

# JRCPTB

Joint Royal Colleges of Physicians Training Board

## Cardiology and GIM Training in 2010

### Introduction

The mechanisms for assessing, 'counting' and accrediting GIM training that occurs concomitant with cardiology higher specialty training has changed across the pre-2007, 2007 and 2010 curricula. This memorandum attempts to clarify these issues for TPDs and trainees.

For all trainees, GIM training is an integral part of cardiology training. Core medical training (ST1 and ST2) is the main entry route to cardiology higher specialty training and requires the trainee to acquire competences across many aspects of acute medical presentations. Further GIM training 'at registrar level' is a component of all cardiology curricula. The cardiology trainee undertaking GIM training will remain part of a cardiology firm and outpatient work will normally be confined to work within this firm. It is anticipated, however, that trainees will undertake acute medical takes including the post-take round with consultant physicians on other firms. During this time trainees will undergo cardiology training as well as GIM training. Whichever curriculum cardiology trainees are following (pre-2007, 2007 or 2010), the same basic principles will apply which could be summarised as 'key GIM' which all trainees will do and 'CCT GIM' which only some trainees will undertake. It is also important to remember that progress through, and completion of, all these curricula is now based on acquisition of competences not time spent.

### Acquisition of competences in GIM

#### 'Key GIM'

During core cardiology training (ST3-5) all cardiology trainees will undertake some GIM training. The minimum competences will be those defined in the 2007 GIM (Acute) and the 2009 GIM curricula as the assessment and care of:

- Shocked patient
- Unconscious patient
- Black out/collapse
- Breathlessness
- Chest Pain
- Haematemesis and Melaena; / GI bleeding
- Palpitation
- Medical Problems following surgical procedures; Medical Complications during acute illness and following surgical procedures
- Syncope and pre-syncope
- Confusion Acute/Delirium ; Acute Confusion

Programmes will vary as to the amount of GIM training delivered each year and so it is not possible to be prescriptive as to whether acquisition of these competences can be achieved entirely within ST3 or whether acquisition should be spread over a longer period.

#### **'CCT GIM'**

Those trainees who wish to have the competences necessary to practise at consultant level as a 'general physician in charge of an acute medical take' will need either dual CCT cardiology + GIM or CCT cardiology + GIM level 2 accreditation. This will require the acquisition of the full range of competences across the GIM spectrum as defined in the 2007 and 2009 GIM curricula, i.e. emergency 4 and top 20 presentations plus defined competences in at least 20 of the other presentations etc. It is envisaged that this will usually occur alongside ongoing advanced modules of cardiology training as part of a cardiology firm in ST6 and/or ST7.

### **Accreditation**

#### **Pre-2007**

Trainees following the pre-2007 curricula who wish to undertake 'CCT GIM' will acquire a dual CCT in Cardiology and GIM if they satisfactorily complete the necessary two years of 'high intensity GIM' alongside cardiology training with both cardiology and GIM PYAs.

#### **2007**

Trainees following the 2007 curricula who wish to undertake 'CCT GIM' will acquire a CCT in Cardiology and a level 2 accreditation in GIM if they acquire the wide range of GIM (Acute) competences as defined in the 2007 GIM (Acute) curriculum. If there are any trainees who believe that they have gained enough GIM competences during ST3 -ST5 to obtain the GIM credential, we would recommend a GIM PYA at this stage. If, as expected, there has been insufficient training so far, then further GIM training will be required during ST6 -ST7 with 2 modules of advanced training in GIM (the two modules for GIM would displace two modules of advanced cardiology). Assessment of cardiology training will require a cardiology PYA against the 2007 curriculum.

Alternatively, trainees following the 2007 curriculum who wish to undertake 'CCT GIM' have the option to transfer from the 2007 GIM (Acute) to the 2009 GIM curriculum in order to be formally eligible for a dual CCT in Cardiology and GIM. We recommend that those trainees who intend to undertake GIM duties as a consultant should transfer to the 2009 GIM curriculum to obtain a dual CCT because this makes their qualification readily recognised outside the UK. Satisfactory completion of the GIM curriculum similarly requires acquisition of competences across the board and a sign off via a GIM PYA. Such trainees are likely to require 2 modules of advanced training in GIM in ST6 and ST7. Assessment of cardiology training will require a cardiology PYA against the 2007 curriculum.

For trainees who intend to only do the 'key GIM' necessary for a cardiology CCT, i.e. those who will undertake only cardiology advanced modules, there is no need to transfer to the 2009 GIM curriculum.

A helpful 'transfer ARCP' process has been agreed whereby a trainee's existing GIM (Acute) competences and experience can be translated into the terms used in the 2009 GIM curriculum. Assessment by the GIM SAC at transition for 2007-9 trainees

plus GIM ARCPs from 2010 onwards will have to be put alongside a GIM PYA to determine if the requirements of GIM CCT will have been met by the end of ST7.

A major difference between the 2007 GIM (Acute) and the 2009 GIM curriculum is the log book.

### **Achieving patient numbers in GIM**

There have been different interpretations of what counts as a 'GIM in-patient', 'GIM out-patient' and 'GIM acute admission'. The GIM SAC has indicated that cardiology StRs can record patients seen as referrals from other specialties as part of a cardiologist's ward-round as fulfilling the criteria for contributing to "at least three years of experience undertaking in-patient ward rounds that must include patients with multi-system disease based in a variety of different specialties".

Similarly "management of [GIM] outpatients can be obtained in specialist clinics" hence general cardiology clinics should suffice to provide the indicative number of 450 new patients and 1500 follow up patients.

In the same way, the indicative number of approximately 1000 patients admitted on the general medical "take" could include patients admitted as part of general cardiology emergency admissions. In counting patients within each of these groups it is anticipated that patients with 'pure' cardiological problems would not be counted but it is recognised that the majority of patients do have co-morbidities.

### **2010**

Trainees following the 2010 cardiology curriculum will acquire a dual CCT cardiology and GIM if, having completed core training, they choose GIM as an advanced module in ST6 or ST7 and fulfill the curricula objectives as laid out in the 2009 GIM curriculum. Their cardiology training will require a cardiology PYA against the 2010 cardiology curriculum.

Dr J A Hall  
Chair  
SAC in Cardiology

Dr I A Barrison  
Chair  
SAC in General Internal Medicine

August 2010