

## Quick Start guide to the 2009 Core Medical Training framework

### The 2009 Core Medical Training (CMT) framework

Core Medical Training (CMT) forms the first stage of speciality training for most doctors training in physicianly specialties, i.e. those specialties managed by the Joint Royal College of Physicians Training Board (JRCPTB) [www.jrcptb.org.uk](http://www.jrcptb.org.uk). The approved curriculum for CMT is a sub-set of both the Curriculum for General Internal Medicine (GIM) and the Curriculum for Acute Internal Medicine (AIM). This “Framework for CMT” has been created for the convenience of trainees, supervisors, tutors and programme directors. The body of the document has been extracted from the approved curricula but only includes the syllabus requirements for CMT and not the further requirements for acquiring a CCT in GIM or AIM.

The framework was revised, along with the GIM and AIM curricula, in 2009 in order to meet the six new GMC standards as detailed in their ‘*Standards for curricula and assessment*’, this framework applied to all trainees entering CMT in August 2009 and onwards. Following a period of implementation and feedback from the medical community the JRCPTB have undergone a further review of the framework in order to reflect the current needs of trainers, trainees and the service.

### Changes to the 2009 CMT framework in 2011

The CMT framework document has not changed drastically, however you should note the following changes as these will apply to all trainees entering CMT from August 2011 onwards.

1. It is desirable that trainees should attain **MRCP (UK) Part 1 by month 11 ARCP**. Failure to achieve MRCP(UK) Part 1 by the end of CT1 should lead to an ARCP 2 outcome at the month 11 ARCP even if other aspects of training are satisfactory. The JRCPTB would not recommend an ARCP 3 at this time for exam failure alone. An ARCP 4 outcome would normally be given at the end of CT 2 if the trainee has not yet passed the Part 1 exam.
2. **Outpatient clinics - a minimum of 24 in the 2 year programme.**

There is evidence (noted in the CMT Annual Specialty Report 2010) that CMT StRs are failing to gain experience and skills in clinics. Because of pressures of acute in-patient work, and the difficulties in scheduling attendance at fixed sessions due to shift work, CMT StRs are not routinely scheduled to attend clinics. Some of the skills required in a clinic are not gained during training involving only inpatient care, but these skills are very important for physicians, because a large proportion of physician care is delivered in a clinic setting. Thus there is an uncomfortable transition between CMT where no clinic experience is required, to ST3+ training, where substantial numbers of clinic contacts are defined. It is felt that attendance at an average of 1 clinic per month (12 per CT year, though we have stated for 24 in a 2-year period because some CMT placements cannot deliver clinic experience) will allow StRs to gain, and

maintain, the clinic competences as already defined in the framework. Stating this minimum number explicitly will assist in delivering this experience and training.

3. **The list of procedural competencies has been revised** to clarify at which stage of training each should be achieved. The competencies have also been split into 4 different sections:
  - a) Essential CMT procedures (clinical independence essential):
    - advanced cardiopulmonary resuscitation (inc external pacing)
    - ascitic tap
    - lumbar puncture
    - nasogastric tube placement and checking
    - pleural tap and aspiration
  - b) Essential CMT procedures (clinical independence desirable):
    - central venous cannulation with U/S guidance where appropriate
    - DC cardioversion
    - intercostal drain insertion using Seldinger technique with U/S guidance (excepting pneumothorax)
  - c) CMT desirable procedures
    - abdominal paracentesis
    - knee aspiration
    - skin biopsy
  - d) Foundation competences to be maintained
4. **Introduction of an annualised pass mark** to the PACES examination. Up until 2011 the pass mark for the PACES examination has been set retrospectively after each diet of the examination (three times per year). This has caused a delay for the trainee in receiving the results, which may prevent the trainees from accepting an ST3 offer or delay a further attempt at the exam. Therefore the MRCP(UK) department have moved to a prospective annualised pass mark which will make the issue of results more efficient and allow trainees to plan earlier for retakes if necessary. This will not alter the standard of the examination. This change will apply to all trainees taking the PACES examination from 1<sup>st</sup> January 2012 and onwards.

Please note that all of the above changes will **apply to trainees commencing CMT from August 2011 (except the change to the PACES which will apply from January 2012)**. It is not usually practicable to apply new attainment targets (ie MRCP Part 1, pro-rata attendance at outpatient clinics) half-way through a 2 year training programme. However, these targets remain highly desirable and existing CMT trainees may want to follow these changes.