



# **Intern Coordinator and Tutor Network Project Report**

## **A Review of the Intern Year**

**Prepared for**

*The Department of Health and Children  
MET Group*

**By**

*The Medical Council*

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## Executive Summary

The overall aim of the intern year is to provide an educationally sound experience for the new doctor in terms of skills, experience, attitudes and personal development. The objectives of the year, according to the Medical Council's *'Intern Handbook: Information and Logbook for Interns'* include *an appropriate educational programme, to experience supervised service commitment, a good balance of education and service and to ensure that the content of each post is monitored and evaluated so that new doctors receive the best education, training and experience possible*. The intern year is a crucial period of transition from medical student to full registration as a doctor. In recent years, it has been recommended, in line with international best practice guidelines, that the intern year be designated the first year of postgraduate training.

The aim of this project was to assess the current status of the intern year and to evaluate the experiences of the interns during their first year. This project has included both quantitative and qualitative research in gathering data.

Section 1 includes historical information on the intern year and steps that have been taken to date to improve the management of the year. This included the setting up of an Intern Coordinators and Tutor Network in 2002. Currently, many new factors have supervened which necessitate further change and improvements in the intern year. They include statutory requirements of working hours (for example the European Working Time Directive), international educational developments, particularly the replacement of the Pre-Registration House Officer in the UK by a two-year Foundation Programme, and issues regarding graduate retention in Ireland.

The key statistical findings from the research include (i) the increased number of women graduating from courses in Medicine (in 2005 the gender mix was 55% female, 45% male), (ii) the regional inequity of intern placements (over a quarter of intern placements are in Dublin alone), (iii) the fact that not all not all Medical Council educationally approved posts are funded by the HSE and (iv) approval by the Medical Council of new internship specialty rotations (including general practice, emergency medicine, paediatrics and psychiatry) has not led to the creation of new intern slots in these disciplines. Information regarding the current intern rotations reveals the fact that only 23 posts are in these newly-recognised specialities, which represents a mere 4.6% of total posts approved.

Information was gathered from (a) medical schools, (b) hospital questionnaires and (c) the Medical Council and Postgraduate Medical and Dental Board databases, supplemented by extensive testimony

from interns throughout the country, derived from interviews conducted both during the study and during the March 2006 Medical Council inspections of all Irish medical schools.

Based on the projected increase in medical school numbers specified in the Fottrell Report, the demand for intern places is estimated to grow significantly over the coming years. Currently, of the forty hospitals that are approved for intern training, thirty-five have interns. In total, 534 places are approved but there are only 499 actual filled posts. This is mainly due to hospitals reporting a lack of funding, or as a result of a policy of converting intern posts into Senior House Officer placements. A ratio of bed numbers to intern places indicates which hospitals may be able to accommodate more intern placements in the future. The main university teaching hospitals average out at a ratio of 16:1 (compared with the largest patient to intern ratio of 321:1). Thus the capacity for expansion of places lies mainly in regional hospitals and in largely unexploited domains of General Practice, Obstetrics, Paediatrics, Peri-operative Medicine/Anaesthesia and Psychiatry, representing the disciplines recognised by the Medical Council.

Most teaching hospitals have an intern tutor, many of whom have developed excellent programmes. However, a substantial number have no dedicated funded sessions to adequately support their role in supervising interns. The Intern Tutor role requires further definition and the establishment of national standards. The report makes it clear that sufficient time and resources will be needed to perform the role properly. While the Medical Council has previously recommended that the ratio of tutor to intern be 1:8, it is clear that many tutors are working in excess of this recommendation. On a national average, only 30-40% of tutors have funded sessions.

Section 3 raises issues and concerns regarding the current intern year. Interviews were conducted with about 10% of interns across the country based in both large teaching hospitals and smaller regional hospitals. In some hospitals, there are significant deficits. Interns expressed specific concerns about (i) a lack of supervised practical experience, (ii) a lack of formal structure to the year, (iii) insufficient practical preparation for their role as a working junior doctor both at medical school level and during hospital induction courses. Frequently, interns spoke of acting 'above grade' (inappropriate unsupervised major tasks beyond their competency) and acting 'below grade' (inappropriate repetitive excessive rote administrative work), both of which have the potential to negatively impact on patient satisfaction and safety. The lack of practical skills allied to acting 'above grade', raises significant clinical risk management issues that require to be addressed. Interpersonal conflicts between interns and other hospital staff continued to be reported and require to be tackled, in order to ensure a more harmonious inter-professional team-work ethos.

Following research undertaken during this project, the Medical Council concerns about the intern year were further reinforced during the 2006 medical school and hospital inspections. There was very low compliance in completing the Medical Council's 'Intern Logbook' in an appropriate way and the Medical Council should look at ways of improving its usefulness and content. Although examples of excellence in intern teaching programmes were encountered, of major concern is that intern teaching sessions often could not be attended by interns, either because they were not permitted to be released from day-to-day service duties, or the sessions were not 'bleep-free' and were constantly interrupted. Some criticisms of the course content included the observation that many presentations repeated standard medical school student topics and lacked practical application. In addition, some teaching sessions may be overtly sponsored by pharmaceutical companies. The Medical Council advocates that teaching and learning should be separated from financial sponsorship and advertising and has recommended that sessions require to be resourced from within the Health Service. Overall, while many interns felt that they receive adequate support and supervision during the intern year, far too many did not. Structured mentoring and formal career advice support was notably deficient. These deficits require urgent addressing.

Appendix 2 suggests a curriculum, core competencies and outcomes template. With the feedback gained from interns, tutors and manpower managers, it is recommended that work should commence on developing a curriculum, outlining core competencies to be achieved throughout the year. The suggested outline education programme has been arbitrarily divided into eight topics, which include areas such as common emergencies, practical procedures and communication skills. Developed from a learning outcomes perspective, it suggests a distinct focus on what needs to be learnt as opposed to what needs to be taught. It is generic enough to be implemented across all hospitals, when agreed, based on a national consensus document approved by the Medical Council.

Currently all five medical schools are affiliated to hospitals that have some form of formal induction programme and methods of assessment but there is enormous variation in structure, content and duration. It is clear that a common induction programme, developed at a national level but delivered locally, is required. As a result, a draft generic assessment form has been developed based on the competency outcomes. A draft induction programme has been produced which, if implemented, will provide practical training on procedural issues to better prepare the graduates for their internship. The introduction of pre-internship job-shadowing is proposed, as it allows for enhanced hands on experience. In order to optimise the knowledge gained from shadowing, a list of its objectives has been developed.

This report will recommend the following:

- That an independent body be assigned to **implement the changes** contained in this report
- That national consensus be reached on **curriculum content**
- That national consensus be reached on **assessment methods**, including sign-off of the year, so that Certificates of Experience and Certificates of Good Standing may be issued
- That national consensus be reached on an **induction programme** and delivery thereof
- That **intern tutors be fully trained and funded** to fulfil their roles as mentors and trainers
- **That practices** (such as acting above grade, ambulance transfers and being first on call in Accident and Emergency Departments), **which may jeopardise patient safety be discontinued immediately.**

Now that the foundation work for the restructuring of the intern year has been completed, the momentum must continue to implement the change across all training hospitals. The change will require commitment from the medical schools, tutors, the Health Service Executive and the Department of Health and Children. The next phase of the project is to establish a body that will oversee the management of the intern year, evaluate current rotations for their suitability and training content, and develop the training programme. The impetus generated by the Buttimer report to support this reform is welcome and should provide a springboard for change.

**Acknowledgements**

This project was conducted by Ms Blánaid Lavelle, Intern Coordinator and Tutor Network Project Manager, and could not have been completed without the help and support of many people including interns, tutors, hospital managers and medical school administrators who gave of their time and knowledge. Particular gratitude must go to Dr Dara Devitt, Surgical Lecturer and Deputy Intern Coordinator at NUI Galway who drove the development of the education and induction programme, and Dr Simon Morgan, Intern Tutor at Letterkenny General Hospital who assisted with the curriculum development.

## **1. Introduction and Background**

### **1.1 Introduction**

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. In 2001 the Medical Council undertook a commitment to re-evaluate the education and training experience of interns, which until then was considered to be unstructured and inconsistent. The educational content of intern posts was usually small and the service component often included much inappropriate clerical work. Medical experience and training was more a product of luck than design. A generic job description identifying interns' duties was produced along with a logbook to record the interns' personal and professional development.

In 2003 the Medical Council took further action with the introduction of the Intern Coordinator and Tutor Network (ICTN). The remit of the network was to supervise the education and training of the internship nationally. The Medical Council also embarked on a national survey of interns to gain a better understanding of the problems facing them and their feelings regarding the experience of the intern year. The survey found that, a majority of interns reported a lack of protected time for education, a lack of formal educational programmes, insufficient feedback on performance and an unnecessarily stressful work environment. (1)

By 2005 a revised, more user friendly logbook was produced, and the Medical Council received funding from the Department of Health and Children to carry out a project on the intern year. It included data gathering on intern hospitals, training programmes, rotation specialities and an evaluation on the progress made by the ICTN. This report details the findings of the project.

### **1.2 The Intern Coordinators and Tutor Network**

The Medical Council convened a meeting of Intern Coordinators and Tutors at Tulfarris, Co Wicklow in September 2002. The principle outcome of the meeting was a decision to establish a 'Network of Intern Coordinators and Tutors' to further develop the education and training aspects of the intern year. It was agreed that five Intern Coordinators (representing each of the medical schools) would get together to formally establish such a Network.

The terms of reference included the development of a set of standards for the education and training of interns, which could be implemented and monitored across all training hospitals. Also the establishment of an infrastructure to allow for the sharing of knowledge and innovation between medical schools.

The inaugural meeting took place in May 2003 where the terms of reference, standing orders and membership of the Network were agreed. It also instigated preliminary work on intern competencies, curriculum, job description and forms of assessment. Although the Network is operating well regionally with Tutors affiliated with specific medical schools meeting biannually, there is very little national integration of best practice. Each medical school has a different induction programme, form of assessment and training programme. The aim is to get consistency across the five medical schools.

### **1.3 Factors Effecting Change**

There are many factors that are effecting changes in the medical education at present. These include Government policy, European directives, undergraduate reform, worry over graduate retention and the decision by the Medical Council that the intern year should be the first year of postgraduate training in line with World Federation guidelines.

#### **1.3.1 International Developments**

Reform in medical education has been ongoing internationally over the years. Many of the English speaking countries have worked on improving their postgraduate training programmes. This has left Ireland behind resulting in problems with graduate retention. It is thus imperative to better structure and define the intern year.

The UK implemented their new foundation year programme in August 2005. They have moved to a two-year schedule and its goal is to ensure an educational continuum between undergraduate medical education and postgraduate medical training. They have moved from an experienced-based model to an outcomes-based model that allows for different forms of teaching and learning. The aim of the two-year foundation programme is to gain broader experience in defined disciplines prior to commencing their general postgraduate training. It should be noted however that doctors are eligible for full registration once they have completed their foundation year one. It will prove difficult for Irish graduates to fulfil the requirements of postgraduate training in the UK from now on, as they will not have fulfilled the foundation programme requirements when applying for SHO posts.

### **1.3.2 Graduate Retention**

The Fottrell report suggests that the lack of sufficient high quality, structured specialist training posts in Ireland has resulted in many medical graduates leaving Ireland to take up such opportunities overseas. Many of these graduates do not return resulting in the necessity to recruit non-Irish trained medics from abroad.

There is thus an urgent need to devise and adopt pro-active strategies to improve graduate retention levels, including the provision of an appropriate number of high quality general professional and specialist training positions. As the intern year is the first year of postgraduate training it is of utmost importance to begin the reform process with the intern year.

It is imperative to have a generic core curriculum with core competencies and outcomes so that all interns will be trained to the same professional standard regardless of where their training took place prior to full registration.

A review is also necessary of all the current intern rotations to evaluate their educational content and the experience interns are gaining. It has become apparent that some rotations are inappropriate because of lack of training, lack of hands on experience or excessive hours. Poor experience of this nature will not encourage our Non-Consultant Hospital Doctors (NCHDs) to remain in Ireland to continue their education and training.

### **1.3.3 European Working Time Directive (EWTD)**

The EU's Social Affairs Council adopted the EWTD in 1993 under Article 118a (now Article 138) of the Treaty on the European Union.

The EWTD provides a basic framework of legal rights. It aims to limit long hours, provide minimum work-break entitlements, protect night workers and establish minimum holiday periods. Most EU member states already had more restrictive working time legislation in place before the EWTD.

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The timetable for the application of the EWTD to the working patterns of doctors in training is as follows: -

- 1 August 2004
  - Interim 58 hour maximum working week over a 17-week period
  - Rest and break requirements become law
    - A rest period of 11 consecutive hours between each working day
    - An uninterrupted rest period of not less than 24 hours in each 7-day period
    - Uninterrupted break of 20 minutes when daily working time is more than six hours
- 1 August 2007
  - Interim 56 hour maximum working week over a 17-week period
- 1 August 2009
  - Deadline for 48 hour maximum working week over a 17 week period
  - This may be extended for another 3 years at 52 hours if exceptional circumstances apply

Intern working hours have to fall by as much as 20% over the coming three years. Conforming to this directive necessitates the reevaluation of the duties of the intern and the education and training they receive. Administration staff, phlebotomists and trained nurses could do much of these duties and this is an area that needs to be investigated.

A EWTD National Implementation Group was set up in September 2005 whose primary consideration is the continued provision of safe, high quality care to patients coupled with the provision of appropriate training to NCHDs during the EWTD implementation period. Currently there are thirty-three pilot studies in place nationwide to look at new ways of organizing work.

#### **1.3.4 Undergraduate Reform and Student Numbers**

In 1978 the intake of EU students to Irish medical schools was capped at 305 per annum. This resulted in the Irish medical schools accepting non-EU students. At present 60% of our graduates are non-EU and many return home following graduation. With the lifting of the cap in February 2006 it is estimated that the number of EU graduates will double over the coming years. This will necessitate the sourcing and funding of additional intern posts and offering a more structured and streamlined training programme. It is estimated that between 150 and 300 additional intern places will be required (Fottrell) to absorb the increased student intake.

As a result of this inevitable demand for intern places, it is more important than ever to have good training programme and management authority, be it an intern postgraduate training body (PGTB) or an intern committee to oversee the establishment of the new rotations and their appropriateness.

With undergraduate reform in place it is the opportune time to feed back to the medical schools the core competencies that are needed by graduates to adequately fulfil their role as an intern as currently graduates lack ability in many basic clinical procedures at the start of their internship.

### **1.3.5 World Federation of Medical Education (WFME) Guidelines**

A central part of the WFME strategy is to give priority to specification of international standards and guidelines for medical education, comprising both institutions and their educational programmes. The WFME standard is that the intern year should be seen as the first year of postgraduate training and in order to follow their recommendations, a set of medical educational standards and governance structure must be adhered to.

The WFME premises for postgraduate medical education standards are: -

- Only general aspects of postgraduate medical education and training should be covered
- Standards should be concerned with broad categories of the content, process, educational environment and outcome of postgraduate medical education
- Standards should function as a lever for change and reform
- Standards are intended not only to set minimal global requirements but also to encourage quality development beyond the levels specified
- Standards should be formulated in such a way that, in addition to respecting global core requirements, they will acknowledge necessary regional and national differences in the educational programme and allow for different local, national and regional profiles and developments
- Compliance with standards must be a matter for each community, country or region
- Use of a common set of international standards does not imply or require complete equivalence of programme content and outcome of postgraduate medical education, but deviations should be clearly described and motivated
- Standards should recognise the dynamic nature of programme development

- Standards are formulated as a tool which authorities, organisations and institutions responsible for postgraduate medical education can use as a basis and a model for their own programme development
- Standards should not be used in order to rank training programmes
- Standards should be further developed through broad international discussion and consensus
- The value of the standards must be tested in evaluation studies in each region

WFME global standards in postgraduate medical education structure ought to be structured according to nine areas: -

- Mission and outcomes
- Training process
- Assessment of trainees
- Trainees
- Staffing
- Training settings and educational resources
- Evaluation of training process
- Governance and administration
- Continuous renewal

Much reform is needed to the intern year to conform to the above WFME guidelines

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## **2. Overview of Intern Year**

While undertaking this project both quantitative and qualitative research was undertaken. Interviews were carried out with interns, NCHDs, intern tutors, intern coordinators, hospital administrators, manpower managers and consultants. Although different opinions were expressed as to how the intern year should be managed, the consensus was that reform was necessary and generic standards and policies needed to be put in place.

A survey was done on all intern-training hospitals and each completed a questionnaire regarding intern rotations and training programmes. It became evident that the intern experience is very different from hospital to hospital with some interns gaining excellent education and support while others do not.

It is desirable in practice yet difficult in theory for smaller regional hospitals with fewer interns to deliver a formal training programme to the extent that the large teaching hospitals can, as they do not have access to as many resources. It is therefore necessary to develop a training mechanism that will suit all locations.

Currently some interns in remote hospitals feel they are losing out on formal education; however they are exposed to more practical work, so their hands on training is enhanced. While some interns welcome this experience, others worry about the lack of supervision and feel they need better support especially at the beginning of their internship. This inconsistency needs to be addressed and a more balanced approach to training undertaken.

For this reason a generic list of core competencies is being developed to assist tutors and consultants in developing a training programme to suit the needs of their interns. The core competencies are a minimum standard requirement for interns. The delivery of the training will vary from hospital to hospital and is dependant on the resources available to them.

The reform programme however will not succeed without the will and commitment of key stakeholders that include the HSE, Department of Health and Children, hospital management, intern tutors and coordinators, consultants, manpower managers etc. There are inevitable funding issues to support the new proposed training scheme that will also have to be addressed.

Some of the main issues and concerns raised by interns and other stakeholders are referred to below.

- Interns being first on call within the first two months without adequate support from more senior colleagues
- They feel unprepared in the clinical skills area i.e. cannulation, catheterisation – occasionally end up practicing on each other
- Interns accompanying patients in ambulance from regional hospitals to city hospitals – feel out of depth
- Excessive hours especially on surgical rotations
- Don't get released from team to attend formal education lessons
- Formal tutorials are not bleep free
- Content of lectures is not always relevant
- Don't know who to go to if they have a problem i.e. feel that there is little mentoring
- Feel out of depth in A&E
- Don't know who to approach if they see something wrong, or feel a colleague has acted inappropriately
- A lot of the work in major hospitals is administrative

### **Intern Education**

The hours of formal and informal education varies greatly from hospital to hospital and rotation to rotation. The individual hospital training schedule can be seen in the hospital questionnaires in the appendices as it is too variable to represent in a table here.

The methods used in teaching are listed below: -

- Formal Tutorials
- Journal Clubs
- Case Presentations
- Ward Rounds
- Grand Rounds
- Conferences

Some medical schools require a minimum attendance at formal tutorials others do not. There are a lot of formal tutorials in large teaching hospitals while the smaller regional hospitals with fewer interns concentrate on more practical teaching methods. The need for defined outcomes is therefore more important than ever if the intern year is to be properly regulated and formally structured.

### **3. Intern Training and Assessment**

As the intern year is the first year of postgraduate training it acts as a transition period from medical student to fully registered doctor. Its aim is to apply the knowledge and skills learned in undergraduate education and to develop competencies in basic clinical skills, medical procedures and patient management.

Improving patient care is at the heart of medical education, thus standards and quality of care must remain consistently high. In order to standardise the training and learning experience of the intern year, a set of core competencies and outcomes are being developed which are generic enough to be achievable regardless of disciplines of the rotations.

Learning outcomes underpin these competencies and describe what interns will be able to do by the end of their education and training programme. Learning outcomes should be verifiable and measurable, allowing for flexibility across the healthcare system.

The Medical Council is placing special emphasis on ensuring future doctors are not just skilled in the art of diagnosing and treating disease but are also skilled in managing information and communicating with their patients.

Communication is one of the most important medical skills. Systematic teaching of communication skills is critical to effective and humane healthcare delivery. Comprehensive training in doctor-patient communications will significantly improve the ability of interns, and all medical professionals to understand and address patients' needs.

In order to ensure that academic and professional skills are achieved, a supervision and assessment mechanism will be put in place. The core competencies will be structured to allow for continued professional development throughout a doctors medical career.

The intern programme is being developed from a learning outcome perspective, where learning is being defined in terms of what the students can do at the end of their training. The use of learning outcomes is a means of describing the contents of a module or course in terms of the learning that is intended to happen. It focuses on learning rather than teaching.

Appropriate teaching strategies will be employed to encourage and support intern learning in terms of modes of teaching and methods of learning:-

<b>Forms of Teaching</b>	<b>Forms of Learning</b>
<ul style="list-style-type: none"> <li>• Ward Rounds</li> <li>• Case Conferences</li> <li>• Journal Clubs</li> <li>• Formal Lectures</li> <li>• E-learning</li> </ul>	<ul style="list-style-type: none"> <li>• Bedside teaching</li> <li>• Discussion</li> <li>• Q &amp; A</li> <li>• Peer learning</li> <li>• Demonstration</li> <li>• Structured observation</li> <li>• Problem based learning</li> </ul>

### 3.1 Curriculum, Competencies and Outcomes

Competencies can be defined as 'the possession of knowledge, skills and abilities required for lawful, safe and effective professional practice without direct supervision'. The following core competencies are to be addressed by the intern education and training programme:-

- Clinical Topics
- Common Emergencies
- Patient Investigation and Examination
- Technical Skills
- Practical Procedures
- Personal and Professional Development
- Communication Skills
- Legal and Ethical Competencies

These are further detailed in Appendix 2.

Intern medical education and training is based on the apprenticeship model of 'learning on the job' as part of a team. The system is designed so that senior colleagues supervise and assess the interns' performance, providing ongoing feedback and gradually increasing their responsibilities according to their abilities.

As communications and ethics are key skills necessary for all doctors it is felt that the intern year should concentrate on developing these skills to a high level. Generic competencies are specified which must be accomplished regardless of rotation discipline or size of hospital.

### 3.2 Induction Programme

Normally induction takes place in the fourth week of June. The recommendation is that the initial three days are held at the university hospitals and the following two are spent at the affiliated hospitals where graduates are beginning their internship, so that hospital specific induction can take place.

The aim of the induction programme is to prepare medical graduates for their impending intern year. It is therefore designed to be informative regarding employment and process issues, and to provide practical training on procedural issues. It is intended to introduce 'shadowing' so that graduates get hands on experience with a working team. Shadowing is due to be introduced formally within the next few years therefore it is felt that it is appropriate to introduce it at this stage to the induction programme.

The Clinical Skills element of the Induction Course can be covered during shadowing, at workshops or in clinical skills labs, whichever is appropriate. Skills that must be covered include arterial blood gas, catheterisation, taking bloods, inserting a drip etc. As shadowing allows for better hands on experience it would be preferable and objectives of shadowing include:-

#### Information Gathering

- Asking information regarding the team
  - Who are the people on the team, which wards are the patients in, when do the ward rounds take place, when and where are clinics, outpatients etc
- Become familiar with layouts of wards and clinical rooms
- Introduce oneself to ward manager, ward clerk, and relevant clinical nurse specialists
- Become familiar with informed consent by listening to senior colleagues consenting patients
- X-ray information
  - Become aware of practical issues regarding a consult, understand reasons for requesting x-rays, know which x-rays need to be requested by senior team members (i.e. MRI and invasive tests)
- Bloods
  - Become familiar with when to write up bloods, where to leave requests and when to sign off bloods. Find out about weekend phlebotomy service
- Learn how to use the pods (used for transporting specimens)

- Know where the arrest trolley and ECG machines are on each ward
- Learn how to print a list of all patients being managed by team

### Practical Procedures

- Procedures to do
  - Do at least three cannulations under supervision, draw at least four sets of bloods under supervision
  - Insert a urinary catheter under supervision if applicable
  - Carry out an ABG under supervision if possible
- Procedures to observe
  - Observe carefully procedures that are necessary for day one such as drawing up of antibiotics, the priming of lines and the erection of drips, the filling in of drug kardex and the writing of prescriptions and discharge summaries
  - Observe carefully the technique of writing in patients' charts

The following generic programme is a guide to the content requirement for the induction programme

### Day 1

<b>AM</b>	Sign in / Registration
	Introduction to registration requirement <ul style="list-style-type: none"> <li>• Intern Assessment</li> <li>• Logbook</li> <li>• Certification courses Advanced Cardiac Life Support (ACLS) and Manual Handling</li> <li>• 70% attendance at educational session requirement</li> </ul>
	Contract of Employment Issues <ul style="list-style-type: none"> <li>• Salary, tax, overtime, rosters</li> <li>• Bleep protocol in hospital</li> <li>• Grievance and disciplinary procedures – Health Service Employers Agency (HSEA) policies</li> <li>• Dignity at work policy – HSEA</li> </ul>
	Education and Training <ul style="list-style-type: none"> <li>• Medical Council</li> <li>• Core Curriculum, Competencies, Outcomes</li> <li>• Role of the Tutor</li> </ul>
	<b>Lunch</b>
<b>PM</b>	Tour of Hospital <ul style="list-style-type: none"> <li>• Various departments (radiology, labs etc...)</li> <li>• Medical Records</li> <li>• Administration</li> </ul>

	<ul style="list-style-type: none"> <li>• Library</li> <li>• Resuscitation training area</li> <li>• On call residence</li> <li>• Restaurant</li> <li>• Security (arrangement for photo ID)</li> <li>• Wards (meet team if possible and arrange shadowing if appropriate)</li> </ul>
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**Day 2**

<b>AM</b>	Prescribing <ul style="list-style-type: none"> <li>• Pharmacy Introduction</li> <li>• Writing prescriptions</li> <li>• Filling of drug kardexs</li> </ul>
	ECG <ul style="list-style-type: none"> <li>• Introduction from cardiac technicians</li> <li>• Use of machine</li> <li>• How to read an ECG (Cardiologist)</li> </ul>
	Radiology <ul style="list-style-type: none"> <li>• Introduction from department</li> <li>• Guide to chest x-ray and common ward x-rays</li> <li>• Picture Archiving and Communication System (PACS)</li> </ul>
<b>Lunch</b>	
<b>PM</b>	Phlebotomy <ul style="list-style-type: none"> <li>• Introduction from department</li> <li>• Taking bloods</li> <li>• Cannulation</li> <li>• Drawing up and administering IV drugs, priming of lines, erecting drips (senior nursing staff)</li> </ul>
	Blood Bank <ul style="list-style-type: none"> <li>• Introduction</li> <li>• Haemovigilance protocol</li> </ul>

**Day 3**

<b>AM</b>	Shadowing (note shadowing objectives)
<b>Lunch</b>	
<b>PM</b>	Medico-Legal <ul style="list-style-type: none"> <li>• Clinical note taking</li> <li>• Consent</li> <li>• Medical records</li> <li>• Patient confidentiality</li> <li>• Clinical Risk Management</li> <li>• Coroner cases</li> <li>• Notifiable infectious diseases</li> </ul>

	Occupational Health <ul style="list-style-type: none"> <li>• Vaccinations</li> <li>• Needlestick injuries and policy</li> <li>• Personal health issues</li> <li>• Self care</li> <li>• Stress management</li> </ul>
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**Day 4**

<b>AM</b>	Shadowing
	<b>Lunch</b>
<b>PM</b>	Hospital Specific <ul style="list-style-type: none"> <li>• Library - hours, medline search, journals</li> <li>• IT Training – systems, Internet, e-mails</li> <li>• Waste Disposal – sharps, hazardous waste</li> <li>• Hand washing</li> <li>• Basic Life Support (BLS)</li> </ul>

**Day 5**

<b>AM</b>	Shadowing / Clinical Skills
	<b>Lunch</b>
<b>PM</b>	Shadowing / Clinical Skills

There are concerns regarding making the induction course compulsory, as graduates are not employees and thus are not on the payroll. However attendance certificates and receipts can be issued enabling interns to draw down funding from their training grant, which currently stands at €4,260.

**3.3 Methods of Assessment**

Moving to an outcomes based model will require a form of assessment to indicate how outcomes have been demonstrated. A copy of the proposed generic assessment form is shown below, and is to be used across all medical schools and all intern-teaching sites.

### INTERN ASSESSMENT REPORT

- To be completed for each rotation or every 3 months -

#### General Information

Intern Name :	.....		
Medical School :	.....	MC Reg # :	.....
Hospital Name :	.....		
Intern Tutor :	.....		
Supervising Consultant :	.....		
Speciality :	.....		
Rotation Period :	From :	/ /	To : / /

#### Assessment

Please rate the above Intern with respect to their competence in the following areas by ticking the appropriate box	Requires Support	Competent
<b>Patient Investigation &amp; Management</b> <small>i.e. competent in ordering and interpretation of common investigations</small>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Common Emergencies</b> <small>i.e. be competent in the investigation and management of common emergencies</small>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Clinical &amp; Technical Skills</b> <small>i.e. be competent in the investigation; diagnosis and management of clinical topics; good history taking; show ability to conduct examinations and interpret results</small>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Practical Procedures</b> <small>i.e. have the technical ability to competently perform common practical procedures</small>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Communication Skills</b> <small>i.e. oral &amp; written communications with patients and relatives and staff; discussing sensitive issues appropriately; breaking bad news compassionately</small>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Legal &amp; Ethical Competencies</b> <small>i.e. confidentiality; dealing with ethical dilemmas regarding social; cultural or religion issues; gaining informed consent; knowledge regarding appropriate statutes &amp; regulations</small>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Personal &amp; Professional Development</b> <small>i.e. show capacity towards self learning; time management; seeking appropriate help; following safe practices; motivation; reliability and dependability</small>	<input type="checkbox"/>	<input type="checkbox"/>

#### Comments

Please convey any additional comments or concerns regarding the above Intern	
.....	
.....	
.....	
Please tick attendance	Satisfactory <input type="checkbox"/> Unsatisfactory <input type="checkbox"/>

#### Conclusion

For the purposes of registration Interns must satisfactorily complete all rotations. Has the above named Intern performed satisfactorily during their attachment?      Yes       No

Consultants Signature : .....      Date : .....

Interns Signature : .....      Date : .....

Tutors Signature : .....      Date : .....

In order to be eligible for full registration an intern must show a level of competence in basic medical and surgical skills and procedures. The assessment forms are a guide to the progress of the intern and will highlight any difficulties that need addressing early in the intern's training. The aim of the assessment form is to indicate competence and is not intended as a tool to grade interns as with exams.

Interns should complete the section on general information prior to their meeting with their consultant. The assessment must be done in the presence of the intern so verbal feedback may also be given. The comments section allows consultants to give both positive feedback and feedback on causes of concern. Both the interns and the consultants sign the form.

A form is to be completed at a minimum every quarter. Therefore if interns are on a six month rotation with one consultant, an assessment must be done mid way.

If interns are on a six month rotation of two months: two months: two months, it is preferable that they have an assessment done at the end of each two month rotation.

It is suggested that in general the assessment reports are filled in: -

- Mid September
- Mid December
- Mid March
- Mid June

Completed assessment forms are reviewed by the Intern Tutor / Intern Committee. Any highlighted actions or remedial training will be arranged and monitored by the Intern Tutor.



The procedures should be done regularly to ensure continuous improvement and must be signed off by a senior colleague. Following the principle of competency-based training there are three levels of achievement:-

- **S** – Performed under Supervision
- **A** – Assisted with procedure
- **P** – Performed unaided

This layout is similar to the layout of other postgraduate logbooks, and will form the basis for their continuous medical education. A list of the procedures will be listed in the appendix of the logbooks, and are listed below.

Compulsory Practical Procedures		Additional Practical Procedures	
1	Basic Life Support	1	Insertion / removal of long line
2	Peripheral IV cannulation	2	Insertion / removal of femoral line
3	Phlebotomy	3	Insertion / removal of central line
4	ABG sampling	4	Suprapubic catheterisation
5	ECG	5	Nasal packing
6	Urinary catheterisation	6	Suture insertion / removal
7	Blood cultures	7	Skin clip insertion / removal
8	IM injections	8	Application of CPAP / BiPAP
9	Draw up and administer IV drugs	9	Pleural aspiration
10	NG tube insertion – wide and narrow bore	10	Pneumothorax aspiration
11	Peak expiratory flow	11	Chest drain insertion / removal
12	Apply a neck collar	12	Peritoneal tap
13	Hand washing	13	Seroma aspiration
14	Rectal examination	14	Joint aspiration
15	Lifting patients	15	Joint injection
16	Inhaler technique assessment	16	Lumbar puncture
17	Removal of sutures	17	Electrical cardioversion
18	Remove central line	18	Exercise stress test
19	BP measurement using sphygmomanometer	19	ACTH stimulation test
20	Erect a drip	20	Glucose tolerance test
21	Scrubbing and gowning for theatre	21	Pituitary function test
22	Donning of sterile gloves	22	Backslab application
23	Use of face mask and bag-valve ventilation *	23	POP application / removal
24	Oropharyngeal airway *	24	Thomas splint application
25	Nasopharyngeal airway *	25	Skin traction application
26	Endotracheal intubation *	26	Punch skin biopsy
27	Defibrillation *	27	Core / trucut biopsy
		28	Proctoscopy
	* Performed on ACLS course	29	Bone marrow biopsy
		30	Mantoux test
		31	Wound inspection
		32	Ankle / brachial index

### 3.5 The Role of the Intern Tutor

The overall role of the Intern Tutor is to support the delivery of a comprehensive Education and Training programme. It also involves the overseeing and continuous review of its effectiveness. The main objective is to ensure that all interns are adequately prepared from a professional and personal aspect for full professional registration.

Tutors are not expected to do all the tasks of the role themselves but must ensure tasks have been accomplished and must be able to steer interns toward the right people when seeking assistance. The suggested breakdown of the role is as follows: -

- Education and Training
  - Organisation and running of induction programme
  - Organisation and delivery of core curriculum
  - Ensure interns have accomplished core competencies
  - Ensure ACLS course has been completed
  - Ensure Manual Handling course has been completed
  - Ensure intern assessments have been done
  - Management of remedial programme when required
  - Liaise with Intern Tutors of affiliated hospitals to review intern progress
  
- Support
  - Provide information regarding research, career options, fellowships etc
  - Provide guidance on personal issues such as stress, bullying, working hours, incident reporting etc
  - Be available to provide guidance and feedback on performance
  
- Progress Monitoring and Assessment
  - Record and monitor attendance at formal teaching session to ensure 70% attendance record
  - Ensure completion of full complement of intern assessment forms
  - Ensure logbook requirements are fulfilled
  - Run group feedback sessions with interns to ensure programme effectiveness and satisfaction level
  - Report to Intern Coordinator / Education Committee / Postgraduate Training Body
  - Liaise regularly with hospital Consultants who have interns

- Organise, Administer and Review of Intern Programme
  - Be aware of the requirements for full registration
    - Core Competencies
    - Curriculum
    - Outcomes
  - Understand the rotation requirements
  - Monitor and review suitability of current rotations
  - Organise and select appropriate people to deliver the teaching programme
  - In the case of affiliated hospitals tutors may have to organise delivery of specific core topics via video link. Tutors must ensure appropriate facilities are made available
  - Ensure funding for education sessions is in place
  - Liaise with Medical Council regarding application for approval for further intern training posts as necessary

### **3.6 Letter of Good Standing Requirement**

Currently the Dean of the Medical School provides a certificate of good standing to the Medical Council which enables interns to apply for full registration. This process will not change until the governance structure of an intern training body is decided upon.

It is however recommended that the following requirements have been fulfilled prior to a letter of good standing being issued

- Proof of attendance at Induction Course
- ACLS Certificate
- Manual Handling Certificate
- Completed Logbook
- A minimum of four satisfactory Intern Assessment Reports
- Proof of 70% attendance at formal training sessions

## **4. The Way Forward**

### **4.1 Standard Policies**

There are standard policies that will have to be draw up by the new intern training body which include such issues as:-

- Working Hours
- Underperformance
- Sickness / Stress
- Disability
- Pregnancy
- Disciplinary Issues

These must support the policies that already exist under the interns' employment contract available in the 'Dignity at Work Policy for the Health Services' and 'Grievance and Disciplinary Procedures for Health Services, which are included in Appendix 2.

### **4.2 Future Setup**

To continue the reform process of the intern year additional structures and policies must be set up.

They include:-

- **A proper governance structure for the 'Intern Body'**. A decision must be made whether this should be a revised Network; a postgraduate 'training body'; or another solution. In any case, it will need the support of the HSE.
- **A policy for signing off for full registration** and a decision whether it should remain the responsibility of the Deans of the medical schools. If this were to change, legislative changes to the Medical Practitioners' Act will be needed. For the time being, the responsibility for 'sign off' will remain with the Deans
- **A decision whether a national matching scheme should be developed** to give interns a better option to choose rotation specialities that may not be offered by hospitals affiliated to their medical schools

- **A decision must be made on whether funding should follow the intern** and not go directly to the hospital, i.e. if a hospital has six interns, it gets funding for six interns. In future, if they lose the intern, they lose the funding. This would eliminate the practice of converting intern posts to SHO posts. This may also encourage hospitals to support the proposed training and induction programme as they may lose interns if they do not provide adequate education and training. This option will also allow for the expansion of GP intern posts. The HSE will thus know how many intern posts are to be provided for annually.

## **Appendices**

## **Appendix 1: Statistical Review**

### **Student Data**

With the lifting of the cap on Irish and EU student entry to medicine, Irish and other EU allocated spaces is set to rise from 305 to 725 over the next four years. This reform is in tandem with the introduction of graduate entry programmes that all five medical schools are planning to introduce. The intake of medical students over the last few years across the five medical schools is illustrated in table 1(a) below.

**Table 1(a) – Current Number of Medical Students for Academic Year '05/'06**

<b>Academic Year</b>	<b>UCD</b>	<b>TCD</b>	<b>RCSI</b>	<b>UCC</b>	<b>NUIG</b>	<b>Totals</b>
Pre Med	86 (10)	76	100 (11)	-	68	-
1 <sup>st</sup> Med	176 (54)	135	206 (65)	128	102	<b>747</b>
2 <sup>nd</sup> Med	177 (63)	132	219 (65)	130	98	<b>756</b>
3 <sup>rd</sup> Med	169 (56)	124	194 (65)	127	87	<b>701</b>
4 <sup>th</sup> Med	197	138	202	113	93	<b>743</b>
Final Med	193	116	202	83	75	<b>671</b>
<b>'05 Final Med</b>	<b>142</b>	<b>108</b>	<b>181</b>	<b>97</b>	<b>71</b>	<b>600</b>

Using the academic year '04/'05 as the base line, the forecasted percentage increase of medical graduates over the coming years is illustrated in table 1(b) below. This does not account for any increase due to the lifting of the cap or graduate entry programmes in the future (note: the numbers in brackets in the above table account for students from Penang Medical School). As they return to Penang for their final years their numbers are not included. It can be seen that there is a significant increase in medical graduates and thus there will be a further demand for intern placements over the coming few years.

**Table 1(b) – Projected Percentage Increase in Medical Graduates using ‘05/’06 as****Baseline**

<b>Final Meds</b>	<b>‘05</b>	<b>‘06 (final)</b>	<b>‘07 (4<sup>th</sup>)</b>	<b>‘08 (3<sup>rd</sup>)</b>	<b>‘09 (2<sup>nd</sup>)</b>	<b>‘10 (1<sup>st</sup>)</b>
<b>Current Number of Students</b>	600	671	743	701	756	747
<b>% from Base of ‘05</b>	100 %	112 %	124 %	117 %	126 %	125 %

**Intern Data**

Following graduation medical graduates must work as an intern for a year under provisional registration from the Medical Council to gain practical experience.

Table 1(c) below illustrated the number of intern placements in Ireland from the five medical schools as of July 2005. Five of the TCD placements rotate with a hospital in Northern Ireland. This is the last year of this arrangement as the UK has introduced the FY1 and FY2 scheme, which is no longer compatible with the Irish system. Also one of the NUIG placements is a GP rotation that rotates with General Medicine in Letterkenny Hospital, Donegal.

**Table 1(c) - Intern Placements as of July 2005**

<b>Medical School</b>	<b>2005 Final Year Students</b>	<b>2005 Summer Graduates</b>	<b>2005 Intern Placements</b>
UCD	142	137	113
TCD	108	100	98
RCSI	181	166	118
UCC	98	91	97
NUIG	71	70	79
<b>Total</b>	<b>600</b>	<b>564</b>	<b>505</b>

The above figures include interns who began their internship in January 2005. There are approximately 25 graduates who begin their intern rotations in January each year. Therefore only about 85 % of graduates do their internship in Ireland. As the student numbers increase, this situation will worsen.

**Table 1(d) – Placement Breakdown**

<b>Irish Hospitals</b>	<b>NI Hospitals</b>	<b>GP Practice</b>
499	5	1

Once internship has been successfully completed, graduates are 'signed off' as being competent by the Dean of their medical schools, and the new doctors receive a Certificate of Experience that entitles them to full registration.

### **Graduate and Intern Ratios**

There have been an increasing number of females entering the medical profession over the years and due to the cap on Irish and EU students there is also an increase in non-EU students.

The following tables illustrate some gender and nationality ratios for the 2005 interns.

**Table 1(e) – 2005 Graduate Gender Mix**

<b>Medical School</b>	<b>Total Graduates</b>	<b>Number of Female</b>	<b>Number of Male</b>	<b>Female %</b>	<b>Male %</b>
UCD	137	68	69	49.6 %	50.4 %
TCD	100	62	38	62.0 %	38.0 %
RCSI	166	69	97	41.6 %	58.4 %
UCC	91	64	27	70.3 %	29.7 %
NUIG	70	41	29	58.6 %	41.4 %
<b>Total</b>	<b>564</b>	<b>304</b>	<b>260</b>	<b>56.4 %</b>	<b>43.6 %</b>

The RCSI numbers distorts some of the national gender figures as many of their students are non-EU and return home following graduation or internship. Thus the female/male ratios totals excluding the RCSI data are 60.1 % female and 39.9 % male.

**Table 1(f) – Gender Mix of 2005 Interns**

	Interns	Number of Female	Number of Male	Female %	Male %
<b>Total</b>	505	278	227	55 %	45 %

The Postgraduate Medical and Dental Board carried out a survey in October 2002. There were 462 interns practicing in the state, of whom 71% were Irish. It can be seen from the figures in table 2.3.3 below that there has been a fall in the ratio of Irish interns to others of 11% in the past three years.

**Table 1(g) – Nationality Mix of Interns as of July 2005**

	Irish	Other EU	Non-EU
<b>Total</b>	60.1 %	5.7 %	34.2 %

As the nationality figures are broken down by gender it is evident that there is an even higher ratio of female to males amongst Irish interns than other nationalities, with two thirds of Irish junior doctors now being female.

**Table 1(h) – Nationality % of Interns by Gender**

Interns	Nationality % of Total Interns	Nationality % of Female Interns	Nationality % of Male Interns
<b>Irish</b>	60.1 %	69.1 %	49.2 %
<b>Other EU</b>	5.7 %	4.2 %	7.6 %
<b>Non-EU</b>	34.2 %	26.7 %	43.3 %
<b>Total</b>	100 %	100 %	100 %

**Table 1(i) – Gender % of Interns by Nationality**

Interns	Total % of Interns by Nationality	% of which are Female Interns	% of which are Male Interns	Total
<b>Irish</b>	60.1 %	63.0 %	37.0 %	100 %
<b>Other EU</b>	5.7 %	40.0 %	60.0 %	100 %

<b>Non-EU</b>	34.2 %		42.8 %	57.2 %	100 %
<b>Total</b>	100%				

**Table 1(j) - % of Interns by Gender and Nationality Totalling 100%**

<b>Interns</b>	<b>Female</b>	<b>Male</b>
<b>Irish</b>	37.8 %	22.3 %
<b>Other EU</b>	2.3 %	3.4 %
<b>Non-EU</b>	14.6 %	19.6 %

### Intern Hospital Data

Intern placements are organised by the medical schools and individual schools may have special affiliations with particular hospitals. Interns often rotate through two hospitals in their intern year, a large teaching hospital and a smaller regional one. Rotations vary in duration from six months to two months.

Currently there are forty hospitals that are approved for intern training by the Medical Council. However five of them no longer have interns. There has been a difficulty in the past with hospitals eliminating intern posts, or converting them into SHO posts. This is an issue that needs addressing, as intern numbers will rise significantly over the coming years with the increase in student numbers. This will also have a significant knock-on effect on the hospitals infrastructure.

Hospitals approved for intern training are listed in tables 1(k) and 1(l) below. Those hospitals currently without interns need to be re-approved prior to intern allocation being permitted in the future.

**Table 1(k) – Hospitals Approved for Intern Training with Interns**

	<b>Hospital</b>	<b>Medicine Approval</b>	<b>Surgery Approval</b>		<b>Medicine Actual</b>	<b>Surgery Actual</b>
1	AMNCH, Tallaght	24	24		17	17
2	Bantry General Hospital	3	3		3	2
3	Beaumont Hospital	35	35		34	31
4	Bon Secours Hospital, Cork	3	3		2	2
5	Connolly Hospital, Blanchardstown	9	9		9	9
6	Cork University Hospital	17	17		17	17
7	Galway Regional Hospitals, Merlin Park and University College Hospital, Galway	24	22		24	22
8	Kerry General Hospital, Tralee	3	3		3	3

9	Letterkenny General Hospital, Donegal	8	5		8	5
10	Louth County Hospital, Dundalk	3	0		3	0
11	Mallow General Hospital	2	2		2	2
12	Mater Misericordiae University Hospital	20	19		20	19
13	Mayo General Hospital, Castlebar	6	6		3	6
14	Mercy University Hospital, Cork	9	7		9	7
15	Midland Regional Hospital, Mullingar	0	3		0	3
16	Midland Regional Hospital, Portlaoise	0	2		0	2
17	Midland Regional Hospital, Tullamore	1	2		1	2
18	Mid Western Regional Hospital, Ennis	0	1		0	1
19	Mid Western Regional Hospital, Limerick	10	11		10	11
20	Naas General Hospital	0	1		0	1
21	Our Lady of Lourdes Hospital, Drogheda	8	13		8	13
22	Portiuncula Hospital, Ballinasloe	5	4		5	4
23	Roscommon County Hospital	2	0		2	0
24	Sligo General Hospital	6	6		6	3
25	South Infirmery & Victoria University Hospital, Cork	7	7		7	7
26	South Tipperary General Hospital, Clonmel	5	2		0	2
27	St Columcille's, Loughlinstown	5	4		5	2
28	St James's Hospital	24	21		24	21
29	St John's Hospital, Limerick	2	2		2	2
30	St Luke's General Hospital, Kilkenny	4	3		4	3
31	St Mary's Hospital, Phoenix Park	1	0		1	0
32	St Michael's Hospital, Dunlaoghaire	0	3		0	3
33	St Vincent's University Hospital	18	15		18	15
34	Waterford Regional Hospital	6	6		6	6
35	Wexford General Hospital	0	3		0	3
	<b>Totals</b>	<b>270</b>	<b>264</b>		<b>253</b>	<b>246</b>
		<b>Total Approved</b>	<b>534</b>		<b>Actual Total</b>	<b>499</b>

**Table 1(l) – Previously Approved Intern Hospitals with No Current Interns Allocation**

	Hospital	Medicine Approval	Surgery Approval	Medicine Actual	Surgery Actual
36	Cavan General Hospital	-	-	0	0
37	Nenagh General Hospital	-	-	0	0
38	Monaghan General Hospital	-	-	0	0
39	Our Lady's Hospital, Cashel	-	3	0	0
40	Our Lady's Hospital, Navan	-	5	0	0
	<b>Re-approval would be needed prior to re-allocation of Intern to these hospitals</b>				

As mentioned previously, there are 505 interns currently training in Ireland, of which 499 are in placements in Irish hospitals. Five of the TCD posts however rotate with Omagh General Hospital in Northern Ireland. These two medical and three surgical posts rotate with posts in St James's Hospital, Dublin. There is also one General Practice post attached to NUIG, which rotates with a medical post in Letterkenny General Hospital, Donegal.

As the number of interns is going to escalate over the coming years the number of placements will have to increase. The capacity of some intern hospitals is quite high while other hospitals could accommodate more. The ratio of interns to hospital beds is illustrated in table 1(m) below.

**Table 1(m) – Ratio of Interns to Hospital Beds**

	Hospital	Number of Beds	Number of Interns	Ratio
1	AMNCH, Tallaght	599	34	18 : 1
2	Bantry General Hospital	76	5	15 : 1
3	Beaumont Hospital	696	65	11 : 1
4	Bon Secours Hospital, Cork	335	4	84 : 1
5	Connolly Hospital, Blanchardstown	202	18	11 : 1
6	Cork University Hospital	615	34	18 : 1
7	Galway Regional Hospitals, Merlin Park and University College Hospital, Galway	904	46	20 : 1
8	Kerry General Hospital, Tralee	377	6	63 : 1
9	Letterkenny General Hospital, Donegal	357	12	30 : 1
10	Louth County Hospital, Dundalk	137	3	46 : 1
11	Mallow General Hospital	76	4	19 : 1
12	Mater Misericordiae University Hospital	574	39	15 : 1
13	Mayo General Hospital, Castlebar	317	9	35 : 1
14	Mercy University Hospital, Cork	350	16	22 : 1
15	Midland Regional Hospital, Mullingar	209	3	69 : 1
16	Midland Regional Hospital, Portlaoise	202	2	101 : 1
17	Midland Regional Hospital, Tullamore	240	3	80 : 1
18	Mid Western Regional Hospital, Ennis	88	1	88 : 1
19	Mid Western Regional Hospital, Limerick	425	21	20 : 1
20	Naas General Hospital	199	1	199 : 1
21	Our Lady of Lourdes Hospital, Drogheda	340	21	16 : 1
22	Portiuncula Hospital, Ballinasloe	203	9	23 : 1
23	Roscommon County Hospital	136	2	68 : 1
24	Sligo General Hospital	320	9	35 : 1

25	South Infirmary & Victoria University Hospital, Cork	258	14	18 : 1
26	South Tipperary General Hospital, Clonmel	271	2	90 : 1
27	St Columcille's, Loughlinstown	150	7	21 : 1
28	St James's Hospital	970	45	21 : 1
29	St John's Hospital, Limerick	104	4	26 : 1
30	St Luke's General Hospital, Kilkenny	317	7	45 : 1
31	St Mary's Hospital, Phoenix Park	321	1	321 : 1
32	St Michael's Hospital, Dunlaoghaire	124	3	41 : 1
33	St Vincent's University Hospital	504	33	15 : 1
34	Waterford Regional Hospital	535	12	45 : 1
35	Wexford General Hospital	223	3	74 : 1

### Intern Tutor Data

Each of the intern training hospitals has an intern tutor who has the responsibility of managing the interns in their care. This includes running the intern training programme in the hospital and offering pastoral support and guidance to interns as they begin their medical career.

It was recommended by the Medical Council that Intern Tutors have a dedicated session each week to allow them time to fulfil the role properly. The recommendation came through the Education and Training Committee in February 2002 and states that Intern Tutors should be resourced at a minimum rate of two sessions for the first eight interns and one extra session for each additional eight interns. Although this recommendation was passed to the employing authority, as yet many of the Intern Tutors give of their time without any dedicated sessions.

Each medical school has an Intern Coordinator who works with the tutors in the hospitals they are affiliated to. It is normal for the coordinators to meet with their tutors biannually. The intention is that innovation is shared across hospitals; it is also a means of reviewing training programmes to ensure that the experience and education interns are receiving is similar across all hospitals.

This is desirable in practice, however it is difficult for smaller regional hospitals with fewer interns to deliver a formal training programme to the extent that the large teaching hospitals can, as they do not have access to as many resources as the larger hospitals. It is therefore necessary to develop a training system that will not leave them at a disadvantage.

There is an intern tutor in each intern hospital and some have two, one medical and one surgical. Of thirty-five hospitals, ten have interns from different medical schools. This results in additional work for

the tutors, as there are different assessment forms for different medical schools. The tutors must also liaise with up to three medical schools on occasion while devising the intern-training programme. This reaffirms the need to have a generic approach to training, curriculum and sign off across all medical schools.

As the role of the Intern Tutor has not been properly defined there is a wide variation in the remit. Many Tutors are uncertain about the role and the need to monitor interns' progression and to receive and give feedback regarding performance. Tutors are also supposed to monitor intern Logbooks to insure they are being properly maintained.

The hospitals and affiliated universities and their respective Tutors are listed in the tables below. Table 1(n) lists hospitals that are affiliated to more than one medical school. The following tables 1(o) to 1(s) list the hospitals that are affiliated to one medical school only. Much of the affiliation is on an historic basis and there is no formal agreement in place. A review of this situation would be prudent.

**Table 1(n) - Hospitals with Multiple Affiliations**

Hospital	Tutor	Number of Sessions	Number of Interns	Affiliated Schools
Galway Regional Hospitals, Merlin Park Hospital, Galway	Dr A O'Regan	0	9	NUIG
	Mr Ken Kaar	0	3	UCD
Kerry General Hospital	Mr R McEaney	0	6	UCC (4) NUIG (2)
Letterkenny General Hospital	Dr Simon Morgan	1	12 (+ 1 GP)	NUIG (8) UCD (2) TCD (2)
Midland Regional Hospital, Tullamore	Dr Paul Shiels	0	1	NUIG (2)
	Mr Hehir		2	TCD (1)
Mid Western Regional Hospital, Limerick	Dr James O'Hare	2	21	UCC (16) UCD (3) TCD (2)
Our Lady of Lourdes Hospital, Drogheda	Peter Gillen	1	21	RCSI (20) UCD (1)
Portiuncula Hospital, Ballinasloe, Galway	Dr Gerard Clarke	0	9	UCD (3) TCD (3) NUIG (3)
Sligo General Hospital	Dr Andy Hodgkins	1	9	NUIG (6) UCD (3)
St Luke's General Hospital, Kilkenny	Dr Gary Courtney	0	4	TCD (4)

	Mr Ian Wilson	0	3	RCSI (3)
Wexford General Hospital	Mr J.B. O'Mahony	0	3	UCD (2) TCD (1)

As can be seen from the above table only five out of the ten hospitals have dedicated time allocated to their intern tutors. However most of those who do not, have less than three interns under their care.

Hospitals affiliated to UDC, TCD and RCSI in tables below

**Table 1(o) – Hospitals Affiliated to UCD only**

UCD Affiliated Hospitals	Tutor	Number of Sessions	Number of Interns
Louth County Hospital, Dundalk	Dr Olwyn Lynch	0	3
Mater Misericordiae University Hospital	Dr Dermot Power	1	39
Midland Regional Hospital, Mullingar	TBA		3
Midland Regional Hospital, Portlaoise	Mr Paul Naughton	1	2
South Tipperary General Hospital, Clonmel	Mr Joseph Mc Glinchey	1	2
St Columcille's, Loughlinstown	Dr Donal O'Shea	1	7
St John's Hospital, Limerick	Dr Cornelius Cronin Mr Paul Burke	0 1	2 2
St Mary's Hospital, Phoenix Park	Dr Dermot Power	1	1
St Michael's Hospital, Dunlaoghaire	Mr Joseph Duignan	1	3
St Vincent's University Hospital	Dr Alan Watson Mr Arnold Hill	1 1	18 15

**Table 1(p) – Hospitals Affiliated to TCD only**

TCD Affiliated Hospitals	Tutor	Number of Sessions	Number of Interns
Adelaide and Meath Hospital, incorporating the National Children's Hospital, Tallaght	Mr Geoff Keye	2	34
Naas General Hospital	Mr Brian Hargan	0	1
St James's Hospital	Dr David Breen Mr Javaid Butt	1 1	24 21

**Table 1(g) – Hospitals Affiliated to RSCI only**

<b>RCSI Affiliated Hospitals</b>	<b>Tutor</b>	<b>Number of Sessions</b>	<b>Number of Interns</b>
Beaumont Hospital	Prof James Finucane	4	65
Connolly Hospital, Blanchardstown	Dr Maisra Yusra	1	9
	Mr Mohammed Atie	1	9
Waterford Regional Hospital	Dr Simon Cross	0	12

Hospitals affiliated to UCC and NUIG in tables below

**Table 1(r) – Hospitals Affiliated to UCC only**

<b>UCC Affiliated Hospitals</b>	<b>Tutor</b>	<b>Number of Sessions</b>	<b>Number of Interns</b>
Bantry General Hospital	Dr Peter Wieneke	0	5
Bon Secours Hospital, Cork	Dr Brian Whooley	0	4
Cork University Hospital	Dr Chris Luke	2	34
Mallow General Hospital	Dr Niall Cronin	0	2
	Mr Aongus Twomey	0	2
Mercy University Hospital, Cork	Dr Niall Colwell	2	16
South Infirmary and Victoria University Hospital, Cork	Dr Fergus Lyons	2	14

**Table 1(s) – Hospitals Affiliated to NUIG only**

<b>NUIG Affiliated Hospitals</b>	<b>Tutor</b>	<b>Number of Sessions</b>	<b>Number of Interns</b>
Galway Regional Hospitals	Dr Donal Reddan	0	15
	Mr Sheris Sultan	0	19
Mayo General Hospital, Castlebar	Dr Luke O'Donnell	1	9
Mid Western Regional Hospital, Ennis	Mr Denis O'Ceallaigh	1	1
Roscommon County Hospital	Dr Patrick McHugh	1	2

The allocation of session time to the intern tutors is at the discretion of the employing authority. Many Consultants and Specialist Registrars also give freely of their time to support the formal educational sessions for interns.

Many hospitals have had to resort to getting sponsorship from pharmaceutical and medical companies to run weekly lecture sessions. This enables the larger hospitals to provide this training, but this type of funding is not so readily accessible to smaller hospitals, and is contrary to good governance.

### **Intern Rotation Data**

Historically interns completed six months surgery training and six months medicine training. This has been amended under and the Statutory Instrument S.I. No 285 of 2003, which states that: -

An intern's prescribed period of employment is a period of not less than 12 months, which should be consecutive, of which at least three months must be spent in General Medicine and three months in General Surgery. As part of this 12-month period, an intern may also be employed for not less than two months and not more than three months in the following specialties: -

- Emergency Medicine
- Obstetrics and Gynaecology
- Paediatrics
- Psychiatry

A recommendation has been made to include Anaesthesia as one of the specialties and it is expected that it will be approved as a rotation by July 2006.

General Practice as a speciality is included under the Medical Practitioners' 2002 Amendment Act section 28(2) which states that: -

Following award of a primary qualification, a certificate of experience shall be granted to any person who for the prescribed period or periods has been employed in the practice of medicine in:-

- A hospital, health institution, clinic or general medical practice, or
- A prescribed health service setting

Although these new rotations have been introduced, very few of them are on offer at present. The only General Practice rotation in Letterkenny is reported as being very successful, however it began as a three year funded project and its continuation into the future is unclear.

The tables below illustrate the rotations that are currently on offer in medicine and surgery. The specialities are included under medicine and surgery.

**Table 1(t) – Medicine Rotations on Offer in Training Hospitals**

<b>Rotations in Medicine by Speciality</b>	<b>Number of Posts</b>	<b>% of Medicine Posts</b>
Cardiology	32	12.6 %
Dermatology	4	1.6 %
Endocrinology and Diabetes Mellitus	27	10.7 %
Emergency Medicine	3	1.2 %
General Internal Medicine	32	12.6 %
Gastroenterology	29	11.5 %
Geriatric Medicine	32	12.6 %
General Practice	1	0.4 %
Haematology	7	2.8 %
Infectious Diseases	5	2.0 %
Medical Rotator (Holiday cover)	6	2.4 %
Nephrology	18	7.1 %
Neurology	8	3.2 %
Oncology	8	3.2 %
Pharmacology	2	0.8 %
Respiratory Medicine	25	9.9 %
Rheumatology	14	5.5 %
<b>Total</b>	<b>253</b>	<b>100%</b>

Out of the above medicine rotations only four of them are in the new specialities and represent a mere 1.6% of medicine rotations.

**Table 1(u) – New Specialities in Medicine**

<b>Speciality</b>	<b>Number of Posts</b>	<b>% of Total</b>
Emergency Medicine	3	1.2 %
General Practice	1	0.4 %
<b>Total</b>	<b>4</b>	<b>1.6 %</b>

**Table 1(v) – Surgery Rotations on Offer in Training Hospitals**

Rotations in Surgery by Speciality	Number of Posts	% of Medicine Posts
Breast Surgery	8	3.3 %
Colorectal Surgery	7	2.8 %
Cardiothoracic Surgery	3	1.2 %
Ear, Nose and Throat Surgery	12	4.9 %
Emergency Surgery	5	2.0 %
General Surgery	74	31.1 %
Gastro	9	3.7 %
Gynaecology	12	4.9 %
Hepatic Surgery	4	1.6 %
Maxillofacial Surgery	2	0.8 %
Neurosurgery	6	2.4 %
Orthopaedic Surgery	29	11.8 %
Ophthalmology	4	1.6 %
Plastic, Reconstructive and Aesthetic Surgery	11	4.5 %
Paediatric Surgery	2	0.8 %
Radiation Oncology	2	0.8 %
Surgical Rotator (Holiday cover)	3	1.2 %
Thoracic Surgery	3	1.2 %
Urology	23	9.3 %
Vascular Surgery	27	11.0 %
<b>Total</b>	<b>246</b>	<b>100 %</b>

Out of the above Surgery rotations nineteen of them are in the new specialities and this represents 7.7 % of surgery rotations.

**Table 1(w) – New Specialities in Surgery**

Speciality	Number of Posts	% of Total
Emergency Surgery	5	2.0 %
Obstetrics and Gynaecology	12	4.9 %
Paediatric Surgery	2	0.8 %
<b>Total</b>	<b>19</b>	<b>7.7 %</b>

A synopsis of the new specialities is illustrated in the table below.

**Table 1(x) – New Speciality Rotations Represented as a Proportion of all the Interns**

<b>Speciality</b>	<b>Number of Posts</b>	<b>% of Total 500 Intern Rotations</b>
General Practice	1	0.2 %
Emergency Medicine	8	1.6 %
Obstetrics and Gynaecology	12	2.4 %
Paediatric Surgery	2	0.4 %
Psychiatry	0	0 %
Anaesthesia	0	0 %
<b>Total</b>	<b>23</b>	<b>4.6%</b>

Out of the 500 intern placements in Ireland (excluding the five in Omagh), 23 of them are in the new specialities representing 4.6% of the total intern placements.

## Summary of Statistical Findings

The salient points from the above data include:-

- Graduate numbers are due to increase by 25 % over the coming few years, and may increase by as much as 35% when the cap is removed and the graduate entry programme is introduced; this necessitates sourcing new intern placements to accommodate the extra graduates
- There are currently 505 intern placements in Ireland of which 499 are in Irish training hospitals, five rotate in Omagh and one is in GP practice
- The gender mix of interns is 55% female and 45% male, however the gender mix amongst Irish interns is 63% female and 37% male
- The nationality mix of interns is approximately 60% Irish, 6% other EU, and 34% non-EU
- There are currently 35 hospitals that train interns in Ireland. There are 534 approved posts but only 499 are currently occupied
- The ratio of interns to hospital beds ranges from 321:1 to 11:1. This indicates the capacity a hospital may have to accommodate more interns
- Each of the 35 hospitals has an Intern Tutor, however only 22 of them have dedicated sessions to fulfil this role
- There are 253 intern rotations in medicine of which 1.6% are in the new specialities. There are 246 intern rotations in surgery of which 7.7% are in new specialities
- There are 19 posts in total in the new specialities that represent a mere 4.6% of all rotations.

## Appendix 2: Core Competencies

### Clinical Topics

The following clinical topics are those most often seen on a day-to-day basis by all medical and surgical interns and are to be included in the intern teaching programme.

Interns must be competent in the **investigation, diagnosis** and **management** of the following clinical topics:-

- Ischaemic heart disease
- Asthma
- Chronic Obstructive Airways Disease / Chronic Obstructive Pulmonary Disease
- Diabetes Mellitus
- Liver disease
- Dementia
- Cancers
- Renal disease
- Stroke
- Arthritis
- Breast lumps
- Colorectal disease
- Thyroid disease
- Peripheral vascular disease
- Prostate disease
- Deep Vein Thrombosis and Pulmonary Embolism
- Fluid balance and acid-base disturbance
- Chronic pain
- Congenital conditions
- Shock

## Common Emergencies

While on duty and especially while on call at night and weekends interns will be expected to deal with common surgical and medical emergencies. It is of vital importance that the intern is capable of recognising a critically ill patient based on vital sign abnormalities. While other members of their team will support them initially, interns are required to be **competent** in the **investigation and management** of common emergencies by the end of the year. The more frequently encountered emergencies such as chest pain, acute dyspnoea, post-operative complications and acute urinary retention should be taught early in the education programme year. Common emergencies include:-

### Common Medical Emergencies

- Chest pain
- Tachycardia
- Acute dyspnoea / acute respiratory failure
- Acute confusion
- Diabetic emergencies
- Acute renal failure
- Acute liver failure
- Collapse
- Sepsis
- Meningitis
- Fits
- Oncological emergencies

### Common Surgical Emergencies

- Acute gastro-intestinal bleeding
- Acute abdomen
- Acutely ischaemic leg
- Post-operative pyrexia
- Post-operative bleeding
- Post-operative oliguria
- Other post-operative complications including pain, Deep Vein Thrombosis/Pulmonary Embolism, vomiting
- Acute urinary retention
- Compartment syndrome
- Septic arthritis / hot joints
- Burns
- Primary survey of the trauma patient and resuscitation
- Secondary survey of the trauma patient and transfer

## Patient Investigations and Examination

Much criticism is levelled at interns for their high diagnostic costs due to unnecessary tests and procedures. Although many interns are proficient in history taking and diagnosis following undergraduate training they must develop patient management skills and become **competent** in the **requesting and interpretation** of common investigations.

Interns must be competent in the interpretation of the following common investigations:-

- Chest X-ray, Anteroposterior and Lateral
- Electrocardiogram
- Arterial Blood Gas
- Blood tests (FBC/U+E/LFT/TFT/coagulation screen)
- Culture and sensitivity of clinical specimens (urine, blood, cerebrospinal fluid, swabs)

To be able to conduct examinations of:-

- The thorax / respiratory system
- The cardiovascular system
- The abdomen / gastrointestinal system
- The central nervous system
- The peripheral nervous system
- The peripheral vascular system
- The spine
- The limbs
- The patient's mental state

## Technical Skills

There are technical skills that must be accomplished to assist interns with the management of patient care. Interns must be able to **perform competently** the following technical skills:-

- Certify death
- Write a drug prescription
- Write a discharge summary
- Nutrition prescription
- Appropriate use of antibiotics / antibiotic prescription

- Referring to specialist services (physiotherapy, occupational therapy, etc)
- Referring to palliative care
- Referring to psychiatry services
- Referring to the anaesthetic / pain management services
- Incident reporting
- Medline searching
- Critical appraisal

### **Practical Procedures**

Practical procedures are those skills required to provide optimal care to patients. They vary depending on speciality and the expected competency level of the healthcare practitioner. The generic competencies that are required by the end of the intern year are specified below. Several of the compulsory procedures may only be performed on the ACLS course and should be recorded as such. These procedures are marked with an \*.

Interns will be required to perform various procedures throughout the year, which will be recorded and signed off in their logbooks. However they must have the technical ability to **perform competently** the following generic procedural skills:-

Compulsory Practical Procedures (In appendix 1 of logbook)

- Basic Life Support
- Peripheral intravenous cannulation
- Phlebotomy
- Arterial blood gas sampling
- Electrocardiogram
- Urinary catheterisation
- Blood cultures
- Intramuscular injections
- Draw up and administer intravenous drugs
- Nasogastric tube insertion – wide and narrow bore
- Peak expiratory flow
- Apply a neck collar
- Hand washing
- Rectal examination
- Lifting patients
- Inhaler technique assessment
- Removal of sutures

- 
- Remove central line
  - Blood pressure measurement using sphygmomanometer
  - Erect a drip
  - Scrubbing and gowning for theatre
  - Donning of sterile gloves
  - Use of a face mask and bag valve ventilation \*
  - Oropharyngeal airway \*
  - Nasopharyngeal airway \*
  - Endotracheal intubation \*
  - Defibrillation \*

Interns may also acquire various additional practical skills that are specific to the rotation discipline they choose.

Other Practical Procedures include:- (in appendix 2 of logbook)

- Long line insertion / removal
- Femoral line insertion / removal
- Central line insertion / removal
- Suprapubic catheterisation
- Nasal packing
- Suture insertion / removal
- Skin clip insertion / removal
- Application of Continuous Positive Airways Pressure / Bilevel Positive Airways Pressure
- Pleural aspiration
- Pneumothorax aspiration
- Chest drain insertion / removal
- Peritoneal tap
- Seroma aspiration
- Joint aspiration
- Joint injection
- Lumbar puncture
- Electrical cardioversion
- Exercise stress test
- Adrenocorticotrophic hormone stimulation test
- Glucose tolerance test
- Pituitary function test
- Backslab application
- Plaster of Paris application / splitting
- Thomas splint application
- Skin traction application

- Punch skin biopsy
- Core / trucut biopsy
- Proctoscopy
- Bone marrow biopsy
- Mantoux test
- Wound inspection
- Ankle / brachial index

### **Personal and Professional Development**

As the intern year is the first year of postgraduate training and many interns are unsure of the speciality they wish to pursue, it is important that personal and professional development issues are addressed in the curriculum and training programmes.

Clear guidance should be given in personal development issues such as:-

- Manage time
- Stress management
- CV writing
- Form filling
- Work in a team
- Career guidance
- Clinical research
- Cultural diversity
- Interview skills

Interns must become proficient in or have an understanding of the following:-

- Bereavement counselling
- Critical appraisal
- Clinical guidelines
- Introduction to epidemiology
- Infection control
- Health promotion
- Disease prevention
- Preparation for registration
- Clinical audit
- Substance abuse
- Feedback session (including giving out feedback forms)

## Communication Skills

One of the most important skills an intern must learn and develop as a doctor is good communication skills. It is core to the profession and ensures clarity and understanding between interns, patients and colleagues. Effective communication is essential for developing trust, confidence and successful relationships. Communicating with people from various ethnic, cultural or religious backgrounds, or who speak different languages, is a growing fact of life, and interns must learn how to address these issues.

It should never be forgotten that the patient's care and wellbeing is of primary consideration. Interns are interacting with patients and relatives at a time of anxiety and vulnerability, and should therefore be treated in a non-threatening or non-judgemental manner. Ultimately patients must be treated with care, respect and dignity at all times.

Ability to:-

- Communicate proposed plan of care to a patient
- Communicate proposed plan of care to relatives with consent of patient
- Clearly explain illness, investigation and treatment to patients of all ages
- Provide comprehensive information to patients on different treatment options
- Involve patients in decisions about themselves
- Obtain informed consent – on procedures you are fully competent with
- Learn how to listen and interpret information
- Deal with difficult situations such as rambling, reticence, crying, hostility
- Discussing sensitive issues tactfully such as sexuality, habits, addiction and dysfunctions
- Develop competency in breaking bad news compassionately
- Communicate good health practices and disease prevention to patients
- Develop effective and appropriate oral communication with patients, relatives, other healthcare professionals; ensuring effective feedback
- Develop clear, effective written communications

Be conscious of:-

- Age of patient
- Illness of patient
- Intellectual level and comprehension ability of patient / relative
- Potential language difficulties
- Cultural, ethnic, religious differences

## Legal and Ethical Competencies

Interns must become aware of the legal and ethical issue associated with medicine. The doctor-patient relationship is based on ethical and legal principles, which describe the quality of the relationship and the obligations and restrictions inherent to it. Interns may need to seek advice about specific legal or ethical dilemmas, and should recognise the circumstances when it is appropriate for advice to be sought.

Interns receive information from and regarding patients, and are legally bound not to disclose such confidences (even after death). However a patient's right to confidentiality may be waived due to legal obligations, such as disclosure to public authorities. Interns need to advise patients of this obligatory disclosure and should address these matters to their superiors.

- Ethical dilemmas faced by interns may be matters of social interest, religious beliefs and community controversy: interns must seek input and guidance on such matters from their superiors
- The informed patient's right to refuse treatment must be respected, even when it may seem medically unwise
- Interns must be aware of the risks of legal and disciplinary action if they fail to achieve the necessary standards of practice and care
- Interns should be aware of the professional conduct expected of them, and should recognise their responsibilities if a colleague demonstrates unprofessional conduct
- Assess the capacity of a patient to give consent or refuse treatment
- Patients hold certain fundamental human and legal rights and interns are required to respect and uphold these.

The laws of society regulate many aspects of human conduct, including medical practice and while always evolving, the laws seek to articulate universal standards. Interns should become aware of the existence of statutes, regulation, by-laws and rulings, which are applicable in various ways to the practice of medicine.

- Interns are to become acquainted with
  - A Guide to Ethical Conduct and Behaviour - Medical Council
  - Data Protection Act
  - Freedom of Information Act
  - Medical Practitioners' Act
  - Mental Health Act
  - Child Protection Act
  - Dignity at Work Policy
- Understanding regarding mandatory informed consent requirement for all medical investigations and treatment
- Knowledge of statutory notifiable infectious diseases
- Knowledge of certification procedures e.g. sick notes, death certificates etc.
- Knowledge of reports to coroner

## **References**

- (1) Paul Finucane and Tom O'Dowd, Working and Training as an intern: A National Survey of Irish Interns, Medical Council (Irl)
- (2) Hanly Report, Reporting on the National Task Force of Medical Staffing, June 2003