

## Quick Start guide to the 2010 Gastroenterology curriculum

The following information is a brief introduction to the 2010 Gastroenterology curriculum which will apply to all trainees beginning on or after 1<sup>st</sup> August 2010.

### 1. Why has the curriculum been re-written

The JRCPTB are required to revise specialty curricula every 3 years in order to keep the curriculum up-to-date with standards set by the Regulator, medical advances, changes in the service and training. All of the specialty curricula under the auspices of the JRCPTB have been rewritten for 2010 to meet the six new PMETB standards as detailed in their '*Standards for curricula and assessment*', to incorporate the framework documents produced by the Academy of Medical Royal Colleges (AoMRC) detailing Common, Medical Leadership and Health Inequality competencies, and to include 5 new assessment methods (Acute Care Assessment Tool, Case based Discussion, Patient Survey, Teaching Observation and Audit Assessment).

### 2. What does the curriculum tell you?

The curriculum defines

- the competencies needed and the assessment strategy for the award of a certificate of completion of training (CCT or CESR (CP)) in Gastroenterology
- the process of training including entry requirements and criteria for annual progression for the award of a certificate of completion of training (CCT) in Gastroenterology

### 3. Who does the curriculum benefit and how should they use it?

- **Trainees** will be able to develop their personal development plans and chart their progress through training, ensuring they are gaining the appropriate experiences and continuing to develop towards a CCT. This contributes to appraisal, self-assessment, self-directed learning and educational meetings.
- **Trainers** will be able to ensure their trainees are developing in the correct areas and ensure their teaching covers the right areas. It will also help them complete their end of post review.
- **Training Programme Directors** will be able to ensure local teaching programmes map to the curriculum.
- **Patients/ Lay people** will be able to see what their specialists have to achieve during in their training.

### 4. How can you use the curriculum and its lay out?

The lay out of the curriculum has been designed with the aim of making it a more user-friendly reference guide for both trainers and trainees. The same familiar titles from previous versions have been used such as rationale, content of learning, assessment, and supervision and feedback. However the new curricula have been structured in a more logical order which details the trainees training pathway from enrolling with the specialty to the components of the training programme, the teaching and learning methods they will experience and the methods by which they will be assessed. The more detailed contents page and use of sub-sections should also help the trainer and the trainee to navigate around the document.

The layout of the syllabus grids has also been redesigned so that each competency is now mapped to:

- Possible assessment methods: It is important to note that not all competencies have to be assessed and that where they are assessed, not every method will be used.
- One or more of the domains of Good Medical Practice: These domains are listed in section 3.2 of the curriculum.

#### 5. Major Changes since the 2007 curriculum

- The previously known 'Generic curriculum' has been revised by the Academy of Medical Royal Colleges and is now embedded into the content of learning as common competencies.
- There is a more explicit requirement to develop leadership skills (personal qualities, setting direction, improving services, managing services and working with others) - these have been incorporated into the knowledge, skills and behaviours relating to specific sections of the syllabus where appropriate.
- There is a clearer acknowledgement of the importance of the recognition of existing health inequalities - these have been incorporated into the knowledge, skills and behaviours relating to specific sections of the syllabus where appropriate.
- The importance of the principles of the GMC's Good Medical Practice have been recognised and incorporated in line with the new formulation as four domains: knowledge, skills and performance; safety and quality; communication, partnership and teamwork; maintaining Trust.
- The assessment system has been updated.
- The assessment 'blueprint' has been embedded within the clinical syllabus.
- Details of the structure and function of the new assessment methods have been included CBD - Case Based Discussions, ACAT - Acute Care Assessment Tool, PS - Patient Survey, DOPS - Direct Observation of Procedural Skills, AA - Audit Assessment and TO - Teaching Observation.
- The ARCP decision grid has been updated to include the new assessment methods.

#### 6 The major changes in the Gastroenterology syllabus for 2010 compared to that of 2007 are:

##### Core Curriculum:

- New section on basic and applied sciences (including genetics, epidemiology, immunology, oncology and radiology)
- Major expansion of hepatology syllabus
- Enlarged nutrition syllabus
- Endoscopic training more explicitly related to JAG standards - but only upper gi endoscopy training mandatory.

Expertise in flexible sigmoidoscopy is no longer required for CCT. Although the SAC encourage trainees most strongly to spend a period of time in research, no training

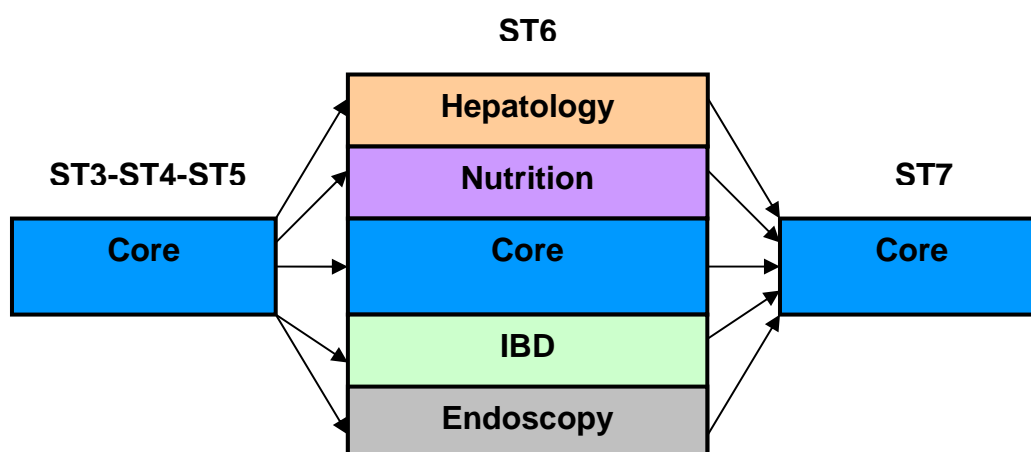
credit can be given *per se* - although training credit may be possible *ad personam* where there is a significant component of clinical training during research time. Most trainees will follow only the core syllabus throughout their training. However, for a selected number, there will be a chance to pursue a concentrated period of more specialised training.

### Subspecialty and Specialist Areas:

Hepatology will continue and indeed will probably expand as a subspecialty. There will be three additional advanced specialist area training modules in:

- Advanced nutrition
- Advanced inflammatory bowel disease
- Advanced endoscopy (ERCP and EUS)

Most gastroenterologists appointed to consultant posts in the UK do practise very broadly and there is no evidence at present that this situation will change. For those wishing to learn subspecialist skills (in liver disease, nutrition, IBD, ERCP/EUS), these modules will be normally followed during the fourth year (ST6) of training.



**Diagram 1.0– Outline of Specialist areas within the 5 year dual CCT training pathway with G(I)M, which a majority of the trainees will undertake.**

Trainees in advanced hepatology will continue to spend a full year of their training in the specialist area as now. In the other three specialist areas, trainees will devote 50% of their time to training in the specialty area and the other 50% to core gastroenterology. No trainee should also be training in GIM during this year. Trainees will gain particular experience in managing patients with complex IBD or complex nutritional needs or will have several sessions in ERCP/EUS each week. The new posts should not be seen as leading to a subspecialty CCT but there will be a real opportunity to gain highly desirable specialist skills. Selection into all these modules will be nationally competitive - the first round of selection will be in early 2013.