experience; and mentoring and support of those placed in their network. It assumes that the process will now be adequately funded. The Medical Schools will work closely with the Medical Council to ensure that the Medical Council's criteria for intern approval and full registration are met by each individual Intern. The process can be subject to periodic or random audit, and be reviewed every two to three years.

This proposal builds on a system that already functions well, is simple, has the capacity to be rapidly responsive, harnesses local knowledge, and builds on the continuum of undergraduate and intern education. It will continue to facilitate feedback from the intern experience to the undergraduate programme design and delivery.

This proposal may help to address concerns raised by those in favour of this approach in relation to remote organisation of the process, the potential for additional complexity, the need for coordination with a number of training bodies within a short timeframe and potential challenges is dealing with individual trainees in difficulty. The proposed pathway is outlined in Figure 1.

Fig. 1 – Pathway of assessment to certification: Options 1& 2 – Assessment by (i) the Postgraduate Medical Training Bodies or (ii) the Medical Schools



5.3.3 Consideration of options by Sub-Committee

The majority view of the sub-Committee was that the former option i.e. assessment by the Postgraduate Training Bodies would be more appropriate in the context of the intern year being the first year of postgraduate medical training. However, it is fully acknowledged that it remains the statutory responsibility of the Medical Council to issue certificates of experience for intern training and that any potential devolution of responsibilities to other bodies is a matter for the Medical Council.

The Sub-Committee acknowledges that there is a role to be played by both the undergraduate medical schools and the postgraduate training bodies in the oversight of the intern year and in providing recommendations on assessment of modules to the Medical Council in order to facilitate the Council's statutory role under Section 49(2) of the Medical Practitioners Act 2007. The Sub-Committee also acknowledges the significant role which the medical schools have played to date in the organisation and governance of the intern year. It is envisaged by the Sub-Committee that the medical schools and postgraduate training bodies will play key roles in the development, in conjunction with the Medical Council, of the core curriculum and specialist curricula for the modules on the intern year, which will be consistent across the six intern networks.

While the Sub-Committee does not wish to dictate to the Medical Council in relation to its statutory responsibilities, the Sub-Committee is of the view that a collaborative approach to the assessment and sign-off process for the intern year involving, principally, the Council, the postgraduate training bodies, the medical schools and the HSE would be of great benefit to the overall organisation, delivery and governance of the intern year.

Arrangements will be required for the approval of internships undertaken outside Ireland. Currently the medical schools must approve these internships. In the context of the move of the intern year from being part of the undergraduate education structure to postgraduate training, this role will have to be taken on by the Medical Council in association with its recognised training bodies.

New arrangements for the assessment of the intern year should form part of the pilot process.

Summary of Recommendations – Management & Supervision

26. The Medical Council recommendations that Intern Tutors have a dedicated session or number of sessions each week to allow them time to fulfil the role properly should be implemented, resourced at a minimum rate of:
    - two sessions for the first eight interns, designated in the practice plan of the tutors' contract
    - one extra session for each additional eight interns, designated in the practice plan of the tutors' contract

27. The relevant training body should devise an intern-specific curriculum and competencies in consultation with the Medical Council.

28. The Sub-Committee acknowledges the statutory role of the Medical Council for the sign-off of the intern year and recommends that there should be a single common pathway for the final assessment of the intern year and its modules, which could assist the Medical Council in fulfilling its statutory role in this regard.

29. The role of intern tutors, particularly in monitoring the performance of interns, should be clearly defined.

30. A database of intern posts should be maintained, in line with the database of SHO and Registrar posts currently being developed.

31. The Sub-Committee notes the feedback from interns arising from the survey undertaken and recommends that the intern year should incorporate structured and protected training sessions and fixed teaching sessions.

32. Other areas identified by the survey on interns should be explored and addressed by the relevant partner organisations as appropriate e.g. supervision of interns.

33. The Medical Council's recommendations with regard to induction should be implemented on a collaborative and consistent basis.

34. The intern contract should reflect the modular structure of the year, training needs, rotations and should include reference to completion of modules, remedial action etc.

35. The Training Principles to be incorporated into New Working Arrangements for Doctors in Training (appendix D Buttimer Report) include a set of General Principles for application to NCHDs and a set of specific principles for each specialty. As the intern year is now the first year of postgraduate training the subcommittee recommends that the general principles should also apply to interns and that specific principles should be developed and agreed by the stakeholders.

6. Resource Requirements

6.1 Introduction

Chapter 3 identified the need to provide for 800 intern positions to support the objectives that:

1. EEA graduates (725) of Irish Medical Schools would have access to an intern position to facilitate registration with the Irish Medical Council.

2. A provision of 75 posts – 10% of EEA intake to Irish Medical Schools – would be made available to non EEA graduates of Irish Medical Schools to support the Government policy of Internationalisation of Third Level Education provision.

It was also agreed that all intern positions must be:

(1) EWTD compliant – targeted at 48 hours/week, averaged over a 13 week period.

(2) Intern positions should be structured to ensure that each post has exposure to core hours – 8.00am -5 pm; evening hours 5pm-12 midnight and night duty within compliance with the EWTD requirements, thus ensuring that the excessive overtime hours currently experienced by some interns at present are discontinued.

This chapter examines the costs of current provision of intern positions and the costs of implementing the recommendations of the Sub Committee.

Existing Intern Provision

There are 514 Intern posts approved/funded in 2008 in HSE managed and funded agencies. In estimating the cost of restructuring these posts and the cost of funding the additional 286 posts recommended by the Sub Committee we have examined the actual hours worked and cost of these hours and recorded – basic and overtime – for each of the existing posts over a 26 week period ending 31.12.2006 and propose to use this costing as a basis for estimating future costs.

The results of this analysis is presented in Table 6.1 below and shows that the total hours worked per week by full cohort of Interns (514) in this period was 33,237 hours/week. This total was comprised of 20,046 basic hours/week and 13,191 overtime hours/week and gives an average hours worked by each Intern of 64.66 hours/week.

The sub committee recommends the provision of 800 Intern positions and that posts be EWTD compliant i.e. average 48 hours/week. For costing purposes the total Intern hours to be provided will therefore be 38,400 hours/week as set out in Table 6.2. This represents a net increase of 5,163 intern hours per week in the sector. However because posts are structured to be EWTD compliant there is a net increase of 11,154 basic Intern hours/week being provided, while the number of overtime hours is reduced by 5991 hours/week. Additionally the average hours/week worked falls by 16.6 hours – Table 6.3

Table 6.1 – Intern Average Working Hours 2006

The hours worked by the intern cohort, (514 posts) based on an average calculated over a 26 week period ending 31/12/2006 was as follows:

Average weekly basic hours	20,046 hours/week
Average weekly overtime hours	13,191 hours/week
Average weekly total hours	33,237 hours/week
Average weekly hours/post	64.66 hours/posts/week

Proposed Intern Provision

Table 6.2 – Average Working Hours – 800 Intern Posts, EWTD Compliant
Number of posts 800

Average weekly basic hours (800X39)	31,200 hours/week
Average weekly overtime hours (800 X 9)	7,200 hours/week
Average weekly total hours	38,400 hours/week
Average weekly hours/post	48 hours/posts/week

Proposed change in Intern Provision

Table 6.3 – Change in average hours per intern post
Number of posts +286 posts

Average weekly basic hours	+ 11,154 hours/week
Average weekly overtime hours	- 5,991 hours/week
Average weekly hours/post	-16.66 hours/posts/week

6.2 Costing

The Sub Committee is required to estimate the cost of providing the additional posts identified and restructuring the existing posts to the proposed 3 module format.

For the purpose of costing the intern posts hourly rates are calculated at current prices as follows: -

1. Basic cost/hour €16.62 + 10.75% PRSI = €18.40/hour
2. Overtime – average Time+½ = €27.60/hour

Tables 4, 5 and 6 below set out the estimated costs of the current annual intern provision and the estimate of proposed implementation of the recommendations of the subcommittee at current payroll prices on an annual basis.

Estimated Current cost of Intern Provision

Existing Intern basic and overtime payroll costs are estimated at €38.12m pa or approx €74k per post as set out in Table 6.4.

Table 6.4 – Current Cost of Intern Provision

	No. Hours	Cost/Hr €	Cost/pw €	Cost/yr €
Existing basic hours	20,046	18.40	368,846	19,179,992
Existing OT hours	13,191	27.60	364,320	18,944,640
Total	33,237		€733,166	€38,124,632

Average Cost/Post €74,172

Estimated cost of future Provision: 800 posts

The estimated payroll cost of future Intern provision – basic and overtime – is €40.18m or approx €50.2k per post – based on current prices as set out in Table 6.5

Table 6.5 – Estimated Cost of Future Intern Provision

	No. Hours	Cost/Hr €	Cost/pw €	Cost/yr €
Basic hours	31,200	18.40	574,080	29,852,160
OT hours	7,200	27.60	198,720	10,333,440
Total Hours	38,400		€772,800	€40,185,600

Average Cost/Post €50,232

This represents an overall increased payroll cost of €2.07m/pa. While this is a modest additional cost/post it is significantly framed by a major reduction in overtime hours/costs – approx €8.5m p.a. The additional cost to the sector of replacing this current service provision by interns is now discussed.

Adjustment for replacement of Service Hours lost due to reduction in overtime worked by Interns

In proposing the increase in the number of posts to 800 there is an increase in the number of basic hours of 11,154 per week reflecting the provision of selective placements in identified specialty departments to which Interns are not presently assigned and a reduction in overtime hours of 5,991 hours per week in departments where interns are currently assigned, reflecting the application of EWTD requirements to all posts.

As the decrease in overtime hours is in the existing core specialties to which interns are currently assigned and the increase in basic hours is outside these specialties there is a need to consider how the service deficit arising from the reduction in overtime hours will be addressed.

Interns undertake considerable duties in relation to ECG, Phlebotomy etc and routine administrative support duties as part of their daily work. While experience in these areas is essential, the requirement to undertake these duties on a frequent, repetitive basis is of little training value.

It is therefore recommended that these services should be provided by other members of the care team as appropriate and that this approach be followed as the basis for replacing hours/services lost as part of the development of the intern programme.

Table 6.3 identified that approx 6,000 Intern hours currently provided on an overtime basis through existing posts will not be provided in the proposed new programme. There is no framework to calculate the basis on which these hours be replaced. Accordingly we have estimated the costs of providing replacement services on a sliding basis, in a shift structure calculated at the mid point of other team member salary scales. This is set out in table 6.6 below.

Table 6.6 – Payroll Cost of Replacement of Intern Service Hours

Hours deficit	Cost/wk K	Cost P.A.
6,000 (100%)	€142,800	€7,425,000
4,500 (75%)	€107,100	€5,569,200
3,000 (50%)	€71,400	€3,712,800

Taking the above and applying a replacement factor of 75%, the increase in payroll cost to replace intern hours is estimated as

	€
Replacement payroll costs	5,569,200
Contingency 10%	763,016
	€6,332,216

Interns on Shift Roster

The shift roster provides the opportunity to 'allocate' available intern hours over an extended working day with a consequential reduction in overtime working across the entire intern cohort. The Sub-Committee therefore considered the cost of structuring the proposed intern programme on a shift basis.

On a shift roster all hours – 24 hour period – are priced at 'time + 1/6' giving a cost per hour at €21.45. The cost of a shift structure is set out in Table 6.7.

Table 6.7 – Payroll Cost for Interns on Shift Roster

Cost per hour	€21.45
Cost per post	@ €53,539
Cost per year	€43,531,360

This represents an estimated additional cost of €3,345,760 p.a. payroll cost above the existing rostering system.

Teaching and Management Costs

In its report the Medical Council identified the lack of structured input by Intern Tutors to the supervision and teaching of interns was a key deficit in the management of the intern programme. To this extent the Sub-Committee endorses the recommendation of the Medical Council that Intern Tutors have a dedicated session or number of sessions each week to allow them time to fulfil the role properly and should be resourced at a minimum rate of:

- two sessions for the first eight interns, designated in the practice plan of the tutors' contract.
- One extra session for each additional eight interns, designated in the practice plan of the tutors' contract.

Furthermore it is essential that the additional costs of co-ordination and administration of the proposed intern programme are identified and provided for. These include:

- NCHD Grant – each additional intern post approved will receive the NCHD Training Grant.
- Intern Co-ordinators – with the expansion of the intern programme it is necessary to appoint Intern Co-ordinators to each of the six Networks.
- Forum/PGTB administration – the implementation of the revised curriculum, assessment etc will place additional responsibilities on the Training Bodies and the Forum of Irish Postgraduate Medical Training Bodies. For the purposes of forecasting these are estimated at

  Training Bodies -
  Overall - 0.5 WTE Consultant Time/Week
  Forum - 1 Administrative WTE/Week

Service Administration:

The revised curriculum, additional posts, contracts etc. will generate significant additional administrative support costs. These were estimated at 10% of the additional payroll cost of implementation at approx €1.5m.

The estimated teaching and management costs are set out in Table 6.8 below.

Table 6.8 – Estimated Teaching and Management Costs

Category	**Cost/PA €**
Intern Tutors (100 sessions/pw)	2,392,200
NCHD Grant (286 posts)	1,144,000
Intern Co-ordinators x 6	375,600
Training Bodies	120,000
Forum Administration 1 WTE	60,000
Administration/Support	1,500,000
	5,591,800

Summary of Total Cost:

The total estimated cost of the proposed Intern provision on a standard roster, EWTD compliant is set out in Table 6.9 below.

Table 6.9 – Summary of Total Costs per annum

1.	Intern	€ 40,185.600
2.	Payroll Replacement	€ 6,332,216
3.	Teaching/Management	€ 5,591,800
		€ 52,109,616
4.	Average cost/post	€ 65,137
5.	Est. Additional cost	**€ 13,984,984**
6.	Est. Additional cost per post created	€ 48,898

This shows that the estimated cost at current prices of the Intern year for 800 posts is €52.1m, an increase of €13.9m. The average cost per post is estimated at €65k, against a current average cost per post of €74k.

Capital Investment

During the course of 2007, the Medical Education, Training and Research (METR) function of the HSE conducted an extensive audit of existing educational facilities on clinical sites. As part of this audit, the current and anticipated increase in numbers of medical trainees at both undergraduate and postgraduate level for each clinical site were identified, together with their scheduled education and training sessions and the models of teaching engaged for example large group versus small group versus self directed.

This audit study was undertaken in cooperation with the educational sector, with the Higher Education Authority (HEA) audit team focusing on the Health Sciences schools whilst the HSE team focused on clinical sites. The range of clinical sites audited included both hospital and community facilities. This exercise was commissioned by the Inter-Departmental MET Steering Group which has responsibility for overseeing the implementation of the changes recommended in the Fottrell and Buttimer medical education strategic reports.

The purpose of the HSE audit was to inform this Steering Group of the nature and extent of the capital investment programme needed in educational infrastructure on clinical sites to underpin the full implementation of the Fottrell and Buttimer Reports. The Inter-Departmental Steering Group has representation drawn from the Department of Education and Science, Department of Health and Children, Department of Finance, HEA and HSE.

The audit reports of both the HSE and HEA have now been submitted to and subsequently accepted by the Inter-Departmental Steering Group. The capital investment programmes identified as required for both the educational and health sectors are now forming the basis of a memorandum to Government. This is expected to be submitted by the Departments of Health & Children and Education & Science shortly.

The Committee recommends that capital investment identified is provided to meet the education training requirements of individual sites including the education and training requirements of interns. The Committee in particular highlights that the additional number of intern positions, together with the restructured teaching and management arrangements cannot be facilitated on clinical sites in the absence of the capital investment identified for education and training facilities.

36. Additional, ring-fenced, funding should be provided by Government to fund the costs identified.

37. Any new consultant posts should include defined and protected time for medical education and training, at undergraduate, intern and postgraduate levels.

7. Roles and Responsibilities of Stakeholders

The Sub-Committee identified the range of bodies involved in the governance, organisation and delivery of the intern year. These are briefly outline below.

In the early stages of its discussions and in line with the Sub-Committee's terms of reference, the Sub-Committee recognised that potential overlaps and areas of collaboration existed between the work of the Sub-Committee and that of the Medical Council's ongoing project on the Intern Year, which is being funded by the HSE. Representatives of the Sub-Committee and the Medical Council met to discuss the respective roles of the two pieces of work and areas of mutual interest and cooperation. The principal focus of the Medical Council's project is to address the Medical Council's responsibilities with respect to interns as provided for in the Medical Practitioners Act 2007.

The key stakeholders identified were as follows:

Department of Health & Children
Department of Finance
Department of Education & Science
Indepartmental Steering Group on Medical Education & Training
National Committee on Medical Education & Training
Medical Council
Health Service Executive
Medical Schools
Forum of Irish Postgraduate Medical Training Bodies & the individual training bodies
Postgraduate Medical & Dental Board
Higher Education Authority
Hospitals & primary care clinical settings
Medical students
Intern Tutors
Intern Coordinators
Trainers (consultants, senior NCHDs)
IMO
Governments of other countries from which students come to Ireland to study medicine

The key responsibilities and principal interdependencies of each are provided at Appendix J.

8 Implementation

The Sub-Committee suggests that its recommendations should be implemented on a **pilot basis.**

It is suggested that the pilot could allow different options to be introduced and assessed, such as the two options for the structure of the intern year as discussed in Chapter 2. It is suggested that the pilot could take place in two (possibly adjacent) intern networks, involving a single medical school and appropriate hospitals / community settings within each of the two regions.

In order to ensure that the recommendations of the Sub-Committee are implemented in time to meet the implications of the roll-out of the recommendations of the Fottrell Report, which will begin to take particular effect in terms of Medical School output from 2011 onwards, it is envisaged that the pilot should be in place for the 2009 intern intake, for a period of one year. A review of the pilot should then be undertaken and based on its success or otherwise, the reforms of the intern year may be rolled out either nationally or incrementally from 2011 onwards.

Prior to the commencement of the pilot, it will be necessary for each partner organisation involved to prepare a detailed implementation plan in relation to their roles. It is envisaged that these partner organisations would work together to discuss and finalise the details of the many recommendations that require an integrated approach. Work on the implementation of the recommendations should commence immediately to ensure that the 2009 target for the pilot is met.

It is envisaged that the National MET Committee will provide the framework for ongoing advice on the organisation, governance and delivery of the intern year. The implementation of the recommendations should be monitored and reviewed in the context of developments in policy, workforce planning and service planning.

38. The Sub-Committee suggests that its recommendations should be implemented on a pilot basis. The pilot should allow different options to be introduced and assessed.

39. While acknowledging the statutory role of the Medical Council and without detracting from this role, the Sub-Committee recommends that the Health Service Executive should take the lead in the initial convening of a working group to progress the implementation of the recommendations set out in this report.

Appendix A

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Career Tracking Study: Factors affecting career choices and retention of Irish medical graduates. Ms. Edel McEntee, Prof. Leslie Daly, Dr. Anna Clarke, Dr. Patricia Fitzpatrick Department of Public Health Medicine and Epidemiology, University College Dublin. July 2005. Published in conjunction with the Final Report of the Postgraduate Medical Education and Training Group

Legislation referred to in the report is available at www.oireachtas.ie.

Appendix B

Membership of the Sub-Committee on the Intern Year

Nominated members were requested from the following bodies, which were represented on the National Committee: Department of Health & Children, Medical Council, Postgraduate Medical and Dental Board, Higher Education Authority, the Deans of the Medical Schools, the Forum of postgraduate medical training bodies, the HSE and the IMO.

The following were members of the Intern Sub-Committee

- Dr. Éilis McGovern, (Chair), Postgraduate Medical and Dental Board
- Dr. Jane Buttimer, Department of Health and Children
- Prof. Anthony Cunningham, Medical Council
- Prof. Cathal Kelly, RCSI
- Prof. Gerry Loftus, NUI Galway
- Prof. T. Joseph McKenna, Forum - RCPI
- Mr. Tommie Martin, Health Service Executive
- Dr. Mick Molloy, IMO
- Prof. Bill Powderly, UCD
- Mr. Des Winter*, Forum - RCSI Postgraduate Training

The secretariat to the Sub-Committee was provided by the HSE, principally by John Magner, Ciara Mellett, Anne Pardy and Lesley Costello.

*Attended on behalf of Prof. Oscar Traynor.

Appendix C

Medical Practitioners Act 2007 – extracts from the Act relating to the Intern Year

Re. Medical Council

Section 7(4)
The Council shall, in performing its functions, have regard to
…
(c) the need to promote efficiencies in the delivery of specialist training and intern training through the development of standard practices.

Section 49
(1) The Council shall register in the Trainee Specialist Division a medical practitioner who has completed a course of study in the State or a Member State resulting in the award of a basic medical qualification and who intends to practise medicine in an individually numbered, identifiable intern post which has been approved by the Council for the purposes of intern training.

(2) Subject to *subsection (3)*, on and after the relevant day, where a medical practitioner has completed a period of internship to the satisfaction of the Council, the Council shall grant the practitioner a certificate of experience.

(3) The Council shall not grant under *subsection* 5 *(2)* a certificate of experience to a medical practitioner unless the Council is satisfied that the practitioner has, for the period or periods specified in rules made under *section 11* for the purposes of this subsection, been employed as a medical practitioner—

(*a*) in a hospital, health institution, clinic, general medical practice, or other health service setting, as is specified in rules made under *section 11* for the purposes of this subsection, and

(*b*) such hospital, health institution, clinic, general medical practice, or other health service setting, as the case may be, has been inspected and approved by the Council for acceptable intern training standards.

(4) Notwithstanding the repeal of the Act of 1978 by *section 3*, section 28 of the Act of 1978 shall, until the relevant day, and with all necessary modifications, apply to the grant of a certificate of experience under this Act as it applies to the grant of a certificate of experience under the Act of 1978.

(5) Where the Council gives the Minister a notice in writing stating the date on which the Council will be ready to grant certificates of experience, the Minister shall publish a notice in *Iris Oifigiúil* specifying that date as the date on which the Council shall commence to grant such certificates.

(6) In this section, "relevant day" means the date specified in the notice referred to in *subsection (5)* published in *Iris Oifigiúil* as the date on which the Council shall commence to grant certificates of experience.

Section 88(3)
The Council shall, in relation to medical education and training for interns—
(*a*) on foot of proposals received from the Health Service Executive under *section 86(3)(c)*, and in accordance with relevant criteria specified in rules made under *section 11*, specify the number of intern training posts it approves for the purposes of intern training,

(*b*) prepare and publish in the prescribed manner guidelines on medical education and raining for interns,

(c) advise the Health Service Executive in regard to the minimum entry criteria for posts approved under *paragraph (a)* in consultation with bodies approved under *section 89(3)(a)(ii)*[*],

(*d*) specify and publish in the prescribed manner the standards for training and experience required for the granting of a certificate of experience,

(*e*) inspect places with posts approved under *paragraph (a)* for the purposes of monitoring adherence to guidelines referred to in *paragraph (b)* and the standards referred to in *paragraph (d)*,

(*f*) following inspections under *paragraph (e)*, issue recommendations to the management of any place referred to in that paragraph on any improvements which may be required or any other issues arising from such inspections,

(*g*) following prior consultation with the Minister, the Health Service Executive and the management of any place referred to in *paragraph (e)*, and having regard to the views expressed in that consultation, remove approval from such place for the purposes of internship training where the Council considers that the guidelines referred 25 to in *paragraph (b)* or the standards referred to in *paragraph (d)* are no longer being adhered to in respect of that place,

(*h*) publish in the prescribed manner details of all inspections carried out under this subsection, and

(*i*) advise the Minister on any issues relating to its functions under this subsection.

Re. Health Service Executive

Section 86
(2) The Health Service Executive, in accordance with section 7(4)(*b*) of the Health Act 2004, shall, with respect to basic medical education and training, facilitate the education and training of students training to be registered medical practitioners.

(3) The Health Service Executive shall, with respect to specialist medical and dental education and training, have the following responsibilities:
…
(*c*) to assess on an annual basis the number of intern training posts and the number and type of specialist medical training posts required by the health service and, pursuant to that assessment, to put proposals to the Council in relation to the Council's functions under *section 88(3)(a)* and *(4)(a).*

[*]Section **89(3)** states: Subject to 87(3), the Council shall, in relation to each medical specialty recognised under *subsection (1)*, with the consent of the Minister and in accordance with the relevant criteria specified in rules made under *section 11*—
(*a*) approve, approve subject to conditions attached to the approval of, amend or remove conditions attached to the approval of, or withdraw the approval of—
(i) programmes of specialist training in relation to that medical specialty, and
(ii) the bodies which may grant evidence of the satisfactory completion of specialist training in relation to that medical specialty,
(*b*) refuse to approve a body as a body which may grant evidence of the satisfactory completion of specialist training in relation to that medical specialty.

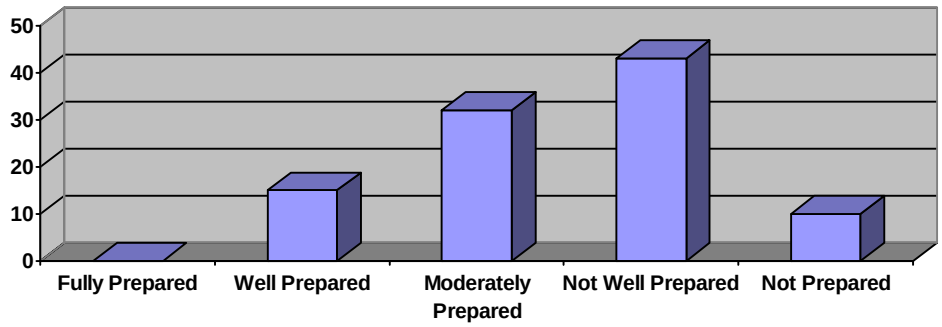
Appendix D

Survey of SHOs who had recently completed their intern year

The survey covered 5 hospitals, (1st year SHOs).

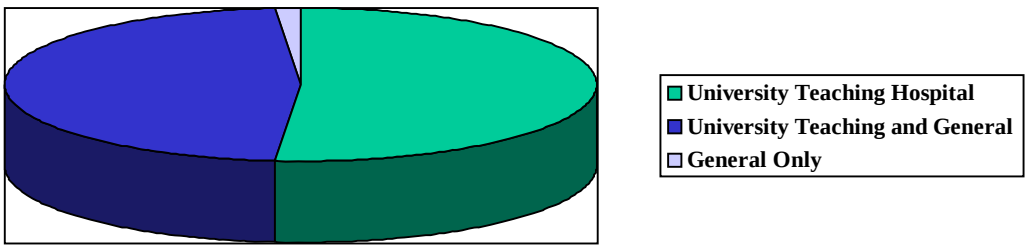
All medical schools, hospitals, and NCHD's are anonymous. 66 completed forms were analysed (Feb 08).

Q. 1 How prepared did you feel to start your Intern Post on 1st July, at the end of medical school:



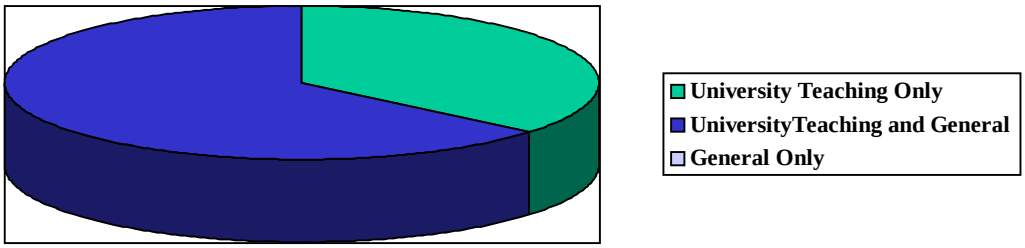
0% stated fully prepared, 15% well prepared, 32% moderately prepared, 43% not well prepared, and 10 % not prepared.

Q. 2 Where did you complete your Internship?



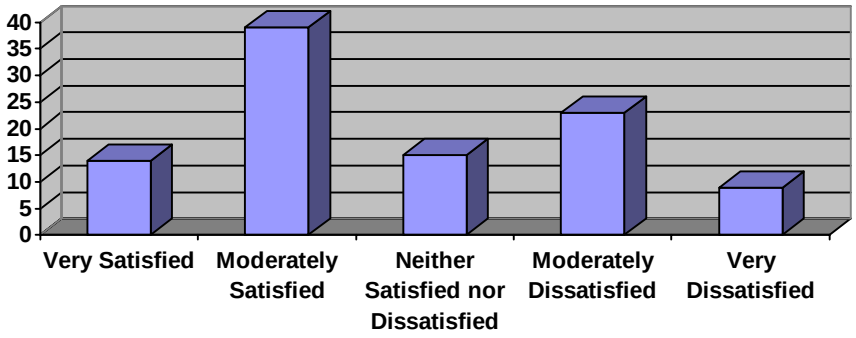
34 completed their internship in a University Teaching Hospital, 31 in both a University Teaching Hospital and a General, and 1 in a General Hospital only.

Q. 3 Would a rotating Internship (University Teaching Hospital and General Hospital) be preferable to a single site rotation?



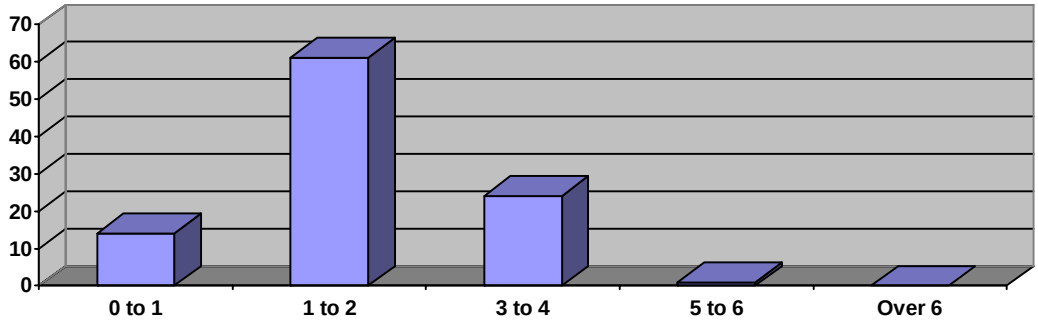
36% stated that their preference for an Intern rotation would by for a University Teaching Hospital only, 64% for a University Teaching and General Hospital rotation, and 0% for a General Hospital only.

Q. 4 Please indicate your level of satisfaction with the level of dedicated Intern Training available during your Intern Year:



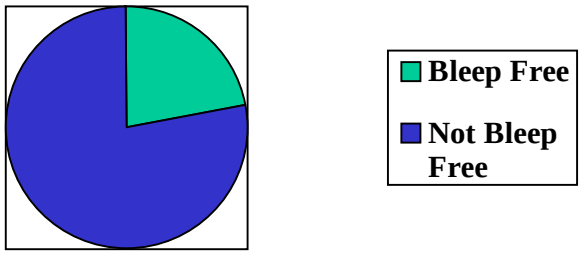
14% stated that they were very satisfied with the level of dedicated training, 39% moderately satisfied, 15% neither satisfied nor dissatisfied, 23% moderately dissatisfied and 9% very dissatisfied.

Q. 5 Please indicate the number of hours per week dedicated to Intern teaching and training:



14% stated that they received 0 – 1 hours dedicated Intern teaching and training weekly, 61% stated 1 – 2 hours, 24% stated 3 – 4 hours, 1% stated 5 – 6 hours, and 0% over 6 hours.

Q. 6 Please indicate whether the formal Intern Teaching sessions were understood to be bleep free:



22% of Intern teaching and training sessions were bleep free (bleeps answered by SHO), 77% of the sessions were not bleep free, 1% stated that they did not receive any formal Intern teaching.

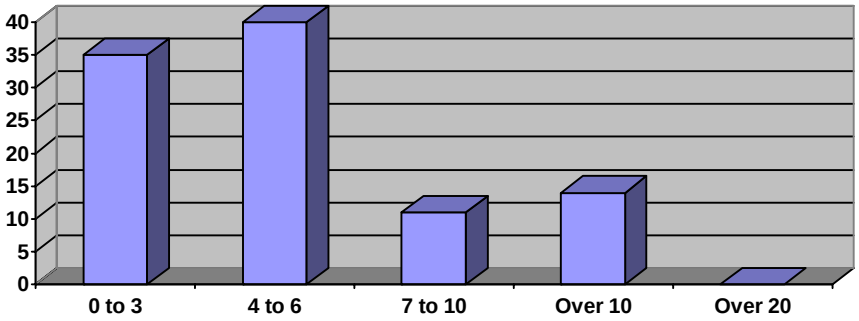
Q. 7 Was there a bleep policy in use in your hospital:

61% of the Interns stated that there was a bleep policy in place. 39% stated that there was no bleep policy.

Q. 8 If yes, was the bleep policy adhered to in the context of Intern Training?

2% stated always, 20% stated mostly, 34% stated mostly not, 44% stated never.

Q. 9 Please indicate the number of hours per week in education and training activity (including dedicated Intern Training, teaching rounds, journal clubs, assisting in theatre, and service sessions eg. ward rounds and out-patient clinics with teaching components etc)



35% stated that they received 0 – 3 hours per week training, 40% stated 4 – 6 hours, 11% stated 7 – 10 hours, 14% stated Over 10 hours, and 0% stated over 20 hours.

Q. 10 Tick if you have had the opportunity of direct education / training in the following areas, within your Intern Year:

Topic	% Interns who had received Direct training / education
Time Management	12%
Communication Skills	21%
Breaking Bad News	29%
Ethical Decision Making	16%
Record Keeping	21%
Career Guidance	40%
Feedback on Clinical Decisions made while on-call	16%
Consent	33%
Infection Control	63%
Hygiene	56%
Clinical Governance	11%
Audit	20%
Leadership	11%
Teamworking	15%
Management / Administration	5%
IT Skills	35%

Q. 11

80% of Interns stated that they had an Intern Tutor.

32% of those Interns stated that they had formal meetings with their Intern Tutor, (varying from weekly to 6 monthly).

24% of Interns stated that they had a Hospital Mentor, and 23% of those had meetings with their Mentor, varying1-2 in a 12 month period.

68% of Interns stated that they had completed a logbook.

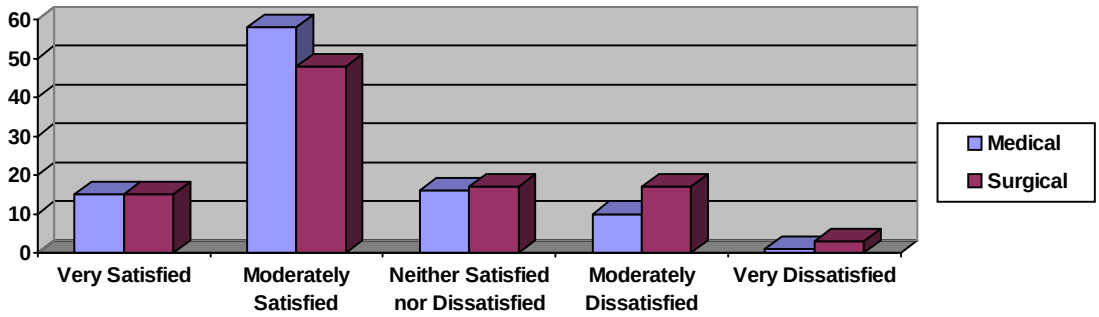
67% of Interns stated that they did receive direct Consultant feedback.

100% of Interns stated that they had access to Occupational Health.

71% of Interns stated that they had an Intern Representative.

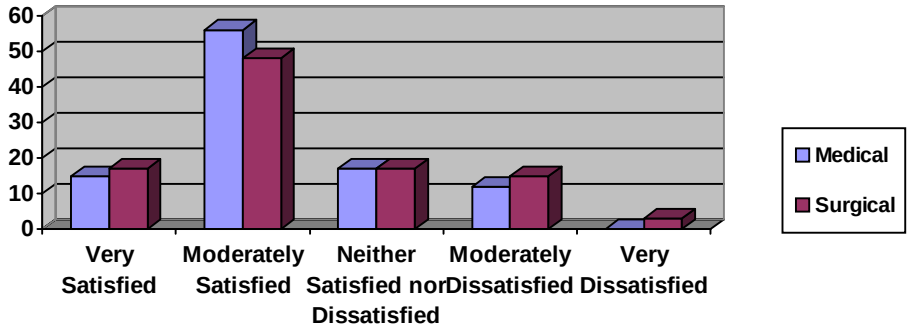
Q. 12 – Table with multiple questions relating to both *medical and surgical rotations*, using some of the core competencies described by the Medical Council.

Q. 13 Indicate your level of satisfaction with the level of personal responsibility while on-call.



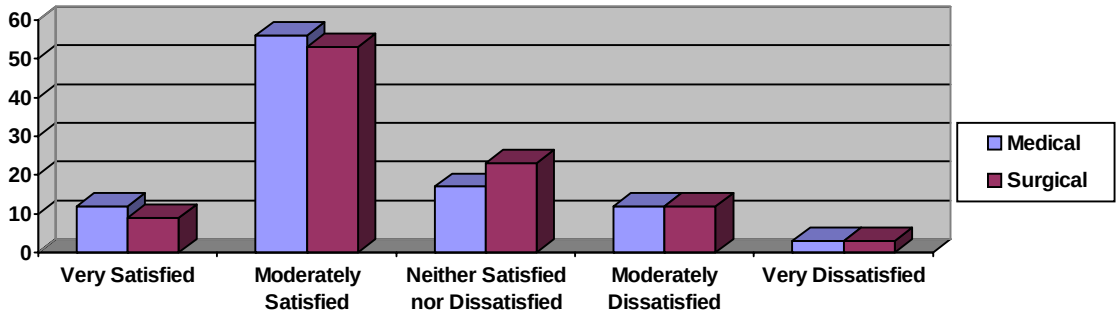
Medical – 15% Very satisfied, 58% moderately satisfied, 16% neither satisfied nor dissatisfied, 10% moderately dissatisfied, 1% very dissatisfied.
Surgical – 15% Very satisfied, 48% moderately satisfied, 17% neither satisfied nor dissatisfied, 17% moderately dissatisfied, 3% moderately dissatisfied.

Q. 14 Indicate your level of satisfaction with the level of decision making while on-call.



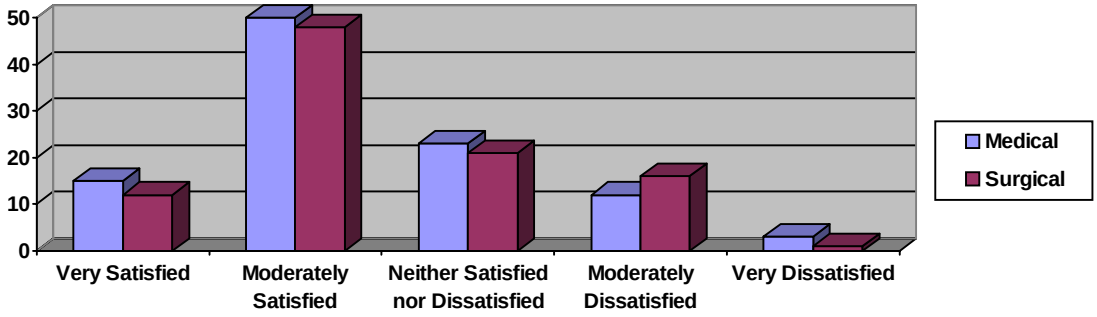
Medical – 15% Very satisfied, 56% moderately satisfied, 17% neither satisfied nor dissatisfied, 12% moderately dissatisfied.
Surgical – 17% Very satisfied, 48% moderately satisfied, 17% neither satisfied nor dissatisfied, 15% moderately dissatisfied, 3% very dissatisfied.

Q.15 Indicate your level of satisfaction in experience received related to assessment and diagnosis of patients.



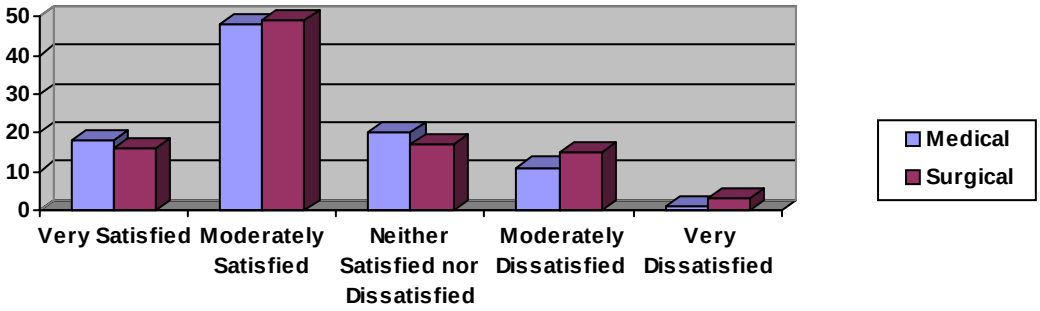
Medical – 12% Very satisfied, 56% moderately satisfied, 17% neither satisfied nor dissatisfied, 12% moderately dissatisfied, 3% very dissatisfied.
Surgical – 9% Very satisfied, 53% moderately satisfied, 23% neither satisfied nor dissatisfied, 12% moderately dissatisfied, 3% very dissatisfied.

Q. 16 Indicate your level of satisfaction in experience received related to patient management and ordering investigations.



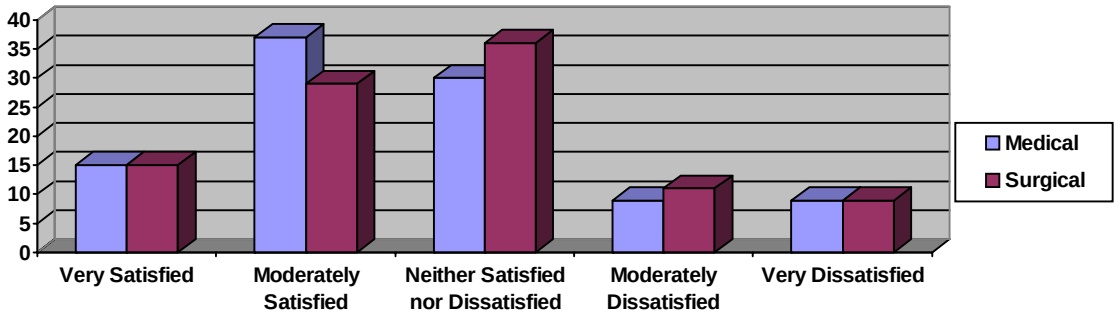
Medical – 15% Very satisfied, 50% moderately satisfied, 23% neither satisfied nor dissatisfied, 12% moderately dissatisfied, and 3% very dissatisfied.
Surgical – 12% Very satisfied, 48% moderately satisfied, 21% neither satisfied nor dissatisfied, 16% moderately dissatisfied, and 3% very dissatisfied.

Q. 17 Indicate your level of satisfaction in experience received related to prescribing.



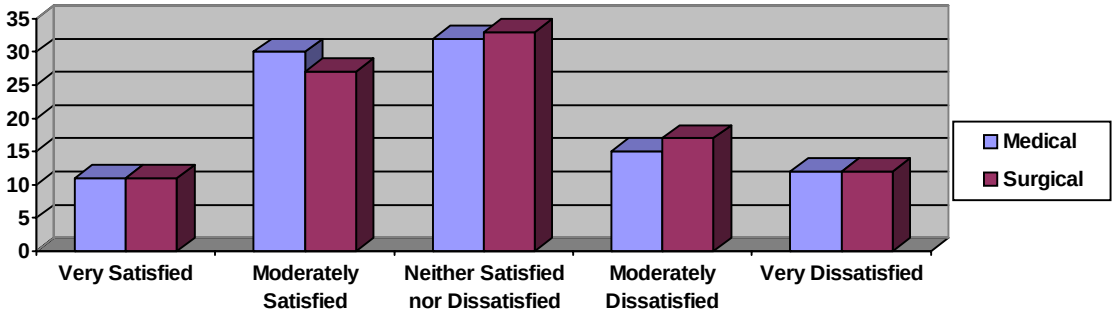
Medical – 18% Very satisfied, 48% moderately satisfied, 20% neither satisfied nor dissatisfied, 11% moderately dissatisfied, and 3% very dissatisfied.
Surgical – 16% Very satisfied, 49% moderately satisfied, 17% neither satisfied nor dissatisfied, 15% moderately dissatisfied, and 3% very dissatisfied.

Q. 18 Indicate your level of satisfaction in non-clinical experience received related to dealing with patients and families.



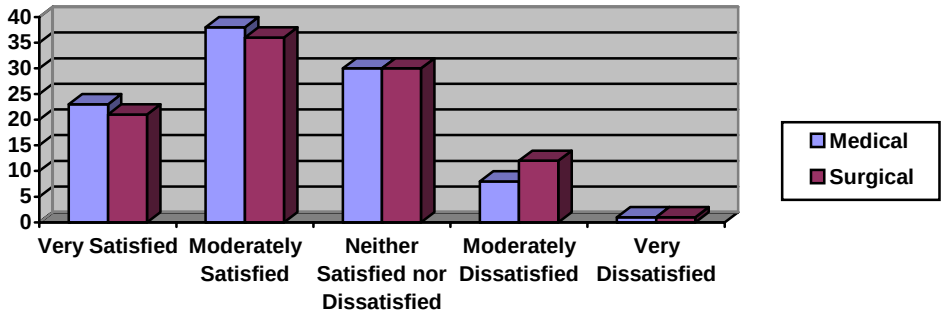
Medical – 15% Very satisfied, 37% moderately satisfied, 30% neither satisfied nor dissatisfied, 9% moderately dissatisfied, and 9% very dissatisfied.
Surgical – 15% Very satisfied, 29% moderately satisfied, 36% neither satisfied nor dissatisfied, 11% moderately dissatisfied, and 9% very dissatisfied.

Q. 19 Indicate your level of satisfaction in non-clinical experience received related to dealing with breaking bad news.



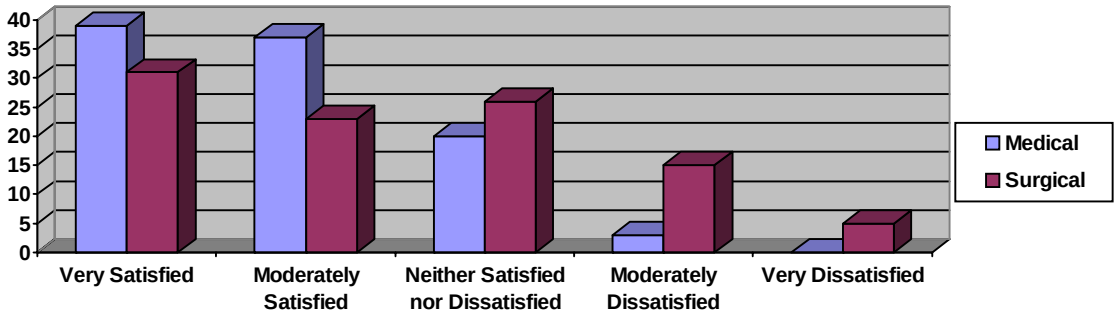
Medical – 11% Very satisfied, 30% moderately satisfied, 32% neither satisfied nor dissatisfied, 15% moderately dissatisfied, and 12% very dissatisfied.
Surgical – 11% Very satisfied, 27% moderately satisfied, 33% neither satisfied nor dissatisfied, 17% moderately dissatisfied, and 12% very dissatisfied.

Q. 20 Indicate your level of satisfaction in non-clinical experience received related to patient dignity and compassion.



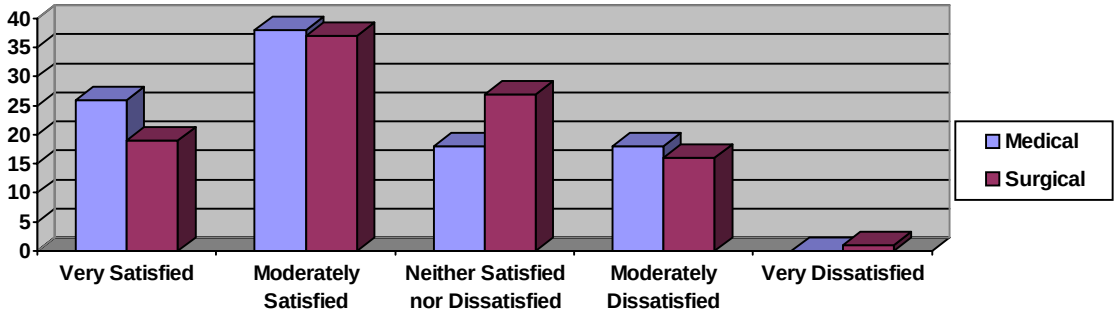
Medical – 23% Very satisfied, 38% moderately satisfied, 30% neither satisfied nor dissatisfied, 8% moderately dissatisfied, 1% very dissatisfied.
Surgical – 21% Very satisfied, 36% moderately satisfied, 30% neither satisfied nor dissatisfied, 12% moderately dissatisfied, 1% very dissatisfied.

Q. 21 Indicate your level of satisfaction in support received from colleagues during on-call periods in a University Teaching Hospital.



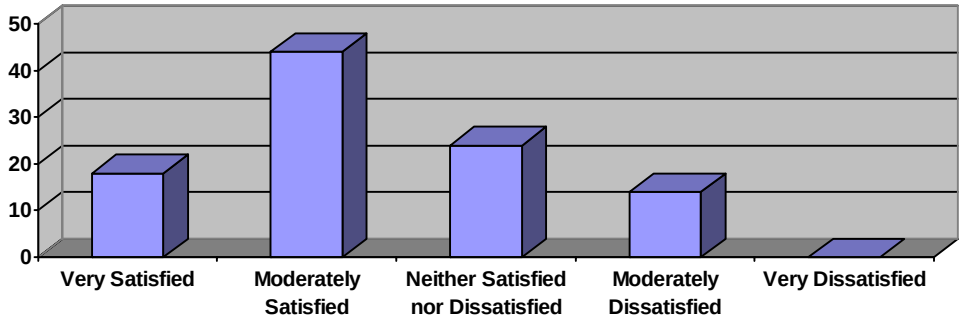
Medical – 37% Very satisfied, 40% moderately satisfied, 20% neither satisfied nor dissatisfied, 3% moderately dissatisfied.
Surgical – 31% Very satisfied, 23% moderately satisfied, 26% neither satisfied nor dissatisfied, 15% moderately dissatisfied, and 5% very dissatisfied.

Q. 22 Indicate your level of satisfaction in support received from colleagues during on-call periods in a General Hospital.



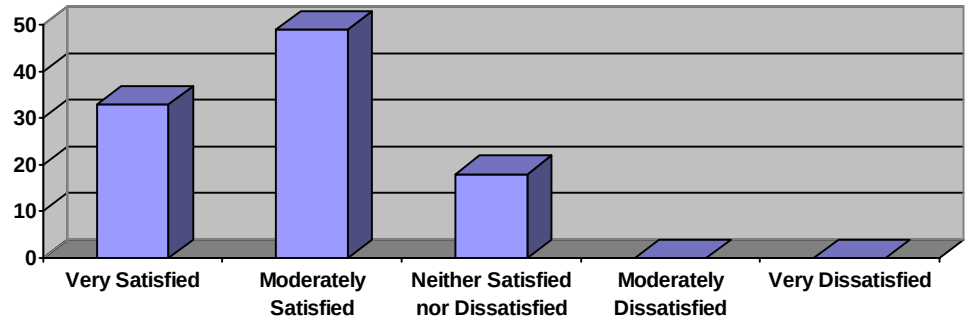
Medical – 26% Very satisfied, 38% moderately satisfied, 18% neither satisfied nor dissatisfied, 18% moderately dissatisfied.
Surgical – 19% Very satisfied, 37% moderately satisfied, 27% neither satisfied nor dissatisfied, 16% moderately dissatisfied, 1% very dissatisfied.

Q. 23 Indicate your level of satisfaction in experience related to communication with families, during your <u>entire</u> intern year.



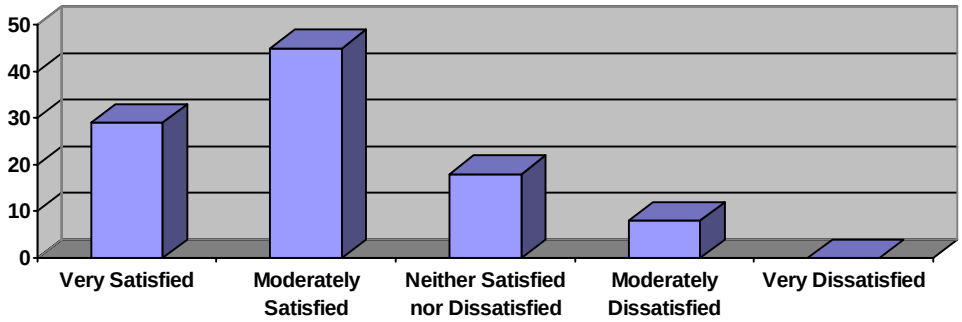
18% stated very satisfied, 44% stated moderately satisfied, 24% neither satisfied nor dissatisfied, and 14% moderately dissatisfied.

Q. 24 Indicate your level of satisfaction in experience related to communication with patients during your entire intern year.



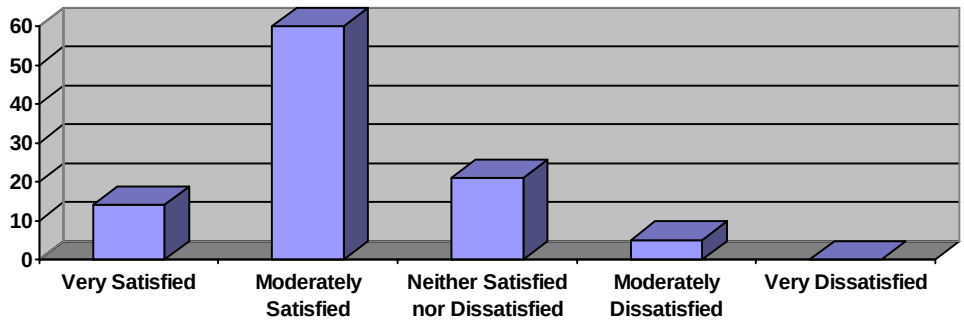
33% stated very satisfied, 49% stated moderately satisfied, 18% neither satisfied nor dissatisfied.

Q. 25 Indicate your level of satisfaction in experience related to record keeping, during your entire intern year.



29% stated very satisfied, 45% stated moderately satisfied, 18% neither satisfied nor dissatisfied, and 8% moderately dissatisfied.

Q. 26 Indicate your level of overall satisfaction with the experience gained in the entire Intern Year.

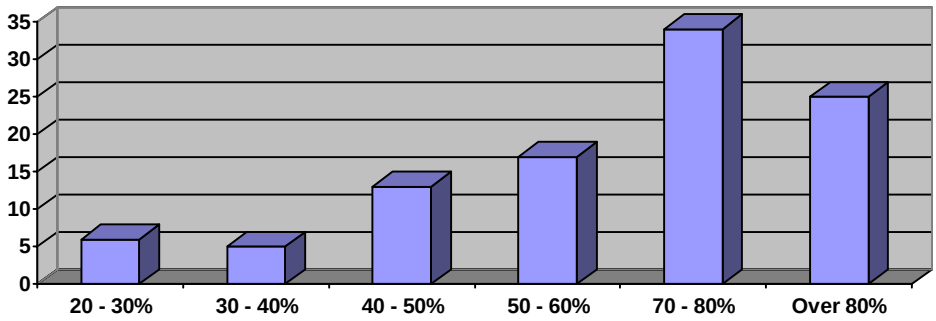


14% stated very satisfied, 60% stated moderately satisfied, 21% neither satisfied nor dissatisfied,
5% moderately dissatisfied.

Q. 27 Indicate how many of the procedures/clinical sessions listed below, you undertook during your Intern year. (Numbers of Interns surveyed who had completed/attended the procedures/clinical sessions indicated in **Red**).

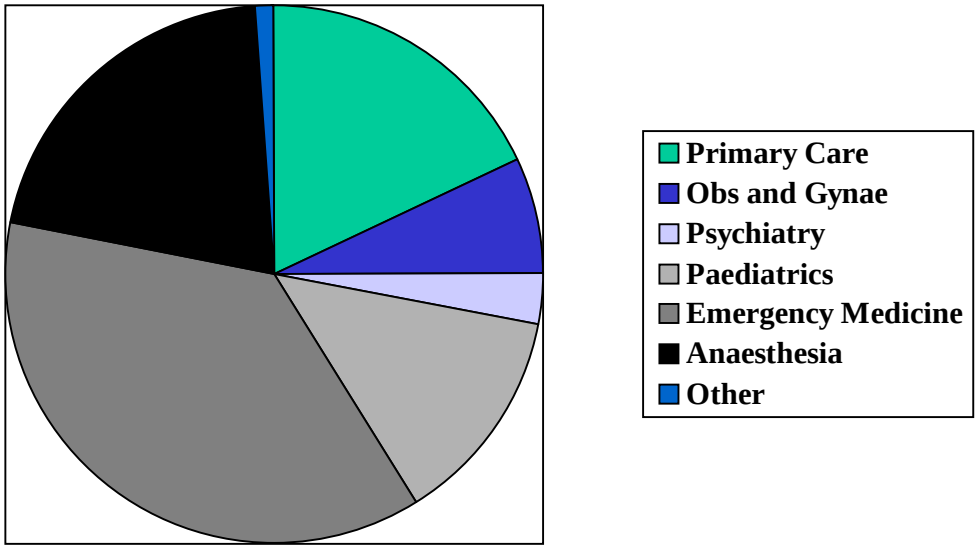
Procedures	None	1 – 5	6 – 20	Over 20
Venesection	**6**	**5**	**1**	**54**
Arterial Blood Gas			**4**	**62**
NG Tube	**3**	**1**	**22**	**40**
Cannulation			**2**	**64**
Urinary Catheter			**15**	**51**
Suturing	**33**	**26**	**4**	**3**
Central Line	**55**	**9**		
Chest aspiration/tap	**36**	**27**	**1**	**2**
LP	**40**	**18**	**6**	**2**
Plaster of Paris	**59**	**5**		**2**
Dressings	**38**	**13**	**6**	**9**
Consent				**66**
Breaking bad news	**4**	**25**	**21**	**165**
Certify Death	**5**	**8**	**32**	**21**
Prescribe controlled drugs		**10**	**21**	**35**
Assist in theatre	**6**	**34**	**16**	**10**
Outpatient clinics	**6**	**4**	**15**	**41**
Day Case procedures	**29**	**8**	**13**	**16**
ECG's	**2**	**1**		**63**
X-Ray Conferences	**2**	**1**	**8**	**55**
Multidisciplinary Meetings	**6**		**15**	**45**

Q. 28 Please indicate the percentage of the working week that in your opinion was directly service related:



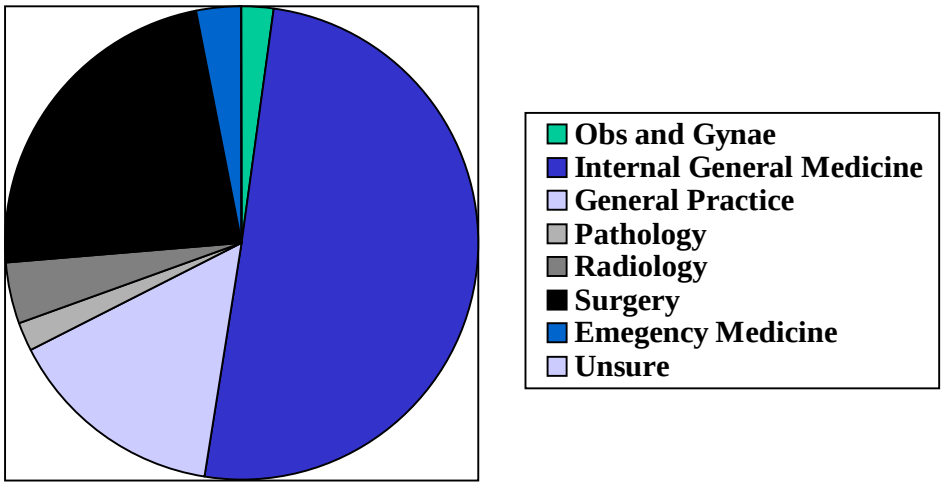
6% of Interns stated that they thought 20-30% of the working week was service related, 5% stated 30-40%, 13% stated 40-50%, 17% stated 50-60%, 34% stated 70-80% and 25% stated over 80%.

Q. 29 Current discussions are on-going regarding the structure of the Intern Year. If additional modules had been available to allow for practical experience in additional specialties, please tick those you would have selected:



18% of interns indicated that they may have selected primary care as an additional module during the Intern Year, 7% stated Obs and Gynae, 3% stated Psychiatry, 13% stated Paediatrics, 37% stated Emergency Medicine, 21% stated Anaesthesia and 1% stated Other (Histopathology).

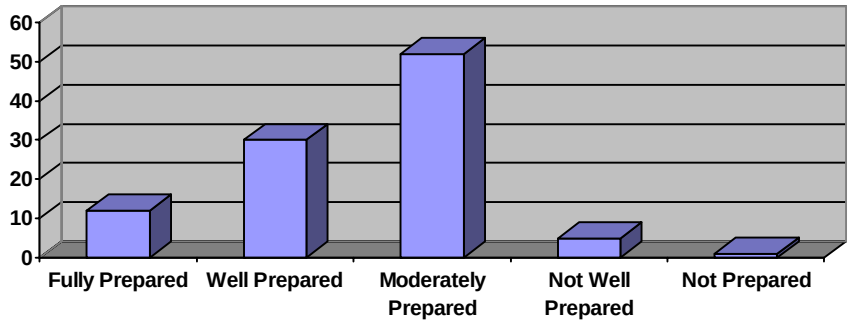
Q. 30 What is your intended career path:



2% of Interns intend to pursue a career in Obs and Gynae, 48% in Internal General Medicine, 14% in General Practice, 2% in Pathology, 5% in Radiology and 22% in Surgery, 3% Emergency Medicine 4% were unsure.

No Intern stated that they intended to pursue a career in Anaesthesia, Ophthalmology, Psychiatry, Sports and Exercise Medicine, Paediatrics, Public Health Medicine, or Occupational Health Medicine. (Ref: Medical Council list of specialties).

Q. 31 After completing your Intern Year, did you feel prepared and experienced enough to proceed to SHO training:



12% of Interns stated that they were fully prepared to proceed to Sho training after completion of the Intern Year, 30% stated that they were well prepared, 52% stated moderately prepared, 5% stated not well prepared and 1% not prepared.

There were very few comments written in the free text allowed on the survey. However several interns stated that they would like to see a full working week shadowing Interns, during the last week of June, to prepare them for 1st July.

Appendix E

Worked example of a modular intern post

Interns rotate through **3 clinical terms** each term being 10 -11 weeks in duration. 2 of the 3 clinical terms are designated compulsory in the disciplines of general medicine and surgery complemented by one optional rotation and one block of taught training

General medicine	General Surgery	Rotational Choice	Dedicated training	Nights	Holidays
11 weeks	11 weeks	10 weeks	8 weeks	6 weeks	6 weeks

Rotation choices in addition to general medicine and surgery:

Medicine	**Cardiology, Geriatrics, Neurology, Respiratory Infectious Diseases Dermatology.**
Surgery	**Upper GI, Colorectal, Vascular, Urology, Orthopaedics,**
General	**Gynaecology. Psychiatry, General Practice, Emergency Medicine**

Details the rotational options for intern training.

Leave consists of 6 weeks holidays. Authorized absence may be requested for reasonable educational purposes and is granted at the discretion of the Site Directors.

Proposed Intern training model based on 48hr working week

	T	SURG	NTH	SURG	NTH	MED	NTH	MED	NTH	ROT	NTH	ROT	NTH
Wks in Block	2	5	3	6	3	5	3	6	3	5	3	5	3

Shows the proposed rotations for the training model.

Nights, Training, Holidays,
NTH is either a week of night, holidays or training. Surg Surgery, Med Medicine, Rot Rotation,

Beaumont Hospital Worked Example

A model of intern placement based on the Beaumont hospital service model was generated by allocating one intern per specialty including the specialties that do not currently have an intern training place. This model allows the individual interns to rotate through the yearly programme including six one week night blocks, 8 one week dedicated training blocks, an optional specialty block of 10 weeks in addition to the traditional medicine and surgery blocks which will now be 11 week each. This model maintains the intern cover at one for each of the specialties while the candidates rotate.

Current Intern Number in Beaumont hospital			
	Specialty	**Number of interns Currently**	**Number of proposed interns**
	Breast/Endo	2	1
	General	5	1
	Gastroentrology	2	1
	General/Vascular	3	1
	Vascular	2	1
	Colorectal	2	1
	Neurosurgery	4	1
	Orthopaedics	4	1
	Urology	4	1
	ENT	2	1
	Plastic	1	1
	Maxillofacial	1	1
	Emergency		1
	Anaesthetics		1
	Radiology		1
	Palliative Care		1
Surgery		32	16
	Respiratory	5	1
	Gastroentrology	5	1
	Endocrinology	4	1
	Rheumatology	2	1
	Cardiology	4	1
	Geriatric Med	2	1
	Nephrology	4	1
	Infectious Disease	1	1
	Oncology	2	1
	Gynaecology	1	1
	Neurology		1
	Neuropathology		1
	Dermatology		1
	Paediatrics		1
	Psychiatry		1
	Histopathology		1
	Opthamology		1
	Immunology		1
	Microbiology		1
	Haematology		1
Medicine		30	20
Total		62	36

Shows the distribution of the current 62 intern places in Beaumont Hospital. 32 surgery, 30 medicine. White boxes indication a service with no intern cover currently.

The model below model was generated by allowing one intern per specialty including the specialties that do not currently have an intern training place.
This model allows the individual interns rotate through the programme whilst maintaining the intern cover at one for each of the specialties.

	Nights	Surgery	Medicine	Optional Rotation	Training Block	Holidays	Total
Present	**6**	**23**	**21**	**0**	**0**	**7**	**62**
EUWTD Current numbers	**42**	**7**	**6**	**0**	**0**	**7**	**62**
EUWTD Current service model	**42**	**40**	**37**	**0**	**0**	**13**	**132**
Proposed Training model	**12**	**16**	**20**	**14**	**20**	**12**	**94**

Table Shows

- The current intern numbers assigned in Beaumont Hospital,
- The interns assigned under EUWTD keeping the current number of posts.
- The numbers assigned under EUWTD at the current service model
- The proposed new intern training model with each service team appointed one intern. Nights are covered by 2 x 8hr shifts with 3 interns for medicine and 3 interns for surgery.

Assumptions
Interns currently work 75hrs per week
This will be reduced to 48 hrs per week
To cover one 24hr/7day week service requires 7 full time equivalent jobs
6 week holidays

Appendix F

Core competencies proposed by the Medical Council

Suggested Core Competencies for Intern Year

1. History taking, examination and record keeping

- Demonstrate clear history taking and communication with patient, incorporating appropriate clinical, sociological culture factors.
- Conduct an examination of the patient in a structured purposeful manner respecting patient's autonomy

2. Diagnosis using sound clinical judgement and decision making and establishing a differential diagnosis.

- Establishes a principle or working diagnosis on the basis of initial examination.
- Constructs a management plan including investigations, treatments, consultation.

3. Understands and applies principles of therapeutics and safe prescribing.

- Takes an accurate drug history including self medication and inquiry about drug allergies.
- Prescribes drugs (including oxygen, fluids and blood products) appropriately.
- Seeks evidence about appropriateness and effectiveness of therapies in prescribing decisions.
- Demonstrates awareness of potential for drug interaction
- Collaborates with pharmacy to ensure accurate error for prescribing.
- Understands guidelines for use of blood and blood products.
- Understands and applies the principles of therapeutics in the management of acute pain and palliative medicine.

4. **Principles of medical data and information management – contemporary, accurate, legible signed and attributable notes.**

- Records accurate logical and comprehensive patient history, examination, investigations and differential diagnosis.
- Records patient progress including diagnosis and management pathway.
- Records information given to patients, details of discussion and patients views on investigations of therapeutic intervention.
- Structures letters clearly to communicate findings and outcomes for patient consultation
- Satisfactory consultation letters and discharge summaries
- Understands the medico legal importance of good record keeping

5. Understand and follows principles of infection control

- Appropriate personal behaviour and practice
- Consider the risk of infection before undertaking procedures.
- Meticulous in following aseptic techniques
- Appropriate use of personal and protective equipment.
- Meticulous in following guidelines for disposal of "sharps" and potentially infective material.
- Understands appropriate microbiological specimen taking.
- Knows and follows institution protocols for antibiotic prescribing.

- Ensure personal immunisations are up to date.

6. Understands and applies the principle of medical ethics and relevant legal consideration.

- Demonstrates basic knowledge of the main principle of medical ethics including autonomy, natural justice and confidentiality.

7. Understanding of practice and appropriate procedures for valid consent

- Gives patient appropriate information in a manner he/she can understand to obtain valid consent.
- Refers consent request to relevant senior colleagues when appropriate.
- Checks patient understands the relevant information.

8. Understands the legal framework for medical practice in Ireland and applies this to everyday management

- Is aware of risk of legal and disciplinary action if doctor fails to achieve necessary standards of practice and care.
- Understand the principle of confidentiality.
- Understands and applies the Medical Council's Code of Ethical Conduct and
- Behaviour.
- Understand and applies the principles of Child Protection procedures.
- Is aware of the principles of the Data Protection Act 1997.
- Understand sick notes and death certificates.
- Understands the doctor's role in cremation procedure.
- Understand the role of medical practitioners in the Coroner Court and criminal/civil legal proceedings.
- Understands requirements involved in obtaining consent for autopsies and human organ retention.
- Understands the implication of do not resuscitate (DNAR) orders and advance directives.

9 Practical Skills

At the end of the intern year, the intern must demonstrate confidence and competence in

- Venepuncture and IV cannulation
- Use of local anaesthetics
- Arterial puncture in an adult
- Blood cultures from peripheral and central lines
- Injections - subcutaneous intradermal, intramuscular and intravenous cannula.
- Prepare and administer IV medication
- Intravenous infusions including prescription of fluids, bloods and blood products.
- Perform and interpret an ECG
- Perform and interpret pulmonary function peak flow and spirometry
- Ureteral catheterisation
- Airway management including adjuncts, intubation and ventilatory support
- Nasogastric tube insertion

Individual specialties may specify a range of procedures relevant to that specialty at which the intern will be expected to come proficient.

- Aspiration of pleural fluid or air
- Skin suturing
- Lumbar puncture
- Insertion of central venous pressure lines
- Aspiration of joint effusion.

10. Management of Acutely Ill Patients

The intern must demonstrate knowledge and skills to assess and initiate management of patients presenting as acute medical emergencies.

It is recognised the application of skills and knowledge would vary according to site at which is provided.

General Practice will offer an opportunity to provide care for acutely ill patients in a very different setting from hospital practice.

Scenario- based assessment competence and skills to recognise critically ill and

- Immediately assess and resuscitate if necessary
- Formulate a differential diagnosis and refer appropriate
- Select relevant investigation and accurately interpret results/reports.
- Communicate the diagnosis and prognosis
- Assess and reassess as appropriate while identifying the effects of chronic disease / co morbidity in management of acute illness.

11. Understanding of principles of teamwork, leadership, professional communication skills and clinical governance.

Appendix G

Distribution of Intern positions 2007

Location	No. of Interns	Beds	Ratio
Mater Hospital	42	570	13.57
St. Mary's Phoenix Park	1	327	327.00
Sligo General	9	323	35.89
St. John's Limerick	4	104	26.00
Limerick Regional	21	400	19.05
Louth County	3	137	45.67
Portiuncula	9	211	23.44
Letterkenny General	11	365	33.18
Mullingar	3	203	67.67
Our Lady's Cashel	2	77	38.50
Our Lady of Lourdes Drogheda	20	339	16.95
St. Vincent's	33	500	15.15
Loughlinstown	7	150	21.43
St. Michael's Dun Laoghaire	3	124	41.33
Portlaoise	2	202	101.00
Wexford General Hospital	3	220	73.33
Beaumont	65	723	11.12
Connolly	18	379	21.06
Waterford Regional	12	600	50.00
St. Luke's Kilkenny	7	317	45.29
Bantry General Hospital	3	110	36.67
Bon Secours	6	344	57.33
Cork University Hospital/Mallow	4	81	20.25
Cork University Hospital	34	610	17.94
Mercy University	18	355	19.72
South Infirmary/Victoria	15	258	17.20
Kerry General	6	377	62.83
Galway University Hospitals UCHG & MPH	46	647 + 327	21.17
Mayo General	9	317	35.22
Ennis	1	88	88.00
Tullamore	3	227	75.67
Roscommon	2	127	63.50
AMNCH	37	447	12.08
St. James's Hospital	45	840	18.67
Naas	1	279	279.00
Total	**505**	**11378**	**22.53**

Appendix H

Average Intern Hours Worked (26 weeks)

Hospital	**General Medicine** and related specialties	**General Surgery** and related specialties
St. Luke's Hospital, Kilkenny	64	60
MWR Limerick	66.6	70.3
Naas Gen. Hospital		45.04
Portiuncla	55.33	61.79
St. James Hospital	73.25	74.07
AMNCH	63.8	71
Roscommon		57.1
MRH Tullamore	53.02	57.01
Kerry General Hospital	53	60
Ennis General Hospital		59.2
Letterkenny Hospital	52.64	64.19
Sligo General Hospital	56.7	68.5
Mayo General Hospital	63.44	68.07
Galway University Hospitals	60.67	65.3
South Infirmary	63.31	64.47
Mercy Uni. Hospital	56.88	55.98
Mallow General Hospital	73	73
Cork University Hospital	62.76	72.6
Bon Secours	56	55
Bantry General Hospital	68.5	68.5
OLLH Drogheda	62.5	64
Waterford Regional Hospital	66.6	81.5
Connolly Hospital	64	70
Beaumont Hospital	64.5	72.66
Wexford General Hospital		70.3
MRH Mullingar		46
MRH Portlaoise		63
St. Michaels Hospital		73.68
St. Colmcille's Hospital	66.5	85
St. Vincent’s University Hospital	66.12	77.81
South Tipperary Hospitals	54.6	68.6
Louth County Hospital, Dundalk	70	
St. John's Limerick	55	55
St. Marys Phoenix Park	39	
Mater Hospital	64.23	69.62

Appendix I

RCPI SHO matching scheme

This system is based on the successful Royal College of Physicians (RCPI) Medical SHO matching process. The flow diagram below outlines the steps. The applications process is centralised and run on-line. The hospitals can determine the number of intern places and the number of candidates to short list for these places. The system then matches the candidate with their chosen rotations based on a score received from the interview. The importance of a partnership model between the education and health sectors for training provision is paramount to create the optimum educational environment for trainee doctors within teaching hospitals.

Application Process

Data Set-up

Application information and short listing dates go on-line

Rotation set-up

Hospital administrators enter the available rotations

Applications Phase

Applications are available to candidates on line

Verification of Applications

Applications close

Applications are verified and acknowledged to candidates

Preference Forms

- Preference forms are now made available to candidates for on-line completion
- All rotations available in the regions that the candidate has applied for are listed and must be ranked by preference
- Preference forms stay open and available up until the first round of matching

Short-Listing

- Hospitals view the online applications for short-listing
- A nominated consultant in the hospital reviews and marks all the applications
- The hospital administrators add their hospital's short-listing scores to the website

A list of short-listed candidates per region is automatically calculated based on agreed cur-off point for the region (i.e. if the region will accept 40 short-listed candidates for interview, the system lists the candidates with the 40 top scores)

Confirm Short-listing

- The regional administrator confirms the shortlist list
- An e-mail is automatically generated from the system to candidates informing them if they have been short-listed.

Interview Process

Interview Set-Up

- The interview schedule goes on the website
- The system generates a timetable based on the number of candidates and the interview duration
- The system allows for multiple interview panels
- E-mails sent to candidates informing them of their interview time

Interviews

Interviews are conducted by each region

Interview marks

- Hospital administrators enter each candidate's interview marks by a predetermined date
- The system automatically ranks candidates
- Each hospital receives a ranked list of candidates

Candidate preference forms

Candidates are no longer able to manipulate their preference forms

Match Day

- The matches are run
- 1st round offers are issued to candidates
- A list of candidates matched to their hospital is provided to hospital administrators
- Candidates are given a deadline to accept of decline the offer

2nd Round Match

Based on who has and has not accepted the first round offer the match is run again. An automatic e0mail is issued to candidates who are offered a position and to hospital administrators informing them of the outcome.

Conclusion of the Match

After the deadline for the second round offers hospitals must themselves fill any vacancies that are left

Appendix J

Responsibilities & interdependencies of stakeholders

Work Plan (Part 6) - Clarification of the roles and responsibilites of stakeholders

Stakeholder	Key responsibilities	Key interdependencies
HSE	▪ statutory role for medical education & training ▪ contract of employment ▪ placements ▪ Number of posts ▪ Workforce planning ▪ Compliance with EU legislation (Access, EWTD etc.)	▪ DoHC, DoF ▪ Medical Council ▪ Medical Schools ▪ Postgrad training bodies
Hospitals / Primary Care placements including voluntaries	▪ on the job training ▪ Intern Tutors ▪ trainers (consultants, GP Trainers, SpRs, Registrars etc.)	▪ HSE ▪ Medical Council ▪ Medical Schools ► Postgrad. training bodies
University Medical Schools	▪ Preparation for intern year (curriculum) ▪ Current sign-off from Deans ▪ Intern Coordinators ▪ Matching Schemes	▪ Medical Council ▪ Postgrad training bodies re. transfer of intern year to postgrad. ▪ HSE
Postgraduate Training Bodies	▪ move of intern year to first year of postgraduate training ▪ Specialty curricular development ▪ potential role in supervision and supervision of intern training, subject to Medical Council decision on devolution ▪ Mentoring & career advice	▪ Medical Council, Medical Schools ▪ PgMDB

Medical Council	▪ minimum entry criteria ▪ inspection, registration & certification ▪ recognition of year as postgrad - timeframe? ▪ International standards ▪ numbers approved ▪ core curriculum ▪ structure & framework re. governance ▪ Intern handbook / logbook ▪ Guidelines on intern medical education and training ▪ Certification of successful completion of intern training	▪ HSE ▪ postgraduate training bodies ▪ HSE ▪ link with Forum re. development of common electronic logbook
Postgraduate Medical & Dental Board	▪ Career advice ▪ increased role in context of intern year being first year of postgrad ►HSE?	
Department of Health & Children	▪ Contracts e.g. protected time ▪ Government policy ▪ monitoring, funding / performance ▪ Approval of WTEs ▪ Compliance with EU legislation (access, EWTD etc.)	▪ HSE Workforce planning
Department of Finance	▪ Employment ceiling, funding.	▪ HSE
Students	(Issues re. access for EU & non-EU interns)	▪ HSE re. placements ▪ Medical Schools re. intake policy
Trainers (consultants, GP trainers senior NCHDs)	▪ training, supervision, structure	▪ hospital management ▪ Intern Coordinators & Tutors
Indepartmental Steering Group	(DoHC, DoES, HSE & HEA) ▪ monitoring / steering role re. work of National MET Committee	
National MET Committee	▪ Oversee and contribute to implementation of Buttimer & Fottrell	▪ Interdepartmental Steering Group ▪ Representative bodies
Department of Education & Science	▪ Common national assessment	▪ Medical Schools, Medical Council
HEA	▪ Common national assessment	▪ Medical Schools, Medical Council
IMO	▪ representation / facilitation of discussion of issues	▪ HSE, Medical Schools ► Postgrad bodies
Governments of Other Countries	▪ funding / payment to non-EU interns in Ireland	