

# JRCPTB

JOINT ROYAL COLLEGES OF PHYSICIANS' TRAINING BOARD  
5 St Andrew's Place, Regent's Park, London NW1 4LB

## General (Internal) Medicine Regulations and Requirements

This document must be read in conjunction with the G(I)M SpR curriculum which can be found on the JRCPTB website under Specialties/General (Internal) Medicine.

Training for a CCT in General (Internal) Medicine (G(I)M) requires a minimum of 5 years under European Directives. When combined with training in a specialty the minimum training period is still 5 years (6 years for Cardiology and G(I)M) as agreement has been reached to allow the UK to 'double count' certain periods/types of training.

The following document explains how the current regulations for training in the specialty of General Internal Medicine are viewed. What can, and what cannot, be counted, where there are exceptions and a brief explanation of G(I)M at the 'higher' and 'lower' levels.

Many Consultants and SpRs will be aware that there is an ongoing review of how and what training in G(I)M should be and what it should cover. These regulations and requirements are for the current curriculum. Any formal changes to the training will be publicised in the future.

The curriculum for General Internal Medicine is a separate document, also available on the website, and both documents should be read together.

Any comments on these Regulations should be sent to [hmt@rcplondon.ac.uk](mailto:hmt@rcplondon.ac.uk) for the attention of the JCHMT G(I)M Specialty Co-ordinator.

### *Section 1: ENTRY REQUIREMENTS*

The entry requirements for Higher Medical Training (HMT) include satisfactory completion of General Professional Training (GPT) and also a postgraduate diploma which is usually the MRCP (UK) or MRCP (I).

#### **1a) Definition of GPT**

A minimum of 2 years in approved posts, usually at SHO level, with direct involvement in patient care and offering a wide range of experience in a variety of specialties. 18 months of the 2 years must be spent in posts providing clinical experience in the admission and early follow-up of acute emergencies with at least 6 months spent on a service or services for which emergency take is "unselected".

**Unselected "take"** is defined as acute medical intake encompassing the broad generality of medicine i.e. not restricted to any single group of specialties. If any major component of acute medicine (e.g. cerebrovascular accidents, myocardial infarctions) is excluded from the take, this experience must be obtained in other posts. During the period on "unselected take" trainees have on-call commitment which averages no less than 4 takes per month, (each period of take must involve admission of an average minimum of 10 patients).

Physicians in training are encouraged to gain wide experience in as many sub specialties as possible. Thus some posts which did not include the acute admission of emergencies would be acceptable for inclusion in GPT for up to 6 months but should always involve patient

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contact and not be laboratory based. It would be unusual for more than six months in a single medical subspecialty to count towards GPT if there was no G(I)M component.

### 1b) Verification of GPT

Applicants for Higher Medical Training will be asked to produce evidence of satisfactory completion of training posts. The information required is: dates, hospital, specialty, emergency component, supervisor and hospital address.

Prior to interview for a HMT post, each applicant should produce a form indicating satisfactory completion of the above posts signed by the Educational Supervisor or College Tutor or Clinical Tutor.

If the trainee has not done a rotation but has completed GPT by a series of stand-alone posts then verification will be needed for each individual post in the same format. For trainees from outside the UK the same documentary evidence allowing verification of GPT will be sought.

### 1c) MRCP equivalence

The following overseas qualifications are currently recognised as equivalent to the MRCP for entry to Higher Medical Training.

American Boards of Internal Medicine

FRACP Part I

FCPS Pakistan

MHKCP

FCP (SA)

M Med Singapore

MD Colombo

M Med Malaysia

FRCP (Canada)

A CCT in G(I)M from an EEA country (currently comprising EU states plus Austria, Finland, Iceland, Liechtenstein, Norway, Sweden)

A postgraduate G(I)M exam passed in an EU country after completion of a GPT programme may be recognised as MRCP equivalent.

The Federation of Royal Colleges of Physicians will only accept other diplomas as equivalent in exceptional circumstances. Trainees would be unwise to assume that their diploma is equivalent and should obtain the MRCP (UK) if they wish to train in the UK.

A maximum of 2 years GPT can be carried forward and can thus count towards the acquisition of the Certificate of Completion of Specialist Training (CCT) in G(I)M.

### ***Section 2: DURATION AND ORGANISATION OF TRAINING***

The duration of Specialist Medical Training in G(I)M is five years including GPT. Those seeking dual certification with another specialty will also need to fulfil the requirements of that specialty. Their programme will be extended to a minimum of 7 years (2 years GPT + 5 years HMT which include the specialty and 3 more years G(I)M).

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HMT will provide experience both in District General Hospitals (DGHs) and in teaching hospitals or other major centres with academic activity. Particular emphasis is put on the acquisition of practical skills which may be needed in the management of medical emergencies.

The majority of trainees enter a programme which combines G(I)M with a specialty.

### 2a) Dual CCT - first year

The first year will normally be in a DGH. The trainee will normally be expected to be on-call, on site and immediately available for at least 4 takes per month for acute unselected medical intake. (See "Acute emergency 'take' responsibilities, G(I)M at the higher level"). The trainee should also undertake at least one outpatient clinic per week which must include a proportion of general medical patients and the ward follow-up clinic. (See "Ongoing/chronic care, outpatient responsibilities"). This training may be undertaken on a firm or team which practices the trainee's intended main specialty or any other medical specialty. At the end of the year the trainee will have completed 3 years G(I)M, including the two years in GPT. Whilst the expectation is that the majority of trainees will spend the first year of HMT in this way, it is not an absolute requirement. There may be circumstances in which this year of G(I)M could come later in the programme.

### 2b) Dual CCT - later years

The trainee should complete the remainder of HMT in the chosen specialty, usually a further four years. During at least 2 of these years, dual training in G(I)M and the other specialty must take place in order to complete the minimum five years specialist training in G(I)M. Provided that such training has relevance to both specialties, it can count towards both CCTs. The overlapping training must include a commitment to acute unselected medical intake with responsibility for the continuing care of patients admitted as emergencies. If the trainee is not involved in the care of patients admitted to a CCU a secondment to such a unit must be arranged. (See "CCU experience"). Experience in managing the acutely ill patient is essential (see "ITU or HDU experience".)

This dual training period would normally take place in a period of 2 years towards the end of HMT but can be spread over the entire period providing the minimum requirements for G(I)M training at "low intensity" are met (see "Emergency Medicine, Acute Emergency 'take' Responsibilities, G(I)M at the lower level"). The trainee need not necessarily be resident for training purposes during the later years, although he/she must have personal 'hands-on' involvement in the acute care of at least ten patients per 'take'. Service commitments may require residence or more frequent take.

### 2c) Geriatric Medicine

Up to one year of the training in G(I)M may be in suitable posts in Geriatric Medicine where an age-related admission policy applies. Such posts must provide experience of acute medical 'take' of patients unselected other than by age. Units where acute G(I)M and Geriatric Medicine are integrated are fully acceptable for G(I)M training. It is expected that the trainee would be responsible for the emergency care of at least 30 patients per month. It is important that these trainees undertake outpatient clinics encompassing adult patients of all ages over two years of their training.

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### 2d) Cardiology and Nephrology

In certain circumstances up to one year of G(I)M training may be in an approved post in Nephrology or Cardiology, provided that the SAC is satisfied that the training includes emergency care which is relevant to G(I)M and provided that the remaining training in G(I)M includes unselected Medical intake at the higher level (at least 4 'takes' per month).

### 2e) Training in 'Pure' General (Internal) Medicine

In the case of trainees planning dual CCT in G(I)M and specialties other than Cardiology or Nephrology, if it is not possible to organise training in G(I)M over three years, it would be acceptable to replace two years of lower intensity G(I)M later in the programme with one year of 'pure' G(I)M and one year of pure subspecialty. The year of pure subspecialty should include emergency admissions for the subspecialty. The year of 'pure' G(I)M should include no more than two sessions per week of the trainee's own subspecialty (including research). This period of training could usefully take place in a DGH setting.

### 2f) Training for the Emergency Medical Physician

Physicians who may be considering taking a leading role in an acute medical receiving unit may wish more extensive experience of acute medicine. For these individuals it is suggested that the training programme should be modified. This may include an attachment to an acute receiving unit, experience in an intensive care or high dependency unit as well as practical education that may be useful in the assessment of acutely unwell patients. Such more intense experience may occur at anytime during the training programme including the first year of training. It is the Medical Royal Colleges recommendation that such individuals should be dually trained in G(I)M and a subspecialty.

### 2g) Single CCT in G(I)M

Specialist training in G(I)M alone is a perfectly acceptable option. It may be attractive to academics who wish to combine their general medical practice with a particular research interest rather than with practice in another specialty. The training of such doctors can be completed in five years, including two years of GPT, but the overall training requirements for the award of a CCT in G(I)M are the same as for those seeking dual certification, and involve all the components in years four and five of a joint programme. As for the other single specialty programmes, G(I)M alone programmes will have to be clearly defined. It is expected that they will include an intensive care medicine component.

## *Section 3: SUPERVISION, APPRAISAL AND ASSESSMENT*

### 3a) The Educational Supervisor

The programme to which the trainee is appointed will have named Educational Supervisors who will be on the Specialist register in G(I)M and be actively involved in G(I)M clinical duties. One consultant within the same region will act as Programme Director to the trainee. The Educational Supervisor may not be the overall Programme Director. A single G(I)M trainer may supervise several trainees dependent upon local circumstances and needs. It is recommended that each hospital has a Training Co-ordinator responsible for all trainees in G(I)M. (See Curriculum, Role of Educational Supervisor).

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### 3b) Record of Training

A training record will be issued to each trainee after their enrolment with JCHMT and maintained by each trainee. The record has been produced by the SAC for G(I)M in consultation with the JCHMT. The record will contain the outcome of Appraisals and Assessments during training and a summary of both the practical procedures carried out and the general professional experience acquired as outlined above. It must be counter-signed by the Educational Supervisors. It will remain the property of the trainee and must be produced at all annual assessments.

### 3c) Assessment and Appraisal

There will be regular review of progress using the training record. The trainee will meet with the trainer/educational supervisor three times during each year of the G(I)M training programme i.e. once at the beginning of the year to set targets and at 3 months and 9 months for an appraisal to discuss progress.

The 3-month appraisal in year 1 will be to ensure that the trainee is familiar with the G(I)M curriculum document and the requirement of the training programme. It is essential at this meeting that possible problems with the programme e.g. availability of general medical referrals in outpatients, 'on take' rotas etc., are identified and steps taken to deal with these as early as possible.

The 9-month appraisal in year 1 will be to review progress and particularly to identify areas of poor progress and/or requirements for additional periods of training e.g. secondment to CCU or ITU. In addition, at this meeting plans should be made for training requirements during the subsequent years to complete the needs of the G(I)M curriculum.

At the end of each year there will be a more formal assessment (RITA) during which the trainee's appraisals and progress will be reviewed and the relevant deanery RITA forms completed and copied to the JCHMT.

The full requirements of the annual RITA exercise, as described in the JCHMT handbook, will be met. In programmes leading to dual certification the annual assessment in G(I)M and the specialty will be combined. The annual assessment in the penultimate year (PYA), to which particular importance attaches, will review the whole training period to date. Separate PYAs will be held for G(I)M and for the trainee's other specialty. The award of the CCT will be based on satisfactory completion of the entire series of annual assessments.

### 3d) Research

Periods of full-time research will not be permitted to count towards the requirements for G(I)M although they may do so in the other specialty in the case of joint programmes. All periods of research require prospective approval of the Regional Postgraduate Dean and Specialty SAC by the trainee completing the Out of Programme Experience Form in their training record. Those opting for G(I)M as a single training programme can apply for non-accredited time out for research whilst retaining their National Training Number (NTN). For those undertaking an extended period of research after entering a programme and obtaining their NTN, a limited amount of additional educational credit may be granted at the discretion of the SAC for clinical work undertaken in the course of research beyond the initial year. Reference should be made to the JCHMT Handbook for full details.

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### 3e) Flexible Training

Trainees who are unable to work full-time are entitled to opt for flexible training programmes. EC Directive 93/16/EEC requires that:

- i. Part-time training shall meet the same requirements as full-time training, from which it will differ only in the possibility of limiting participation in medical activities to a period of at least half of that provided for full-time trainees;
- ii. The competent authorities shall ensure that the total duration and quality of part-time training of specialists are equivalent to those of full-time trainees

Flexible trainees should undertake a pro rata share of the out of hours duties (including on-call and other out of hours commitments) required of their full-time colleagues in the same programme. As is the case for full-time trainees, a period "on take" may be less than 24 hours, provided an average of at least 10 patients are admitted per "take". For flexible trainees, there should be flexibility as to when in the training and how the trainee undertakes this on-call. The requirements are that by the end of HMT the total number of "takes" should be equivalent to those of a full-time trainee and that a proportion of the "takes" should be undertaken in the last two years of training. Further guidance may be obtained from the JCHMT office.

It should be noted that as GPT counts towards the minimum five years training for a CCT in G(I)M, the above rules also apply to flexible SHO posts which are to contribute to G(I)M higher training. For details of appointment and funding arrangements for flexible trainees, please see the revised 'Guide to Specialist Registrar Training' (February 1998).

### *Section 4: TRAINING IN G(I)M*

Training in G(I)M should be considered under the following headings: -

#### *EMERGENCY MEDICINE*

##### 4a) Acute Medicine experience

###### i) Throughout training in General Medicine

Extensive experience in acute 'unselected' take is an essential part of training in G(I)M. There are several different patterns of organising acute take and it is strongly recommended that trainees gain exposure to more than one receiving system. (For definition of 'unselected take', see Section 1 a)

The trainee must have personal 'hands-on' involvement in the acute care of at least 10 patients per 'take.' Involvement in post-receiving rounds without active input to patient care during the take period does not count as a training experience. When 'on call', other service commitments must not be undertaken except under exceptional circumstances so that the trainee can concentrate their efforts on this crucial training and service area. There must be evidence of direct supervision of the activity of the more junior members of the 'on-take' team.

The Specialist Registrar Supervising Acute Take. All medical patients admitted acutely should be seen and assessed within 24 hours by a senior physician who will usually be a consultant. Prior to being awarded a CCT a trainee should have had the opportunity to carry out post take ward rounds without the immediate supervision by a consultant.

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However, a consultant must be available on site for advice and remain responsible for the patient. The SpR must previously have been demonstrated to have been competent. The SAC would recommend that SpRs in their last year of G(I)M training are shadowed over a series of post take ward rounds by a training consultant, being allowed staged increases in responsibility, until they can be "signed off" as competent to deliver the service without immediate supervision.

In addition the trainee will be expected to have responsibility for on-going care. A minimum commitment of a personal 'post-take' ward round and continuing care of at least 10 general medical patients (see "Ongoing/chronic care, inpatient responsibilities") is required.

### ii) G(I)M at the 'higher' level

During G(I)M training in the early part of HMT (normally year 1 in the DGH environment) the trainee will be required to undertake a minimum commitment of 4 takes per month of acute unselected emergency intake responsibilities. The trainee must be on site and immediately available and in the early part of training. An attachment of up to six months to a medical admissions ward or medical assessment unit can count as G(I)M at the higher level.

### iii) G(I)M at the 'lower' level

During G(I)M training towards the end of HMT, which will usually be years 4-5 when dual training in the desired specialty is also occurring, 'on-take' commitment is required to be a minimum of 2 takes per month on average. When on 'take' the trainee must be immediately available to supervise the more junior medical staff.

### iv) Continuous G(I)M

In dual CCT programmes where G(I)M experience is spread evenly over the entire period of HMT, 'on-take' commitment should be no less than 2 takes per month on average.

### v) Minimum v. Desirable G(I)M Experience

It can be seen that the minimum acceptable G(I)M training is one year of G(I)M at the higher level and two years G(I)M at the lower level. Many trainees and educational supervisors will consider that this is insufficient to develop all the skills required and described in the syllabus. The amount of G(I)M experience necessary for each trainee will be based on individual circumstances. The SAC will not accept the training of an individual who has not fulfilled the minimum and will expect many trainees to have more than the minimum G(I)M exposure.

### 4b) CCU experience

This is considered an essential part of acute G(I)M training. Normally this is part of the on-call responsibility and preferably the trainee should have first line responsibility for admissions to CCU. The minimum requirement however is that for one year of HMT the trainee must have at least shared care of patients admitted with acute coronary syndromes and should have first line responsibility for all other acute cardiovascular problems. This may require, for example, joint ward rounds on the CCU between the trainee and the cardiologists. If this is not possible in a particular hospital or training programme then a 4

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to 6 week period of secondment to CCU will be required. The training needs of the trainee with regards to CCU should be assessed at the initial meeting with the Educational Supervisor; progress should be assessed at subsequent meetings.

### 4c) ITU or HDU experience

Some experience in the care of critically ill patients is required. It is not expected that all trainees will have detailed experience of ITU medicine although up to six months in an ITU post will count towards G(I)M training for those who have a particular interest. Experience in the care of the critically ill must be obtained over one year of the training programme and may be achieved in a number of ways:

- by being involved in the care of patients in a high dependency unit
- by being involved in the care of patients in a medical intensive care unit
- by admitting and sharing responsibility for patients admitted to a respiratory intensive care unit.
- A secondment for 4-6 weeks to an ITU should be organised

### 4d) Training experience in Acute Medical Receiving Systems

Rationalisation of hospital services has meant that a number of hospitals no longer have A&E Departments. There are a number of different methods used to receive medical emergencies. Training is enhanced by being exposed to different systems of acute medical care. It would be inappropriate for a G(I)M trainee only to be exposed to acute receiving in a hospital which does not receive 999 calls or self-referred patients. At least one year of the minimum required acute takes during HMT should take place in a system which is unselected, i.e. in a hospital which takes both GP and emergency referrals and patients who present "off the street".

### *ONGOING/CHRONIC CARE*

As well as acute emergency medicine, G(I)M training requires the development of expertise in ongoing care and the management of chronic diseases including preventative and public health medicine and the community aspects of disease.

### 4e) Inpatient responsibilities

The trainee will be expected to have direct supervisory responsibilities for the continuing care of at least 10 general medical inpatients. This will require at least one personal ward round per week and the supervision of junior members (SHO/JHO) of the clinical team at other times. An additional ward round with the consultant each week is also expected.

### 4f) Outpatient responsibilities

The trainee is expected to have personal responsibility for the assessment and review of G(I)M outpatients in at least one consultant-led clinic per week for at least two years of HMT. New patient referrals should be assessed by the trainee independently but access to consultant opinion and supervision as necessary during the clinic is an essential requirement. These cases may be seen as part of a specialist clinic but, as far as possible,

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should retain the 'flavour' of multi-system disorder or generic general medicine. Ward 'follow-ups' are an essential part of G(I)M training particularly for the purposes of ongoing care commitment by the trainee. Some training programmes may use the 'follow-up' clinics as the principal vehicle for G(I)M outpatient experience but this should also normally include exposure to new patient referrals. Where suitable general medical clinics are not available, it would be acceptable for trainees to have a planned rotation through a number of clinics in specialties other than their own.

### *PROCEDURES*

During training the trainee should acquire those practical skills which are needed in the management of medical emergencies, particularly those which occur out of normal working hours. Some exposure to these skills may have occurred during the period of GPT but experience must be consolidated and competencies reviewed during HMT. The procedures with which the trainee must be familiar and show competence in are listed in the syllabus.

### *EDUCATIONAL TRAINING*

For full details please see the Generic Curriculum available at [www.jchmt.org.uk](http://www.jchmt.org.uk)

The trainee is expected to spend at least 2 hours a week, and preferably 4 hours per week, in formal general professional education for certification of training. In the types of experience noted in sections 4g - 4m, time must be fairly distributed between G(I)M and the other specialty in joint specialty programmes.

The SAC expects each Deanery to organise, through its training committees, a regular teaching programme in G(I)M, based upon the G(I)M curriculum (mandatory from August 2003)

This Training Programme should be equivalent to 10 sessions per annum. (one session = a half day or 3.5 hours). Trainees must attend at least 70% of sessions over the whole of the 5 year training programme (a minimum of 35 sessions in total) and a verified attendance record must be placed in the Training Record. For those undertaking G(I)M-only training, every effort should be made to attend the 30 sessions available over the three year programme.

Where attendance at the Deanery programme falls below these levels, credit may be given for attendance at equivalent external G(I)M-related courses such as those run by the Royal College of Physicians, at the discretion of the annual RITA panel.

#### **4g) Management**

All trainees will be required to undergo training in management. This will take the form of day-to-day involvement in the administration of the team or hospital and ideally attendance at a management course at some stage during their training period.

#### **4h) Audit**

Trainees will be expected to be actively involved in audit throughout their training and should have experience of running the unit's audit programme and presenting results of projects at audit meetings. They should also regularly attend other audit activities

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including journal clubs, X-ray conferences, pathology meetings etc. Audit skills are generic and it is acceptable for trainees to gain experience through their subspecialty training.

### 4i) Research

Research experience is considered an essential part of training. The form that this experience takes will vary between programmes. Trainees are encouraged to become involved in the research activity of the unit and may wish to take 'time out' periods for a specific period of research training leading to a higher degree. These 'time out' periods however cannot be counted towards training in G(I)M although this is usually acceptable (up to 1 year) for the other specialties.

### 4j) Study Leave

Trainees are expected to take a significant proportion of their study leave in G(I)M areas.

### 4k) Teaching

Trainees should become involved in the teaching activities of the unit. This may include teaching sessions for medical undergraduates and postgraduates as well as nurses and PAMs. The exact nature and content of these sessions will vary between programmes and units.

### 4l) Presentation and Computing skills

Trainees should show evidence of the development of effective communication skills by taking part in formal case presentations and/or giving lectures/seminars to other staff or research/audit presentations at unit meetings. The general use of computers in medicine and the development of expertise in word processing, database handling and simple statistical packages is required.

### 4m) Advanced Life Support

All trainees are expected to have completed successfully Resuscitation Council (UK) approved training in Advanced Life Support by the time of completion of Higher Medical Training.

Updated July 2003 from July 2002  
Relates to first four paragraphs preceding 4g.