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1 Introduction

Internal Medicine stage 1 will form the first stage of specialty training for most doctors training in physician specialties, i.e. those specialties managed by the Joint Royal College of Physicians Training Board (JRCPTB). Internal Medicine stage 1 may also form the core training programme for other specialties, such as Clinical Oncology. This document only includes the learning outcomes for Internal Medicine Stage 1 and not the further requirements for acquiring a CCT in a physician specialty.

This curriculum defines the purpose, content of learning, process of training and the programme of assessment for the Internal Medicine Stage 1 training.

2 Purpose

2.1 Purpose statement

The Shape of Training (SoT) review was a catalyst for reform of postgraduate training of all doctors to ensure it is more patient focused, more general (especially in the early years) and with more flexibility of career structure. For physician training, the views and recommendations of SoT were similar to those of the Future Hospital Commission and the Francis report. With an ageing population, elderly patients exhibit many co-morbidities and acute medical services need a different approach to training the physician of the future.

This has led to the development and re-design of training in Internal Medicine and the physicianly specialties.

Acting on behalf of the three Royal Colleges of Physicians, the JRCPTB and MRCP(UK) have produced a new model for physician training consisting of a minimum of seven years (dual) training period after the initial two foundation years, leading to a CCT in a specialty and Internal Medicine. The new curriculum has a particular focus on formally demonstrating the General Medical Council’s (GMC) requirements around general professional capabilities (GPCs).

The proposed model of training will:

- Provide patients and the NHS with both the trained generalists and specialists they need (especially in the provision of acute and unscheduled care)
- Deliver better support to trainees and more relevant training
- Strengthen, not lengthen training
- Address the serious issue of rota gaps

The curriculum for stage 1 of Internal Medicine training has been developed with input from trainees, service representatives, lay persons and consultants who are actively involved in delivering teaching and training across the UK. This has been through the work of the Internal Medicine Committee and its subgroups and at regular stakeholder engagement.
events. In addition, a 'proof of concept' study was conducted in 2016 which led to significant changes to the draft curriculum (please see the proof of concept page for the full report).

The new curriculum is based on high level outcomes rather than multiple competencies and the programme of assessment will be more holistic and authentic, continuing the move away from a ‘tick-box’ culture. This curriculum has 14 Competencies in Practice (CiPs) which must be delivered over the usual seven years of training. CiPs are defined as a ‘critical path to professional work that can be identified as a unit to be entrusted to a trainee once efficient competency has been reached’. CiPs emphasise the role of observation and judgement as it occurs in real life.

This model will help to deliver exceptionally trained general physicians with diverse specialist skills to manage the changing needs of our population through:

- Simulation training will offer time and a safe learning environment for all stages of trainees to learn new skills
- Increased exposure to outpatients in a set period of training aims to help trainees focus on this area of learning and reduce inter-hospital variability
- Experience in HDU/ITU will also enable trainees to be exposed to these different areas at an earlier stage
- Training in geriatrics will help equip doctors with the skills required to treat our ageing multi-morbid population
- The third year will focus on a ‘step-up’ role in Acute Medicine as the Medical Registrar which will allow trainees to learn to lead the acute take in a supportive environment.

2.2 Rationale

The Federation of the Royal Colleges of Physicians supports change to meet patient and public needs by training doctors who can

- provide better care to the growing number of people with multiple comorbidities
- provide better care to an ageing population
- recognise and treat acutely unwell patients
- respond appropriately to the increase in patient expectations
- deal with health inequalities appropriately.

There is unanimous agreement that any proposal must have quality of care and patient safety and need as its foundation. The number of older patients with multiple comorbidities faced by increasingly pressurised acute medical services, as well as the challenge of chronic disease management, requires a balanced approach to training if we are to address failings identified by the Francis\(^1\) and other reports.

JRCPTB, on behalf of the Federation of Royal Colleges of Physicians, has produced a model for physician training that consists of a minimum seven year (dual) training period after the initial two foundation years, leading to a CCT in a specialty and Internal Medicine (see

\(^1\) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013
training pathway). This is consistent with the European Standards for Postgraduate Medical Specialist Training (UEMS 2012/29 Internal Medicine) and with current developments in Internal Medicine in Europe. The seven years, starting from completion of foundation training, should consist of three years initial training in internal medicine during which increasing responsibility for the acute medical take would be experienced in year three, and MRCP(UK) would be achieved by the end of this period. After these three years, there would be competitive entry into specialty training (combined with Internal Medicine) for a usual minimum of four years. During this period, an indicative three years will be spent training for the CCT specialty and a further one year of internal medicine will be integrated flexibly within the specialty training to ensure that CCT holders are competent to practice at post-CCT consultant independent level in both their specialty and internal medicine. This further year of internal medicine will facilitate the acquisition and demonstration of the GMC mandated Generic Professional Capabilities (GPCs).

In our response to the Academy of Medical Royal Colleges mapping exercise, we have demonstrated how the model addresses the key recommendations of the Shape of Training review report. Physician specialities have sought to ensure that their training programmes equip their pre-CCT doctors with the knowledge, capability, experience, attitudes and behaviours needed to meet the changing needs of the population. These principles will continue to serve as the foundation for the development of the specialty training content in the coming years.

The model provides an opportunity to enhance the training in internal medicine for all physicians. In particular, it will promote the management of the acutely unwell patient with an increased focus on chronic disease management, comorbidity and complexity in the main specialties supporting acute hospital care. This should be in conjunction with appropriate work force transformation to facilitate increased working and collaboration with non medical healthcare professionals and increased working and collaboration between hospitals and community environments.

None of the work to date neither through the Shape of Training workshops nor the main principles within the Shape of Training report suggested that shortening the duration of training would be desirable. The evidence base, in particular for dual training, does not provide any international model that could shorten training. For example, those comparable countries with dual training such as Australia and Ireland have a minimum of seven year training programmes. Accordingly the programme length for dual training will be a (minimum) seven years after the foundation programme. We do not envisage any enthusiasm or role for single specialty accreditation in Internal Medicine alone. A curriculum for training in General Internal Medicine (GIM) alone as opposed to specialty with GIM was not utilised.

SACs felt that to suggest a reduction in the length of training would have implications for patient safety as it would not be possible to deliver the skills and competences the service currently expects from the trained physician in a shorter time frame. To attempt this would undermine the very principles behind shape of training.

2 Shape of Training: Securing the future of excellent patient care, October 2013
However, trainees do inevitably vary in the speed with which they progress through training and, therefore, where appropriate, we have already introduced a mechanism for accelerated attainment of CCT.

We recognise the implementation of this curriculum will need to accommodate the range of physician specialties and the changing demands of the demographic of the trainee workforce in each specialty. The development of the flexible curriculum in internal medicine aligns with the increasingly flexible approach to workforce development exemplified in the Shape of Caring\(^3\) Review. We believe a flexible approach is necessary to deliver a sustainable model for the training of physicians, agile enough to respond to meet evolving patient need.

The curriculum for physician training will

- ensure trainee physicians can provide safe emergency and acute care during and at the end of their postgraduate training.
- encourage flexibility between specialties through Generic Professional Capabilities (GPCs) and higher level learning outcomes
- build on foundation training by developing the attributes of professionalism and the primacy of patient welfare, which are required for safe and effective care of patients with both acute and long-term conditions.
- provide generic training that ensures that internal medicine doctors develop and demonstrate a range of essential interpersonal and clinical skills for managing patients with both acute and long-term conditions
- provide the opportunity to develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team and to work towards making independent clinical decisions with appropriate support
- provide doctors with a variety of hospital, community and academic workplace experience during their programme. All doctors must have opportunities to build on community experience gained in Foundation training and understand the interface with community care provision
- build on the knowledge, skills and attitudes that were acquired during undergraduate and foundation training
- ensure the flexibility to allow trainees to train in academic medicine alongside their acquisition of clinical and generic competencies.

### 2.3 Development

This curriculum was developed by the Internal Medicine Committee (IMC) and its subgroups under the direction of the Joint Royal Colleges of Physicians Training Board (JRCPTB). The members of the IMC have broad UK representation and include trainees, service representatives, lay persons and consultants who are actively involved in teaching and training.

\(^3\)Shape of Caring: A Review of the Future Education and Training of Registered Nurses and Care Assistants, Health Education England, March 2015
To facilitate consultation and input from the 29 specialties and 3 sub-specialties that we oversee, JRCPTB held meetings with all the chairs of the specialty advisory committees (SACs). In addition the model has been shared widely including: councils of the three colleges and regional advisors, the trainees committees of the three colleges, the medical specialties board based in London, heads of school of medicine and the postgraduate deans. JRCPTB has held a series of consultation events with these stakeholders. In addition, podcasts have been available on YouTube and the JRCPTB website.

2.4 Training Pathway

Internal medicine (IM) stage 1 training is entered following completion of the foundation programme and its purpose is to ensure doctors demonstrate the ability to learn in the workplace and develop their clinical and professional skills in readiness for higher specialty training. Internal Medicine stage 1 forms the initial training programme for the physician specialties and doctors in training must complete further Internal Medicine training alongside specialty training following selection to ST4.

During specialty training, an indicative three years will be spent training for the specialty and a further year of internal medicine will be integrated flexibly within the specialty training programme (some programmes will choose to run this as a separate year whilst others will integrate it within the specialty training). Internal medicine training will include supporting the acute specialty take [IM stage 2 – in specialty] and the acute unselected take [IM stage 2 – acute care].

There are a small number of specialties managed by JRCPTB which will continue to deliver non-acute, primarily outpatient-based services. They may wish to allow recruitment into ST3 posts from IM2. However, they may also recruit from those who have completed the full three year IM programme and there will be no preference in selection to those who have done two or three years of training.

Alternative core training pathways may be accepted for some physician specialties and will be defined in the relevant curricula.

[Add reference to ACCS and BBT training pathways]
The physician training pathway

[Internal Medicine stage 2 training curriculum and revised specialty curricula are under development].

2.5 Flexibility

[To be updated to reflect outcome of GMC Flexibility review and changes to Academy Accreditation of transferrable competencies framework (ATCF). The section below is based on the current arrangements for CMT]

**Accreditation of transferrable competencies**

When moving from one approved training programme to another, a trainee doctor who has gained relevant competences should not have to repeat training already achieved. The Academy of Medical Royal Colleges (AoMRC) Accreditation of Transferable Competences Framework (ATCF) assists trainees in transferring competences achieved in one training programme, where appropriate and valid, to another. This could save time for trainee doctors who decide to change career path after completing a part of one training programme by allowing them to transfer to the most appropriate place in another training programme.

The ATCF applies only to those moving between periods of GMC approved training and is aimed at the early years of training. The time to be recognised within the ATCF is subject to review at the first Annual Review of Competence Progression (ARCP) in the new training programme.
The Internal Medicine stage 1 programme accepts transferable competences from Acute Care Common Stem (ACCS) Anaesthesia [Anaes], ACCS Emergency Medicine [EM] and ACCS Intensive Care Medicine [ICM]. Details of the maximum duration and a mapping of transferrable competences are set out below.

ATCF will only be available to doctors who have successfully completed at least one year of an ACCS [Anaes, EM and ICM] programme and have obtained ARCP outcome 1. The maximum amount of time that can be credited for competences obtained during ACCS [Anaes, EM and ICM] is 12 months towards training in IM Stage 1.

Approval for the previous experience must be agreed by the relevant Internal Medicine stage 1 training programme director on an individual trainee basis, and must be reviewed and confirmed at the first ARCP.

The table below defines which components of other programmes will be recognised for Internal Medicine stage 1.

<table>
<thead>
<tr>
<th>1st CCT Programme</th>
<th>Transferring to</th>
<th>Completed component</th>
<th>Expected counted time</th>
<th>Maximum counted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCS [Anaes] [EM] [ICM]</td>
<td>IM Stage 1</td>
<td>EM, GiM, ICM</td>
<td>6 months GiM 3 months EM 3 months ICM</td>
<td>12 months</td>
</tr>
</tbody>
</table>

2.6 Enrolment with JRCPTB

Trainees are required to register for specialist training with JRCPTB at the start of their Internal Medicine training programme. Further information is available on the JRCPTB website (www.jrcptb.org.uk).

2.7 Duration of training

Internal Medicine Stage 1 training from will usually be completed in three years of full time training. Duration of specialty training and completion of further Internal Medicine training to CCT will vary by specialty. There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of competence to complete training more rapidly that the current indicative time although it is recognised that clinical experience is a fundamental aspect of development as a good physician. It is therefore unlikely that Stage1 IM could be completed in less than 30 months in line with the principles of competency based education. There may also be a small number of trainees who develop more slowly and will require an extension of training in line with normal ARCP and The Gold Guide procedures.

2.8 Less than Full Time Training

Trainees are entitled to opt for less than full time training programmes. Less than full time trainees should undertake a pro rata share of the out-of-hours duties (including on-call and

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4 A Reference Guide for Postgraduate Specialty Training in the UK
other out-of-hours commitments) required of their full-time colleagues in the same programme and at the equivalent stage.

Less than full time trainees should assume that their clinical training will be of a duration pro-rata with the time indicated/recommended, but this should be reviewed in accordance with HEE local teams/deaneries requirements.

3 Content of Learning

The practice of Internal Medicine requires the generic and specialty knowledge, skills and attitudes to manage patients presenting with a wide range of medical symptoms and conditions. It involves particular emphasis on diagnostic reasoning, managing uncertainty, dealing with comorbidities, and recognising when specialty opinion or care is required. This section of the curriculum details the generic and specialty learning outcomes for Internal Medicine Stage 1 with expected levels of performance.

3.1 Generic Professional Capabilities and Good Medical Practice

[This section to be reviewed in light of final Academy/GMC guidance]

The General Medical Council (GMC) has developed the Generic Professional Capabilities (GPC) framework\(^5\) in partnership with the Academy of Medical Royal Colleges (AoMRC) to ensure that doctors in specialty training develop holistically as responsible professionals. In order to complete specialty training satisfactorily each doctor will need to demonstrate that their professional identity is underpinned by appropriate professional values, behaviours, knowledge, insights, skills, capabilities and experience.

Good medical practice (GMP)\(^6\) is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment. The GPC framework is a fundamental requirement of all postgraduate specialty curricula. Additionally the GPCs are a system-wide, regulatory response to recent concerns about patient safety and fitness to practise (FtP) within the medical profession.

The GPC framework describes nine broad domains with associated descriptor outlining the ‘minimum common regulatory requirement’ of performance and professional behaviour for those completing a certificate of completion of training (CCT) or its equivalent. These attributes are common, minimum and generic standards expected of all medical practitioners achieving a CCT or its equivalent.

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\(^5\) Generic Professional Capabilities Framework
\(^6\) Good Medical Practice
The primary purpose of GPCs is to describe the fundamental, career-long, generic capabilities required to develop and maintain key professional behaviours, skills, knowledge and values, described in a common language that can be shared between and across all postgraduate medical specialty curricula.

### 3.2 Generic outcomes

These are the universal requirements of all specialties. Assessment of these generic outcomes will be underpinned by the descriptors in the GPC framework and evidenced against the performance and behaviour expected at that stage of training. Satisfactory sign off will indicate that there are no concerns before the trainee can progress to the next part of the assessment of clinical capabilities.

In order to ensure consistency, the generic outcomes have been grouped into four sections as used in the Foundation Programme curriculum, which are aligned to GMP:

- Professional behaviour and trust
- Communication, team-working and leadership
- Safety and quality
- Wider professional practice

For each generic learning outcome a set of descriptors of the observable skills and behaviours which would demonstrate that a trainee has met the minimum level expected. The descriptors are not a comprehensive list and there may be more examples that would provide equally valid evidence of performance.

*[To be reviewed and updated when final Academy/GMC GPC guidance is available]*
## Generic outcomes

### Professional behaviour and trust

<table>
<thead>
<tr>
<th>1. The ability to successfully function within NHS organisational and management systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Descriptors</strong></td>
</tr>
<tr>
<td>• Aware of and adheres to the GMC professional requirements</td>
</tr>
<tr>
<td>• Aware of public health issues including population health, social detriments</td>
</tr>
<tr>
<td>of health and global health perspectives</td>
</tr>
<tr>
<td>• Demonstrates effective clinical leadership</td>
</tr>
<tr>
<td>• Demonstrates promotion of an open and transparent culture</td>
</tr>
<tr>
<td>• Keeps practice up to date through learning and teaching</td>
</tr>
<tr>
<td>• Demonstrates engagement in career planning</td>
</tr>
<tr>
<td>• Demonstrates capabilities in dealing with complexity and uncertainty</td>
</tr>
<tr>
<td><strong>Informing GPCs</strong></td>
</tr>
<tr>
<td>Domain 1: Professional values and behaviours</td>
</tr>
<tr>
<td>Domain 3: Professional knowledge</td>
</tr>
<tr>
<td>Domain 9: Capabilities in research and scholarship</td>
</tr>
<tr>
<td><strong>Evidence to inform decision</strong></td>
</tr>
<tr>
<td>MCR</td>
</tr>
<tr>
<td>MSF</td>
</tr>
<tr>
<td>Lead role in governance structures</td>
</tr>
<tr>
<td>Management course</td>
</tr>
<tr>
<td>End of placement reports</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Able to deal with ethical and legal issues related to clinical practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Descriptors</strong></td>
</tr>
<tr>
<td>• Aware of national legislation and legal responsibilities, including</td>
</tr>
<tr>
<td>safeguarding vulnerable groups</td>
</tr>
<tr>
<td>• Behaves in accordance with ethical and legal requirements</td>
</tr>
<tr>
<td>• Demonstrates ability to offer apology or explanation when appropriate</td>
</tr>
<tr>
<td>• Demonstrates ability to lead the clinical team in ensuring that medical</td>
</tr>
<tr>
<td>legal factors are considered openly and consistently</td>
</tr>
<tr>
<td><strong>Informing GPCs</strong></td>
</tr>
<tr>
<td>Domain 3: Professional knowledge</td>
</tr>
<tr>
<td>Domain 4: Capabilities in health promotion and illness prevention</td>
</tr>
<tr>
<td>Domain 7: Capabilities in safeguarding vulnerable groups</td>
</tr>
<tr>
<td>Domain 8: Capabilities in education and training</td>
</tr>
<tr>
<td>Domain 9: Capabilities in research and scholarship</td>
</tr>
<tr>
<td><strong>Evidence to inform decision</strong></td>
</tr>
<tr>
<td>MCR</td>
</tr>
<tr>
<td>MSF</td>
</tr>
<tr>
<td>CbD</td>
</tr>
<tr>
<td>DOPS</td>
</tr>
<tr>
<td>Mini-CEX</td>
</tr>
<tr>
<td>MRCP(UK)</td>
</tr>
<tr>
<td>ALS certificate</td>
</tr>
<tr>
<td>End of life care and capacity assessment</td>
</tr>
<tr>
<td>End of placement reports</td>
</tr>
</tbody>
</table>

### Communication, teamworking and leadership

<table>
<thead>
<tr>
<th>3. Communicates effectively and is able to share decision making, while maintaining appropriate</th>
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</thead>
</table>

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*Internal Medicine Stage 1 – DRAFT V12*
### Situational Awareness, Professional Behaviour and Professional Judgement

| Descriptors | Communicates clearly with patients and carers in a variety of settings  
|             | Communicates appropriately with clinical and other professional colleagues  
|             | Identifies and manages barriers to communication (e.g., cognitive impairment, speech and hearing problems, capacity issues)  
|             | Demonstrates effective consultation skills including effective verbal and nonverbal interpersonal skills  
|             | Shares decision making by informing the patient, prioritising the patient’s wishes, and respecting the patient’s beliefs, concerns and expectations  
|             | Shares decision making with children and young people  
|             | Applies management and team working skills appropriately, including influencing, negotiating, re-assessing priorities and effectively managing complex, dynamic situations |

### Informing GPCs

| Domain 2: Professional skills  
| Domain 5: Capabilities in leadership and teamworking |

### Evidence to inform decision

| MCR  
| MSF  
| PS  
| MRCP(UK)  
| End of placement reports  
| ES report |

### Safety and Quality

4. Is focused on patient safety and delivers effective quality improvement in patient care

| Descriptors | Makes patient safety a priority in clinical practice  
|             | Raises and escalates concerns where there is an issue with patient safety or quality of care  
|             | Demonstrates commitment to learning from patient safety investigations and complaints  
|             | Shares good practice appropriately  
|             | Contributes to and delivers quality improvement  
|             | Understands basic Human Factors principles and practice at individual, team, organisational and system levels  
|             | Understands the importance of non-technical skills and crisis resource management  
|             | Recognises and works within limit of personal competence |

### Informing GPCs

| Domain 1: Professional values and behaviours  
| Domain 2: Professional skills  
| Domain 3: Professional knowledge  
| Domain 4: Capabilities in health promotion and illness prevention  
| Domain 5: Capabilities in leadership and teamworking  
| Domain 6: Capabilities in patient safety and quality improvement |

### Evidence to inform decision

| MCR  
| MSF  
| QIPAT  
| End of placement reports |
### Wider professional practice

#### 5. Carrying out research and managing data appropriately

**Descriptors**
- Manages clinical information/data appropriately
- Understands principles of research and academic writing
- Demonstrates ability to carry out critical appraisal of the literature
- Understands public health epidemiology and global health patterns
- Follows guidelines on ethical conduct in research and consent for research

**Informing GPCs**
- Domain 3: Professional knowledge
- Domain 7: Capabilities in safeguarding vulnerable groups
- Domain 9: Capabilities in research and scholarship

**Evidence to inform decision**
- MCR
- MSF
- MRCP(UK)
- GPC certificate
- Evidence of research activity
- End of placement reports

#### 6. Acting as a clinical teacher and clinical supervisor

**Descriptors**
- Delivers effective teaching and training to medical students, junior doctors and other health care professionals, including:
  - Delivers effective feedback with action plan
  - Able to supervise less experienced trainees in their clinical assessment and management of patients
  - Able to supervise less experienced trainees in carrying out appropriate practical procedures
  - Able to act a Clinical Supervisor to the standard required by the GMC

**Informing GPCs**
- Domain 1: Professional values and behaviours
- Domain 8: Capabilities in education and training

**Evidence to inform decision**
- MCR
- MSF
- TO
- Relevant training course
- End of placement reports

### 3.3 Specialty outcomes

#### 3.3.1 Competencies in Practice (CiPs)

Competencies in Practice (CiPs) describe the professional tasks or work within the scope of internal medicine. Each CiP has a set of descriptors of the observable activities, tasks and behaviours that will help inform entrustment decisions.

Satisfactory sign off at the end of Internal Medicine stage 1 requires demonstration that, for each of the CiPs, the doctor in training’s performance meets or exceeds the minimum expected level of performance expected for completion of this stage of internal medicine training.
Each CiP has descriptors that provide examples of clinical and professional accomplishments related to that CiP as guidance on what is expected. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated by stage 1 internal medicine doctors. Doctors in training may use these capabilities to provide evidence of how their performance meets or exceeds the minimum expected level of performance for their year of training. The descriptors are not a comprehensive list and there are many more examples that would provide equally valid evidence of performance.

By the completion of training and award of CCT, the doctor must demonstrate that they are capable of unsupervised practice in all generic and specialty-specific outcomes.

**Internal Medicine CiPs**

| 1. Managing an acute unselected take |  |

**Descriptors**
- Demonstrates appropriate professional behaviour with regard to patients, carers, colleagues and others
- Delivers patient centred care including shared decision making
- Takes a relevant patient history including patient symptoms, concerns, priorities and preferences
- Performs accurate clinical examinations
- Shows appropriate clinical reasoning by analysing physical and psychological findings
- Formulates an appropriate differential diagnosis
- Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required
- Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues
- Appropriately selects, manages and interprets investigations
- Recognises need to liaise with specialty services and refers where appropriate

**Informing GPCs**
- Domain 1: Professional values and behaviours
- Domain 2: Professional skills
- Domain 3: Professional knowledge
- Domain 4: Capabilities in health promotion and illness prevention
- Domain 5: Capabilities in leadership and teamwork
- Domain 6: Capabilities in patient safety and quality improvement

**Evidence to inform decision**
- MCR
- MSF
- Cbd
- ACAT
- MRCP(UK)
- Logbook of cases
- Simulation training with assessment (eg IMPACT)

| 2. Managing an acute specialty–related take |  |

**Descriptors**
- Demonstrates appropriate professional behaviour with regard to patients,
carers, colleagues and others
● Delivers patient centred care including shared decision making
● Takes a relevant patient history including patient symptoms, concerns, priorities and preferences
● Performs accurate clinical examinations
● Shows appropriate clinical reasoning by analysing physical and psychological findings
● Formulates an appropriate differential diagnosis
● Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required
● Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues
● Appropriately selects, manages and interprets investigations
● Demonstrates appropriate continuing management of acute medical illness in patients admitted to hospital on an acute unselected take or selected take

**Informing GPCs**

| Domain 1: Professional values and behaviours |
| Domain 2: Professional skills |
| Domain 3: Professional knowledge |
| Domain 4: Capabilities in health promotion and illness prevention |
| Domain 5: Capabilities in leadership and teamworking |
| Domain 6: Capabilities in patient safety and quality improvement |

**Evidence to inform decision**

- MCR
- MSF
- CbD
- ACAT
- MRCP(UK)
- Logbook of cases
- Simulation training with assessment (eg IMPACT)

### 3. Providing continuity of care to medical in-patients, including management of comorbidities and cognitive impairment

**Descriptors**

- Demonstrates appropriate professional behaviour with regard to patients, carers, colleagues and others
- Delivers patient centred care including shared decision making
- Demonstrates effective consultation skills
- Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required
- Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues
- Demonstrates appropriate continuing management of acute medical illness in patients admitted to hospital on an acute unselected take or selected take
- Recognises need to liaise with specialty services and refers where appropriate
- Appropriately manages comorbidities in medical inpatients (unselected take, selected acute take or specialty admissions)
- Demonstrates awareness of the quality of patient experience

**Informing GPCs**

<p>| Domain 1: Professional values and behaviours |
| Domain 2: Professional skills |
| Domain 3: Professional knowledge |
| Domain 4: Capabilities in health promotion and illness prevention |
| Domain 5: Capabilities in leadership and teamworking |</p>
<table>
<thead>
<tr>
<th>Evidence to inform decision</th>
<th>Domain 6: Capabilities in patient safety and quality improvement</th>
</tr>
</thead>
</table>

4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions

**Descriptors**
- Demonstrates appropriate professional behaviour with regard to patients, carers, colleagues and others
- Delivers patient centred care including shared decision making
- Demonstrates effective consultation skills
- Formulates an appropriate diagnostic and management plan, taking into account patient preferences
- Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues
- Appropriately manages comorbidities in outpatient clinic, ambulatory or community setting
- Demonstrates awareness of the quality of patient experience

**Informing GPCs**
- Domain 1: Professional values and behaviours
- Domain 2: Professional skills
- Domain 3: Professional knowledge
- Domain 5: Capabilities in leadership and teamworking

**Evidence to inform decision**
- MCR
- MSF
- ACAT
- Mini-CEX
- DOPS
- MRCP(UK)
- Letters generated at outpatient clinics

5. Managing medical problems in patients in other specialties and special cases

**Descriptors**
- Demonstrates effective consultation skills including challenging circumstances
- Demonstrates management of medical problems in inpatients under the care of other specialties
- Appropriate and timely liaison with other medical specialty services when required

**Informing GPCs**
- Domain 1: Professional values and behaviours
- Domain 2: Professional skills
- Domain 7: Capabilities in safeguarding vulnerable groups

**Evidence to inform decision**
- MCR
- ACAT
- Cbd
- MRCP(UK)

6. Managing a multi-disciplinary team including effective discharge planning

**Descriptors**
- Applies management and team working skills appropriately, including influencing, negotiating, continuously re-assessing priorities and effectively managing complex, dynamic situations
| Informing GPCs | Domain 1: Professional values and behaviours  
Domain 2: Professional skills  
Domain 5: Capabilities in leadership and teamworking |
|---|---|
| Evidence to inform decision | MCR  
MSF  
ACAT  
MRCP(UK)  
Discharge summaries |

### 7. Delivering effective resuscitation and managing the acutely deteriorating patient

| Descriptors | • Demonstrates prompt assessment of the acutely deteriorating patient, including those who are shocked or unconscious  
• Demonstrates the professional requirements and legal processes associated with consent for resuscitation  
• Participates effectively in decision making with regard to resuscitation decisions, including decisions not to attempt CPR, and involves patients and their families  
• Demonstrates competence in carrying out resuscitation |
|---|---|
| Informing GPCs | Domain 1: Professional values and behaviours  
Domain 2: Professional skills  
Domain 3: Professional knowledge  
Domain 5: Capabilities in leadership and teamworking  
Domain 6: Capabilities in patient safety and quality improvement  
Domain 7: Capabilities in safeguarding vulnerable groups |
| Evidence to inform decision | MCR  
DOPS  
ACAT  
MSF  
MRCP(UK)  
ALS certificate  
Logbook of cases  
Reflection  
Simulation training with assessment (e.g., IMPACT) |

### 8. Managing end of life and palliative care skills

| Descriptors | • Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs  
• Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing at end of life  
• Demonstrates safe and effective use of syringe pumps in the palliative care population  
• Able to manage non-complex symptom control including pain  
• Facilitates referrals to specialist palliative care across all settings |
|---|---|
3.3.2 Presentations and conditions

The scope of Internal Medicine is broad and cannot be encapsulated by a finite list of presentations and conditions/issues. Any attempt to list all relevant presentations and conditions/issues would be extensive but inevitably incomplete and rapidly become out of date.

The table below details the key presentations and conditions of internal medicine. Each of these should be regarded as a clinical context in which trainees should be able to demonstrate CiPs and GPCs. Additionally trainees will need to become familiar with the knowledge skills and attitudes around managing patients with these conditions and presentations.

Particular presentations and conditions/issues are listed either because they are common (and therefore the internal medicine physician must be familiar with them) or serious (having high morbidity/mortality and/or serious implications for treatment or public health).

Some presentations may be caused by conditions attributed to more than one system, or presenting to more than one specialty, and some conditions may be the rightful province of two or more specialties. The table of systems/specialties, presentations and conditions of Internal Medicine is to be interpreted with common sense. Each condition and presentation.
appears once in the syllabus, or on a limited number of occasions, e.g. chest pain is listed as a cardiology or respiratory medicine presentation. The fact that chest pain is not listed as a rheumatological presentation does not mean that the Internal Medicine curriculum does not require that the trainee recognises that there can be musculoskeletal causes of chest pain. It is not felt necessary to document the specific attributes of each presentation and condition with which trainees need to be familiar as this will vary between conditions and presentations. However, clearly for each condition/presentation, trainees will need to be familiar with such aspects as aetiology, epidemiology, clinical features, investigation, management and prognosis. Once again this list is not exhaustive but is general guidance.

**Presentations and conditions of Internal Medicine by system/specialty**

<table>
<thead>
<tr>
<th>System/Specialty and subspecialty</th>
<th>Presentations</th>
<th>Conditions/Issues</th>
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<tr>
<td><strong>Emergency presentations</strong></td>
<td>Cardiorespiratory arrest</td>
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<td>Shocked patient</td>
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<td>Anaphylaxis</td>
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<td><strong>Allergy</strong></td>
<td>Acute and chronic allergic symptoms</td>
<td>Allergy – food, latex, insect venom, transfusion</td>
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<td>Angioedema</td>
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<td>Asthma</td>
<td>Drug – allergy and intolerance</td>
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<td>Nose and sinus symptoms</td>
<td>Rhinitis / sinusitis / conjunctivitis</td>
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<td>Urticaria</td>
<td>Skin disorders</td>
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<td>Urticaria and angioedema</td>
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<td><strong>Cardiology</strong></td>
<td>Blackout / collapse</td>
<td>Cardiac arrhythmias</td>
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<td>Breathlessness</td>
<td>Cardiac failure</td>
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<td>Limb pain</td>
<td>Cardiac involvement in infectious disease</td>
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<td>Limb swelling</td>
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<td>Palpitations</td>
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<td>Syncope and pre-syncope</td>
<td>Diseases of the arteries, including aortic dissection</td>
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<td>Diseases of the pulmonary circulation</td>
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<td>Request for genetic testing</td>
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<td>Drug side effects</td>
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<td>Use national or local guidelines on appropriate and safe prescribing</td>
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<td><strong>Mouth ulcer</strong></td>
<td>Blood and lymphatic vessel disorders</td>
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<td><strong>Rash</strong></td>
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<td>Cutaneous vasculitis, connective tissue diseases and urticaria</td>
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<td>Dermatitis / eczema</td>
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<td>Disorders of pigmentation</td>
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<td>Hair and nail disorders</td>
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<td>Infections of the skin and soft tissues</td>
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<td>Sebaceous and sweat gland disorders</td>
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<td>Blistering disorders</td>
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<td><strong>Endocrinology and diabetes mellitus</strong></td>
<td><strong>Amenorrhoea</strong></td>
<td>Adrenal disorders</td>
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<td>Diseases of the mouth and salivary glands</td>
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<td><strong>Jaundice</strong></td>
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<td><strong>Nausea and vomiting</strong></td>
<td>Diseases of the small bowel</td>
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<td><strong>Rectal bleeding</strong></td>
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<td>Gastrointestinal infections</td>
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<td>Erectile dysfunction, genital lumps, rectal discharge, post coital and intermenstrual bleeding, pelvic pain, dyspareunia</td>
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<td>Prevention of conditions related to sexual behaviour</td>
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<td>Sexually transmitted infections and systemic complications</td>
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<td><strong>Viral infections</strong></td>
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<td><strong>Medical ophthalmology</strong></td>
<td>Diplopia, Optic disc swelling, Painful eye, Red eye, Vision loss</td>
<td>Cranial nerve palsy, Glaucoma, Inflammatory eye disease, TIA/stroke, Retinal vascular disease</td>
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<tr>
<td><strong>Neurology</strong></td>
<td>Abnormal sensation, Abnormal behaviour, Acute confusion, Bladder, bowel and sexual dysfunction, Breathlessness, Headache, Hearing loss, Involuntary movements, Memory loss and intellectual decline, Pain, Seizures (epileptic and non-epileptic), Speech disturbance, Swallowing difficulties, Syncope and pre-syncope, Unsteadiness, Visual disturbance, Weakness and paralysis</td>
<td>Basal ganglia disease, Cerebellar disease, Cranial nerve lesions, Diseases of the motor and sensory tracts, Disorders of the skull, Focal lesions of the cerebral hemispheres, Meningoencephalopathies, Muscle disease, Neuromuscular diseases, Peripheral nerve disorders, Plexopathies, Radiculopathies, Spinal cord disorders, Tendon and joint disease complicating neurological disease, Thalamic and brain stem disorders</td>
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<td><strong>Oncology</strong></td>
<td>Weight loss</td>
<td>Common cancers, Hypercalcaemia, Neutropenic sepsis, Paraneoplastic conditions, Premalignant conditions, Spinal cord compression, SVC obstruction</td>
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<tr>
<td><strong>Palliative medicine and end of life care</strong></td>
<td>Pain, Physical Symptoms other than pain, Psychosocial concerns including spiritual care and care of family, The dying patient</td>
<td>Advanced malignancy, End stage organ failure, Frailty, Multiple comorbidity</td>
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<td><strong>Public health and health promotion</strong></td>
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<td>Alcohol, Exercise, Mental health, Non-communicable diseases, Nutrition, Obesity, Occupation</td>
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<td><strong>Internal Medicine Stage 1 – DRAFT V12</strong></td>
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<td>UK and global health</td>
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<td>Psychiatry</td>
<td>Aggressive or disturbed behaviour</td>
<td>Alcohol and substance misuse</td>
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<td>Alcohol and substance dependence</td>
<td>Anxiety disorders</td>
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<td></td>
<td>Anxiety or panic</td>
<td>Bipolar disorder</td>
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<tr>
<td></td>
<td>Physical symptoms</td>
<td>Delirium</td>
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<tr>
<td></td>
<td>unexplained by organic disease</td>
<td>Dementias</td>
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<tr>
<td></td>
<td>Self-harm</td>
<td>Depression</td>
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<tr>
<td></td>
<td>Treatment refusal</td>
<td>Eating disorders</td>
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<td>Personality disorder</td>
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<td>Phobias</td>
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<td>Psychoses</td>
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<td>Schizophrenia</td>
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<td>Somatic symptom disorders</td>
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<td>Stress disorders</td>
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<tr>
<td></td>
<td></td>
<td>Suicide and self-harm</td>
</tr>
<tr>
<td>Renal medicine</td>
<td>Dysuria</td>
<td>Acute kidney injury</td>
</tr>
<tr>
<td></td>
<td>Electrolyte abnormality</td>
<td>Chronic kidney disease</td>
</tr>
<tr>
<td></td>
<td>Fluid balance abnormality</td>
<td>Drugs and the kidney</td>
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<tr>
<td></td>
<td>Haematuria</td>
<td>Electrolyte disorders</td>
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<tr>
<td></td>
<td>Hypertension</td>
<td>Fluid balance disorders</td>
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<tr>
<td></td>
<td>Loin pain</td>
<td>Genetic disorders affecting the kidneys</td>
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<tr>
<td></td>
<td>Micturition difficulties</td>
<td>Glomerular diseases</td>
</tr>
<tr>
<td></td>
<td>Polyuria</td>
<td>Malignant disease of the urinary tract</td>
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<tr>
<td></td>
<td>Proteinuria</td>
<td>Nephrotic syndrome</td>
</tr>
<tr>
<td></td>
<td>Raised serum creatinine</td>
<td>Renal replacement therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renal tubular disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Systemic disorders affecting the kidneys</td>
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<tr>
<td></td>
<td></td>
<td>Tubulointerstitial diseases</td>
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<tr>
<td></td>
<td></td>
<td>Urinary tract infection</td>
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<tr>
<td></td>
<td></td>
<td>Urinary tract obstruction</td>
</tr>
<tr>
<td>Respiratory medicine</td>
<td>Breathlessness</td>
<td>Asthma</td>
</tr>
<tr>
<td></td>
<td>Pleuritic chest pain</td>
<td>Bronchiectasis</td>
</tr>
<tr>
<td></td>
<td>Cough</td>
<td>Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td></td>
<td>Haemoptysis</td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td></td>
<td>Hoarseness</td>
<td>Diffuse parenchymal lung diseases</td>
</tr>
<tr>
<td></td>
<td>Stridor</td>
<td>Diseases of the pulmonary circulation</td>
</tr>
<tr>
<td></td>
<td>Pleural effusion</td>
<td>Disorders of the thoracic cage and diaphragm</td>
</tr>
<tr>
<td></td>
<td>Wheeze</td>
<td>Disorders of the upper respiratory tract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Immune mediated respiratory diseases</td>
</tr>
<tr>
<td>System/Specialty and subspecialty</td>
<td>Presentations</td>
<td>Conditions/Issues</td>
</tr>
<tr>
<td>----------------------------------</td>
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<tr>
<td></td>
<td></td>
<td>Malignant diseases of the respiratory system</td>
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<tr>
<td></td>
<td></td>
<td>Pleural diseases including pneumothorax</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Occupational lung diseases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pulmonary embolism</td>
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<tr>
<td></td>
<td></td>
<td>Sarcoidosis</td>
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<tr>
<td></td>
<td></td>
<td>Sleep related breathing disorders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respiratory infections</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respiratory failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>Back pain</td>
<td>Multisystem rheumatic disorders</td>
</tr>
<tr>
<td></td>
<td>Joint pain and swelling</td>
<td>Spinal pain and regional disorders</td>
</tr>
<tr>
<td></td>
<td>Neck pain</td>
<td>Crystal-related arthropathies</td>
</tr>
<tr>
<td></td>
<td>Rash and weakness</td>
<td>Infection and arthritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Metabolic bone diseases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitoring and toxicity of immunosuppressive drugs including biologics</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Osteoarthritis</td>
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<tr>
<td></td>
<td></td>
<td>Osteoporosis</td>
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<tr>
<td></td>
<td></td>
<td>Rheumatoid arthritis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spondyloarthritides</td>
</tr>
<tr>
<td>Other / all - clinical</td>
<td>Incidental findings</td>
<td>Chronic Fatigue Syndrome</td>
</tr>
<tr>
<td></td>
<td>Medical problems following surgical procedures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical problems in pregnancy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>unexplained by organic disease</td>
<td></td>
</tr>
</tbody>
</table>

**Presentations and conditions and the underpinning clinical science**

These are described in the form of three targets, with the ‘bulls eyes’ always being the patient, at the centre of knowledge, learning and care. All presentations or conditions can be slotted into the centre of each target, with associated knowledge, skills and attitudes – shown in the outer rings – always context dependent. The sequence of rings does not imply that the activities within each ring are undertaken in a fixed order: for example, treatment of the patient with an acute life-threatening illness will begin before or concurrent with history taking and examination. The ‘depth’ of each ring will vary depending on the symptom or condition: in some presentations or diseases much more has to be known about investigations than treatment, and vice versa.
Core bedside skills are those of information gathering, through history and physical examination, information sharing (with patients, families and colleagues), and all other associated communication skills.

Generic professional capabilities encircle all other components, emphasising their importance, but also recognising that they are context dependent.
Treatment care and strategy covers how a doctor selects drug treatments or interventions for a patient. It includes discussions and decisions as to whether treatment should be active or palliative, and also broader aspects of care, including involvement of other professionals or services. As for the ‘presentation target’, ‘Generic professional capabilities’ encircle all other components, emphasising their importance, but also recognising that they are context dependent.

**Figure 3: The clinical science target**

[Update diagram to change symptom to presentation]

For all presentations or conditions the doctor must have an understanding of the relevant clinical science.

### 3.3.3 Practical procedures

There are a number of procedural skills in which a trainee must become proficient to the level expected by the end of Internal Medicine stage 1.

Trainees must be able to outline the indications for these procedures and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthetics, minimisation of patient discomfort, and requesting for help when appropriate. Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool.

Trainees must receive training in procedural skills in a clinical skills lab before performing these procedures clinically.

The table below sets out the minimum competency level expected for each of the practical procedures at the end of each year of training in Internal Medicine and indicates the expectation at higher levels of internal medicine training [currently General Internal Medicine, Internal Medicine stage 2 curriculum in development].

Obtaining independence in these procedures is desirable. Trusts that require trainees to perform these procedures for service reasons will need to put in place mechanisms to provide training and assure competence. Trainees working in Trusts that do not provide
such training are required to have skills lab training on a minimum of three occasions in Internal Medicine stage 1 training.

When a trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure, unless they or their educational supervisor think that this is required (in line with standard professional conduct). This also applies to procedures that have been signed off during Foundation Year training or in other training programmes (e.g. ACCS).

**Internal medicine practical procedures**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Internal Medicine stage 1</th>
<th>IM stage 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced cardiopulmonary resuscitation (CPR)</td>
<td>Skills lab</td>
<td>Participation in CPR team</td>
</tr>
<tr>
<td>Direct current (DC) cardioversion</td>
<td>Skills lab</td>
<td>Competent to perform unsupervised</td>
</tr>
<tr>
<td>Temporary cardiac pacing using an external device</td>
<td>Skills lab</td>
<td>Competent to perform unsupervised</td>
</tr>
<tr>
<td>Central venous cannulation - femoral³</td>
<td>Skills lab</td>
<td>Skills lab*</td>
</tr>
<tr>
<td>Central venous cannulation – neck</td>
<td>Skills lab</td>
<td>Skills lab*</td>
</tr>
<tr>
<td>Intraosseous infusion¹</td>
<td>Skills lab</td>
<td>Skills lab*</td>
</tr>
<tr>
<td>Pleural aspiration (diagnostic)</td>
<td>Skills lab</td>
<td>Competent to perform unsupervised</td>
</tr>
<tr>
<td>Pleural aspiration (pneumothorax)²</td>
<td>Skills lab</td>
<td>Competent to perform unsupervised</td>
</tr>
<tr>
<td>Intercostal drain for pneumothorax³</td>
<td>Skills lab</td>
<td>Skills lab*</td>
</tr>
<tr>
<td>Intercostal drain for effusion²</td>
<td>Skills lab</td>
<td>Skills lab*</td>
</tr>
<tr>
<td>Nasogastric (NG) tube</td>
<td>Skills lab</td>
<td>Competent to perform unsupervised</td>
</tr>
<tr>
<td>Ascitic tap</td>
<td>Skills lab</td>
<td>Competent to perform unsupervised</td>
</tr>
<tr>
<td>Abdominal paracentesis</td>
<td>Skills lab</td>
<td>Skills lab*</td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td>Skills lab</td>
<td>Competent to perform unsupervised</td>
</tr>
<tr>
<td>Knee aspiration</td>
<td>Skills lab</td>
<td>Skills lab</td>
</tr>
<tr>
<td>Procedure</td>
<td>IM1</td>
<td>IM2</td>
</tr>
<tr>
<td>-----------</td>
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<td>-----</td>
</tr>
<tr>
<td>perform unsupervised</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes**

a The requirement is for a minimum of skills lab training in one of these two mechanisms for obtaining access to the circulation to allow infusion of fluid in the patient where peripheral venous access cannot be established.

b The requirement is for the trainee to be able to decompress a large symptomatic pneumothorax. This is a relatively uncommon clinical scenario, and it is not expected that all trainees will encounter it during their training. A trainee who can satisfactorily perform pleural aspiration of fluid can be regarded as having the necessary competency.

c With ultrasound guidance provided by a pleural-trained practitioner.

4 Learning and Teaching

4.1 The training programme

The organisation and delivery of postgraduate training is the statutory responsibility of the Health Education England (HEE) which devolves responsibility for the local organisation and delivery of training to HEE local teams/deaneries. Each HEE local team/deanery oversees a School of Medicine which is responsible for the organisation and delivery of training in each deanery. Each School of Medicine will have a Training Programme Director for who will be responsible for coordinating the Internal Medicine Stage 1 training programme.

Progression through the programme will be determined by the Annual Review of Competence Progression (ARCP) process and the training requirements for each indicative year of training are summarised in the Internal Medicine Stage 1 ARCP decision aid (available on the JRCPTB website). The successful completion of Internal Medicine Stage 1 will be dependent on achieving the expected level in all CiPs, GPCs and procedural skills. The programme of assessment will be used to monitor and determine progress through the programme. Training will normally take place in a range of District General Hospitals and Teaching Hospitals.

The sequence of training should ensure appropriate progression in experience and responsibility. The training to be provided at each training site is defined to ensure that, during the programme, the entire syllabus is covered and also that unnecessary duplication and educationally unrewarding experiences are avoided. However, the sequence of training should ideally be flexible enough to allow the trainee to develop a special interest.

The following provides a guide on how training programmes should be structured to ensure a key focus for each training year in order for trainees to gain the experience and develop the competencies to the level required. It is not intended that trainees in year 1 will spend
all their time in acute care but it should be the central focus for the year. Similarly, trainees in year 2 will not be expected to exclusively attend clinics.

**Internal Medicine stage 1 training programme**

<table>
<thead>
<tr>
<th>Indicative year</th>
<th>Focus of training placements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Assessment of the acutely ill patient and the management of the acute medical intake of patients</td>
</tr>
<tr>
<td>2</td>
<td>Experience in out-patient clinics</td>
</tr>
<tr>
<td>3</td>
<td>Primarily involved in the acute take and functioning as the ‘Medical Registrar’</td>
</tr>
</tbody>
</table>

**Mandatory training elements**

All training should be conducted in institutions which meet the JRCPTB Quality Criteria, GMC standards for training and education and the relevant Health and Safety standards.

**Outpatients**

Trainees should attend and be actively involved in a minimum of 80 clinics over the internal medicine stage 1 training programme. It is accepted that there may be some attachments (eg ITU, acute medicine) where there is little scope to attend out-patient clinics but there are other attachments where it should be a regular weekly or twice weekly commitment. It is expected that trainees will do clinics in all 3 years of IM training but as noted above the main focus on clinics will be in year 2 when they should participate in at least 40 clinics. These may be in the parent specialty of their own attachment but also in other departmental clinics and it will be up to TPDs and Educational Supervisors to construct imaginative clinic attendances in order for the trainee to have a satisfactory educational experience. (See below for more detail on clinic attendance)

**Geriatric medicine**

With an increasing elderly population it is essential that all trainees in IM have adequate exposure to and experience of geriatric medicine. It is felt that a 4 month attachment to a team led by a consultant geriatrician during the 3 years is an absolute minimum.

**Intensive care/high dependency experience**

Trainees should spend a minimum of 10 weeks in a critical care environment. This can be done in one or more separate attachments throughout the training programme. However, it is preferable that trainees complete at least four weeks of critical care experience before the key progression point at the end of the second year that allows entry into the third year when they will be acting as the ‘medical registrar’.

**Simulation**

All essential and desirable practical procedures in the Internal Medicine stage 1 curriculum should be taught by simulation as early as possible in IM1 with further simulation teaching
involving human factors and scenarios training carried out in either IM1 or IM2. Further years should include refresher training for procedural skills where necessary.

4.2 Teaching and learning methods

The curriculum will be delivered through a variety of learning experiences and will achieve the competencies described in the syllabus through a variety of learning methods. There will be a balance of different modes of learning from formal teaching programmes to experiential learning ‘on the job’. The proportion of time allocated to different learning methods may vary depending on the nature of the attachment within a rotation.

This section identifies the types of situations in which a trainee will learn.

Learning with peers - There are many opportunities for trainees to learn with their peers. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions. Examination preparation encourages the formation of self-help groups and learning sets.

Work-based experiential learning - The content of work-based experiential learning is decided by the local faculty for education but includes active participation in:

- **Medical clinics including specialty clinics**
  A clinic can be any activity involving care of patients in a scheduled manner (ie not unplanned acute care). Clinics can take place in a variety of settings, including hospitals, day care facilities and the community. Patients with new problems referred from another clinician and patients returning for review can be included. The clinic might be primarily run by a specialist nurse (or other qualified health care professionals) rather than a consultant physician. After initial induction, trainees will review patients in clinic settings, under direct supervision. The degree of responsibility taken by the trainee will increase as competency increases. As experience and clinical competence increase trainees will assess ‘new’ and ‘review’ patients and present their findings to their clinical supervisor.

- **Unselected and specialty-specific takes**

- **Post-take consultant ward-rounds**

It is important that trainees have an opportunity to present at least a proportion of the patients whom they have admitted to their consultant for senior review in order to obtain immediate feedback into their performance (that may be supplemented by an appropriate WBA such as an ACAT, mini-CEX or CBD.

- **Personal ward rounds** and provision of ongoing clinical care on specialist medical ward attachments. Every patient seen, on the ward or in out-patients, provides a learning opportunity, which will be enhanced by following the patient through the course of their illness. The experience of the evolution of patients’ problems over time is a critical part
both of the diagnostic process as well as management. Patients seen should provide the basis for critical reading and reflection on clinical problems.

- **Consultant-led ward rounds**

  Every time a trainee observes another doctor, consultant or fellow trainee, seeing a patient or their relatives there is an opportunity for learning. Ward rounds, including those post-take, led by a consultant should include feedback on clinical and decision-making skills.

- **Multi-disciplinary team meetings**

  There are many situations where clinical problems are discussed with clinicians in other disciplines. These provide excellent opportunities for observation of clinical reasoning.

Trainees have supervised responsibility for the care of in-patients. This includes day-to-day review of clinical conditions, note keeping, and the initial management of the acutely ill patient with referral to and liaison with clinical colleagues as necessary. The degree of responsibility taken by the trainee will increase as competency increases. There should be appropriate levels of clinical supervision throughout training, with increasing clinical independence and responsibility.

- **Intensive care/high dependency**

  Trainees should have significant experience of critical care preferably in a level 3 intensive care (therapy) unit (ICU/ITU) or in a level 2 high dependency unit. The benefits to the trainee are:
  - Enhanced skills of recognising the very sick or rapidly deteriorating patient
  - Ability to work in the multi-disciplinary teams that run critical care units
  - Recognition of the limited resource of critical care and gaining an understanding of how admission to critical care should be prioritised
  - Opportunity to develop enhanced skills such as placement of chest drains, central venous catheters etc
  - Experience of the way that critical units operate in terms of human factors and technology
  - Lessening the level of anxiety when being involved with critical care units at later stages of training

**Formal postgraduate teaching**

The content of these sessions are determined by the local faculty of medical education and will be based on the curriculum. There are many opportunities throughout the year for formal teaching in the local postgraduate teaching sessions and at regional, national and international meetings. Many of these are organised by the Royal Colleges of Physicians.

Suggested activities include:

- a programme of formal bleep-free regular teaching sessions to cohorts of trainees (eg a weekly training hour for IM stage 1 teaching within a Trust)
- case presentations
• research, audit and quality improvement projects
• lectures and small group teaching
• Grand Rounds
• clinical skills demonstrations and teaching
• critical appraisal and evidence based medicine and journal clubs
• joint specialty meetings
• attendance at training programmes organised on a deanery or regional basis, which are designed to cover aspects of the training programme outlined in this curriculum.

**Independent self-directed learning**
Trainees will use this time in a variety of ways depending upon their stage of learning. Suggested activities include:
• reading, including web-based material such as e-Learning for Healthcare (e-LfH)
• maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
• audit, quality improvement and research projects
• reading journals
• achieving personal learning goals beyond the essential, core curriculum

**Formal study courses**
Time to be made available for formal courses is encouraged, subject to local conditions of service. Examples include management courses and communication courses.

**Simulation training**
All essential and desirable practical procedures in the Internal Medicine stage 1 curriculum should be taught by simulation as early as possible in IM1 with further simulation teaching involving human factors and scenarios training carried out in either IM1 or IM2. Further years should include refresher training for procedural skills where necessary.

4.3 **Academic training**

Trainees may train in academic medicine as an academic clinical fellow (ACF) or equivalent. Academic trainees may be recruited at any stage of IM training - ie at IM1, IM2 or IM3 or in the first year of specialty training (ST4). If a trainee has been appointed to an IM training programme before they are successfully appointed to an academic programme, they will not require further clinical benchmarking.

Training will be competency based and it is expected that trainees will spend an indicative 75% of their training time acquiring clinical competences and 25% in academic training. Provided the academic trainee is acquiring and demonstrating competency at the appropriate rate there is no minimum time required in any particular post. If they are not on track for acquiring the appropriate clinical competency it may be necessary to extend their duration of training.

Academic trainees who wish to enter a specialty where there is no requirement to look after acutely unwell patients (such as Clinical Genetics) will not have to complete internal medicine stage 1 training. However, if they enter a specialty where Internal Medicine is an
integrated part of the curriculum then they will have to complete stage 1 internal medicine training in order to fulfil the GMC requirements to acquire and demonstrate Generic Professional Capabilities.

Some trainees may opt to do research leading to a higher degree without being appointed to a formal academic programme. This new curriculum should not impact in any way on the facility to take time out of programme for research (OOPR) but as now, such time requires discussion between the trainee, the TPD and the Deanery as to what is appropriate together with guidance from the appropriate SAC that the proposed period and scope of study is sensible.

5 Programme of Assessment

5.1 Purpose of assessment

[This section will be updated in line with GMC curricula standards, assessment guidance and revised Academy Improving Assessment guidance]

The purpose of the assessment system is to:

- assess trainees’ actual performance in the workplace
- enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand their own performance and identify areas for development
- drive learning and enhance the training process by making it clear what is required of trainees and motivating them to ensure they receive suitable training and experience
- demonstrate trainees have acquired the Generic Professional Capabilities and meet the requirements of Good Medical Practice
- ensure that trainees possess the essential underlying knowledge required for their specialty
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme;
- inform the Annual Review of Competence Progression (ARCP), identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme;
- identify trainees who should be advised to consider changes of career direction.

The programme of assessment comprises a mixture of workplace-based assessments and knowledge-based assessments. Individual assessment methods are described in more detail below.

The assessments will be supported by structured feedback for trainees. Assessment tools will be both formative and summative and have been selected on the basis of their fitness for purpose.

Assessment will take place throughout the training programme to allow trainees to continually gather evidence of learning and to provide formative feedback. Those
assessment tools which are not identified individually as summative will contribute to summative judgements about a trainee’s progress as part of the programme of assessment. The number and range of these will ensure a reliable assessment of the training relevant to their stage of training and achieve coverage of the curriculum.

5.2 Assessment of learning outcomes

Clinical supervisors and others contributing to assessment will provide formative feedback to the trainee on their performance throughout the training year. This feedback will include a global rating in order to indicate to the trainee and their educational supervisor how they are progressing at that stage of training. To support this, workplace based assessments will include global assessment anchor statements:

- Below expectations for this year of training; may not meet the requirements for critical progression point
- Meeting expectations for this year of training; expected to progress to next stage of training
- Above expectations for this year of training; expected to progress to next stage of training

Towards the end of the training year, trainees will make a self-assessment of the level of supervision they require for each CiP and record this in the ePortfolio with signposting to the evidence to support the level selected.

The educational supervisor (ES) will review the evidence in the ePortfolio including workplace based assessments, feedback received from clinical supervisors (via the Multiple Consultant Report) and the trainee’s self-assessment and record their judgement on the trainee’s performance in the ES report.

For generic outcomes, the ES will indicate whether the trainee is meeting expectations or not using the anchor statements above. Trainees will need to be meeting expectations for the stage of training as a minimum to be judged satisfactory to progress to the next training year.

For specialty outcomes, the ES will make an entrustment decision for each CiP and record the indicative level of supervision required. The ES will also indicate the most appropriate anchor statement (see above) for overall performance.

The Annual Review of Competence Progression (ARCP) will be informed by the ES report and the evidence presented in the ePortfolio. The ARCP panel will make the final summative judgement on whether the trainee has achieved the generic outcomes and the appropriate level of supervision for each CiP. The ARCP panel will determine whether the trainee can progress to the next year/level of training in accordance with the Gold Guide.
Level descriptors for Internal Medicine competencies in practice (CiPs)

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Entrusted to observe only – no execution</td>
</tr>
<tr>
<td>Level 2</td>
<td>Entrusted to act with direct supervision: The supervising physician is physically within the hospital or other site of patient care and is immediately available to provide direct supervision</td>
</tr>
<tr>
<td>Level 3</td>
<td>Entrusted to act with indirect supervision: The supervising physician is not physically present within the hospital or other site of patient care, but is immediately available by means of telephone and/or electronic media, to provide advice and can attend physically if required to provide direct supervision</td>
</tr>
<tr>
<td>Level 4</td>
<td>Entrusted to act unsupervised</td>
</tr>
</tbody>
</table>

Entrustability scales are behaviourally anchored ordinal scales based on progression to competence and reflect a judgment that has clinical meaning for assessors (Rekman et al 2016).

5.3 Critical progression points

There will be two key progression points during Internal Medicine stage 1 training (see the outline grid of level of supervision and entrustment for Internal Medicine competencies in practice in section 5.4).

The first critical progression point will be from IM2 to IM3 as the trainee will be “stepping up” to become the medical registrar. It is essential that educational and clinical supervisors are confident that the trainee has the ability to perform in this role.

Trainees will be normally be expected to complete all parts of MRCP(UK) by the end of year 2 of training (IM2) but not holding MRCP(UK) will not in itself be a barrier for progression into IM3. Passing MRCP(UK) is neither necessary nor sufficient to act as medical registrar. If a trainee holds MRCP(UK) by the end of IM2 but in the opinion of their supervisors are not capable of acting as medical registrar they should not progress or should only do so with enhanced supervision. Equally there may be a number of trainees who are performing very well and in whom their supervisors have every confidence but they have not (for a variety of reasons yet passed MRCP(UK).

The second critical progression point will be at the end of Internal Medicine stage 1 when the trainee must be signed off for all generic and specialty outcomes in order to complete the stage of training. A satisfactory ARCP outcome will be required for entry to specialty training and further Internal Medicine training [currently General Internal Medicine, Internal Medicine stage 2 curriculum under development]
There will be a final critical progression point at the end of specialty and internal medicine training. Doctors in training will be required to reach level 4 in all CiPs by the completion of Internal Medicine and specialty training. They will need to meet the appropriate level of entrustment for each CiP for the key progression point between IM2 and IM3 and at completion of Internal Medicine stage 1 and entry to Internal Medicine stage 2/specialty training as set out in the levels of entrustment grid.

The educational supervisor report will make a recommendation to the ARCP panel as to whether the trainee has met the defined levels for the CiPs and acquired the procedural competence required for the critical progression points. The ARCP panel will make the final decision on whether the trainee can be signed off.

5.4 Assessment blueprint

Blueprint of MRCP(UK) mapped to generic and specialty outcomes

<table>
<thead>
<tr>
<th>Learning outcomes</th>
<th>Part 1</th>
<th>Part 2 written</th>
<th>PACES</th>
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</thead>
<tbody>
<tr>
<td>Generic outcomes</td>
<td></td>
<td></td>
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<tr>
<td>The ability to successfully function within NHS organisational and management systems</td>
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<tr>
<td>Able to deal with ethical and legal issues related to clinical practice</td>
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<tr>
<td>Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement</td>
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<tr>
<td>Is focussed on patient safety and delivers effective quality improvement in patient care</td>
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<tr>
<td>Carrying out research and managing data appropriately</td>
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<tr>
<td>Acting as a clinical teacher and clinical supervisor</td>
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<tr>
<td>Specialty outcomes</td>
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<tr>
<td>Managing an acute unselected take</td>
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<tr>
<td>Managing an acute specialty-related take</td>
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<tr>
<td>Providing continuity of care to medical in-patients, including management of comorbidities and cognitive impairment</td>
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<tr>
<td>Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions</td>
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<tr>
<td>Managing medical problems in patients in other specialties and special cases</td>
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<tr>
<td>Managing a multi-disciplinary team including effective discharge planning</td>
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<tr>
<td>Delivering effective resuscitation and managing the acutely deteriorating patient</td>
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<tr>
<td>Managing end of life and palliative care skills</td>
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</table>
### Blueprint for workplace based assessments mapped to generic and specialty outcomes

<table>
<thead>
<tr>
<th>Learning outcomes</th>
<th>AA</th>
<th>ACAT</th>
<th>Cbd</th>
<th>DOPS</th>
<th>MCR</th>
<th>Mini- CEX</th>
<th>MSF</th>
<th>PS</th>
<th>QIPAT</th>
<th>TO</th>
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<td><strong>Generic outcomes</strong></td>
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<td>Professional behaviour and trust</td>
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<tr>
<td>Communication, teamworking and leadership</td>
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<td>Safety and quality</td>
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<td>Wider professional practice</td>
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<td><strong>Specialty outcomes</strong></td>
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<td>Managing an acute unselected take</td>
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<tr>
<td>Managing an acute specialty-related take</td>
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<tr>
<td>Providing continuity of care to medical in-patients, including management of comorbidities and cognitive impairment</td>
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<td>Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions</td>
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<tr>
<td>Managing medical problems in patients in other specialties and special cases</td>
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<td>Managing a multi-disciplinary team including effective discharge planning</td>
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<tr>
<td>Delivering effective resuscitation and managing the acutely deteriorating patient</td>
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<tr>
<td>Managing end of life and palliative care skills</td>
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<td>Practical procedural skills</td>
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**KEY**

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<tr>
<th>AA</th>
<th>ACAT</th>
<th>Cbd</th>
<th>DOPS</th>
<th>MCR</th>
<th>Mini- CEX</th>
<th>MSF</th>
<th>PS</th>
<th>QIPAT</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit assessment</td>
<td>Acute care assessment tool</td>
<td>Case-based discussion</td>
<td>Direct observation of procedural skills</td>
<td>Multiple consultant report</td>
<td>Mini-clinical evaluation exercise</td>
<td>Multi source feedback</td>
<td>Patient survey</td>
<td>Quality improvement project assessment tool</td>
<td>Teaching observation</td>
</tr>
</tbody>
</table>
Outline grid of levels expected for Internal Medicine specialty competencies in practice

Levels to be achieved by critical progression points

**Level descriptors**
- Level 1: Entrusted to observe only – no execution
- Level 2: Entrusted to act with direct supervision
- Level 3: Entrusted to act with indirect supervision
- Level 4: Entrusted to act unsupervised

<table>
<thead>
<tr>
<th>Specialty CIP</th>
<th>Internal Medicine Stage 1</th>
<th>Selection</th>
<th>Internal Medicine Stage 2 + Specialty</th>
<th>CCT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IM1</td>
<td>IM2</td>
<td>IM3</td>
<td>ST4</td>
</tr>
<tr>
<td>1. Managing an acute unselected take</td>
<td>3</td>
<td>3</td>
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<tr>
<td>2. Managing an acute specialty-related take</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
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<tr>
<td>3. Providing continuity of care to medical in-patients</td>
<td>3</td>
<td>2</td>
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<tr>
<td>4. Managing outpatients with long term conditions</td>
<td>2</td>
<td>3</td>
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<tr>
<td>5. Managing medical problems in patients in other specialties and special cases</td>
<td>2</td>
<td>3</td>
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<tr>
<td>6. Managing an MDT including discharge planning</td>
<td>2</td>
<td>3</td>
<td></td>
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<tr>
<td>7. Delivering effective resuscitation and managing the deteriorating patient</td>
<td>3</td>
<td>4</td>
<td></td>
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</tr>
<tr>
<td>8. Managing end of life and palliative care skills</td>
<td>2</td>
<td>3</td>
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</tbody>
</table>
5.5 Assessment methods

The following methods are used in the integrated assessment system:

Examinations and certificates
- The MRCP(UK) Examination: Part 1, Part 2 Written and Part 2 Clinical (PACES)
- Advanced Life Support Certificate (ALS)

Information about MRCP(UK), including guidance for candidates and how to receive feedback, is available on the MRCP(UK) website [www.mrcpuk.org](http://www.mrcpuk.org).

Workplace-based assessments

Supervised Learning Events (SLEs)
- Acute Care Assessment Tool (ACAT)
- Case-Based Discussions (CbD)
- mini-Clinical Evaluation Exercise (mini-CEX)

Other workplace-based assessments (WPBAs)
- Multiple Consultant Report (MCR)
- Direct Observation of Procedural Skills (DOPS)
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

These methods are described briefly below. More information about these methods including guidance for trainees and assessors is available in the ePortfolio and on the JRCPTB website [www.jrcptb.org.uk](http://www.jrcptb.org.uk). SLEs and WPBAs should be recorded in the trainee’s ePortfolio. These methods include feedback opportunities as an integral part of the programme of assessment.

Multiple Consultant Report (MCR)
The Multiple Consultant Report (MCR) captures the views of consultant supervisors on a trainee’s performance. The MCR feedback and comments received, give valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required. MCR feedback will be available to the trainee and included in the educational supervisor’s report.

Acute Care Assessment Tool (ACAT)
The ACAT is designed to assess and facilitate feedback on a doctor’s performance during their practice on the acute medical take. Any doctor who has been responsible for the supervision of the acute medical take can be the assessor for an ACAT. This tool can also be used to assess other situations where a trainee is interacting with a number of different patients (eg in a day hospital or a business ward round).
**Case-based Discussion (CbD)**
The CbD assesses the performance of a trainee in their management of a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should focus on a written record (such as written case notes, outpatient letter, discharge summary). A typical encounter might be when presenting newly referred patients in the out-patient department.

**mini-Clinical Evaluation Exercise (mini-CEX)**
This tool evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid learning. The mini-CEX can be used at any time and in any setting when there is a trainee and patient interaction and an assessor is available.

**Direct Observation of Procedural Skills (DOPS)**
A DOPS is an assessment tool designed to evaluate the performance of a trainee in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development.

*Add more detail of formative and summative use*

**Multi-source feedback (MSF)**
This tool is a method of assessing generic skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. ‘Raters’ are individuals with whom the trainee works, and includes doctors, administrative staff, and other allied professionals. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the Educational Supervisor.

**Patient Survey (PS)**
The Patient Survey address issues, including the behaviour of the doctor and effectiveness of the consultation, which are important to patients. It is intended to assess the trainee’s performance in areas such as interpersonal skills, communication skills and professionalism by concentrating solely on their performance during one consultation.

**Quality Improvement Project Assessment Tool (QIPAT)**
The Quality Improvement Project Assessment tool is designed to assess a trainee’s competence in completing a quality improvement project. The Quality Improvement Project Assessment can be based on review of quality improvement project documentation OR on a presentation of the quality improvement project at a meeting. If possible the trainee should be assessed on the same quality improvement project by more than one assessor.
Teaching Observation (TO)
The Teaching Observation form is designed to provide structured, formative feedback to trainees on their competence at teaching. The Teaching Observation can be based on any instance of formalised teaching by the trainee which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).

5.6 Decisions on progress (ARCP)

The Annual Review of Competence Progression (ARCP) is the formal method by which a trainee’s progression through her/his training programme is monitored and recorded. ARCP is not an assessment – it is the review of evidence of training and assessment. The ARCP process is described in A Reference Guide for Postgraduate Specialty Training in the UK (the “Gold Guide”- add link). Deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee’s ePortfolio.

As a precursor to ARCPs, JRCPTB strongly recommend that trainees have an informal ePortfolio review either with their educational supervisor or arranged by the local school of medicine. These provide opportunities for early detection of trainees who are failing to gather the required evidence for ARCP.

In order to guide trainees, supervisors and the ARCP panel, JRCPTB has produced an ARCP decision aid which sets out the requirements for a satisfactory ARCP outcome at the end of each training year and critical progression point. The ARCP decision aid is available on the JRCPTB website www.jrcptb.org.uk.

5.7 Complaints and Appeals

The MRCP(UK) office has complaints procedures and appeals regulations documented on its website which apply to all examinations run by the Royal Colleges of Physicians.

All workplace-based assessment methods incorporate direct feedback from the assessor to the trainee and the opportunity to discuss the outcome. If a trainee has a complaint about the outcome from a specific assessment this is their first opportunity to raise it.

Appeals against decisions concerning in-year assessments will be handled at HEE local team/deanery level and they will be responsible for setting up and reviewing suitable processes. If a formal complaint about assessment is to be pursued this should be referred in the first instance to the chair of the Specialty Training Committee who is accountable to the regional deanery. Continuing concerns should be referred to the Postgraduate Dean (or deputy).
6 Supervision and feedback

[To be updated in line with new Academy guidance]

This section of the curriculum describes how trainees will be supervised, and how they will receive feedback on performance.

6.1 Supervision

All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. Outpatient and referral supervision must routinely include the opportunity to personally discuss all cases if required. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

Trainees will at all times have a named Educational Supervisor and Clinical Supervisor, responsible for overseeing their education. Depending on local arrangements these roles may be combined into a single role of Educational Supervisor. However, it is preferred that a single Educational Supervisor is associated with the same trainee for (at least) a full training year, thus the Clinical Supervisor is likely to be a different consultant during some placements.

The responsibilities of supervisors have been defined by the GMC in the document “Quality Framework Operational Guide”. These definitions have been agreed with the National Association of Clinical Tutors, the Academy of Medical Royal Colleges and the Gold Guide team at MMC, and are reproduced below:

**Educational supervisor**

A trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee’s educational progress during a training placement or series of placements. The Educational Supervisor is responsible for the trainee’s Educational Agreement.

**Clinical supervisor**

A trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee’s clinical work and providing constructive feedback during a training placement. Some training schemes appoint an Educational Supervisor for each placement. The roles of Clinical and Educational Supervisor may then be merged.

The Educational Supervisor, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. The Educational Supervisor should be part of the clinical specialty team. Thus if the clinical directorate (clinical director) have any concerns about the performance of the trainee, or there were issues of doctor or patient safety, these would be discussed with the Educational Supervisor. These processes, which are integral to trainee development, must not detract from the
statutory duty of the trust to deliver effective clinical governance through its management systems.

Opportunities for feedback to trainees about their performance will arise through the use of the workplace-based assessments, regular appraisal meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from ARCP.

6.2 Appraisal

A formal process of appraisals and reviews underpins training. This process ensures adequate supervision during training, provides continuity between posts and different supervisors and is one of the main ways of providing feedback to trainees. All appraisals should be recorded in the ePortfolio

**Induction Appraisal**
The trainee and educational supervisor should have an appraisal meeting at the beginning of each post to review the trainee’s progress so far, agree learning objectives for the post ahead and identify the learning opportunities presented by the post. Reviewing progress through the curriculum will help trainees to compile an effective Personal Development Plan (PDP) of objectives for the upcoming post. This PDP should be agreed during the Induction Appraisal. The trainee and supervisor should also both sign the educational agreement in the e-portfolio at this time, recording their commitment to the training process.

**Mid-point Review**
This meeting between trainee and educational supervisor is not mandatory (particularly when an attachment is shorter than 6 months) but is encouraged particularly if either the trainee or educational or clinical supervisor has training concerns or the trainee has been set specific targeted training objectives at their ARCP). At this meeting trainees should review their PDP with their supervisor using evidence from the e-portfolio. Workplace-based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed. The PDP can be amended at this review.

**End of Attachment Appraisal**
Trainees should review the PDP and curriculum progress with their educational supervisor using evidence from the e-portfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be recorded. If there are significant concerns following the end of attachment appraisal then the programme director should be informed.
7 Quality Management

[To be updated to reflect final GMC standards and JRCPTB quality assurance processes]

This section of the curriculum provides an indication of how the curriculum is managed locally and within programmes.

The organisation of training programs for Internal Medicine Stage 1 is the responsibility of the HEE local teams/postgraduate deaneries.

The HEE local teams/deaneries are establishing appropriate programs for postgraduate medical training in their regions. These schemes will be run by Schools of Medicine in England, Wales and Northern Ireland and Transitional Board Schemes in Scotland. In this curriculum, they will be referred to as local faculties for medical education. The role of the faculties will be to coordinate local postgraduate medical training, with terms of reference as follows:

- oversee recruitment and induction of trainees from Foundation to Internal Medicine stage 1
- allocate trainees into particular rotations for Internal Medicine stage 1 appropriate to their training needs
- oversee the quality of training posts provided locally
- interface with other specialty training faculties (General Practice, Anaesthesia etc)
- ensure adequate provision of appropriate educational events
- ensure curricula implementation across training programmes
- oversee the workplace-based assessment process within programmes
- coordinate the ARCP process for trainees
- provide adequate and appropriate career advice
- provide systems to identify and assist doctors with training difficulties
- provide flexible training
- recognise the potential of specific trainees to progress into an academic career.

Educational programmes to train educational supervisors and assessors in workplace based assessment may be delivered by HEE local teams/deaneries or by the colleges or both.

Implementation of the curriculum is the responsibility of the JRCPTB via the Specialist Advisory Committee responsible for Internal Medicine Stage 1. The committee will be formally constituted with representatives from each health region in England, from the devolved nations and with trainee and lay representation.

It is the responsibility of the JRCPTB to ensure that curriculum developments are communicated to heads of school, regional specialty training committees and TPDs.
8 Intended use of curriculum by trainers and trainees

This curriculum and ARCP decision aid are available from the Joint Royal Colleges of Physicians Training Board (JRCPTB) via the website www.jrcptb.org.uk.

The educational supervisors and trainers can access the up-to-date curriculum from the JRCPTB website and will be expected to use this as the basis of their discussion with trainees. Both trainers and trainees are expected to have a good knowledge of the curriculum and should use it as a guide for their training programme.

Each trainee will engage with the curriculum by maintaining an ePortfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences.

8.1 Recording progress in the ePortfolio

On enrolling with JRCPTB trainees will be given access to the ePortfolio for Internal Medicine Stage 1. The ePortfolio allows evidence to be built up to inform decisions on a trainee’s progress and provides tools to support trainees’ education and development.

The trainee’s main responsibilities are to ensure the ePortfolio is kept up to date, arrange assessments and ensure they are recorded, prepare drafts of appraisal forms, maintain their personal development plan, record their reflections on learning and record their progress through the curriculum.

The supervisor’s main responsibilities are to use ePortfolio evidence such as outcomes of assessments, reflections and personal development plans to inform appraisal meetings. They are also expected to update the trainee’s record of progress through the curriculum, write end-of-attachment appraisals and supervisor’s reports.

Deaneries, training programme directors, college tutors and ARCP panels may use the ePortfolio to monitor the progress of trainees for whom they are responsible.

JRCPTB will use summarised, anonymous ePortfolio data to support its work in quality assurance.

All appraisal meetings, personal development plans and workplace based assessments (including MSF) should be recorded in the ePortfolio. Trainees and supervisors should electronically sign the educational agreement. Trainees are encouraged to reflect on their learning experiences and to record these in the ePortfolio. Reflections can be kept private or shared with supervisors.

Reflections, assessments and other ePortfolio content should be linked to curriculum competencies in order to provide evidence towards acquisition of these
competencies. Trainees can add their own self-assessment ratings to record their view of their progress. The aims of the self-assessment are:

- to provide the means for reflection and evaluation of current practice
- to inform discussions with supervisors to help both gain insight and assists in developing personal development plans.
- to identify shortcomings between experience, competency and areas defined in the curriculum so as to guide future clinical exposure and learning.

Supervisors can sign-off and comment on curriculum competencies to build up a picture of progression and to inform ARCP panels.

9 Equality and diversity

The Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

The Federation of the Royal Colleges of Physicians believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers; as advisers from the medical profession; as members of the Colleges' professional bodies or as doctors in training and examination candidates.

HEE local teams / deaneries quality assurance will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by GMC. They should provide access to a professional support unit or equivalent for trainees requiring additional support.

Compliance with anti-discriminatory practice will be assured through:

- monitoring of recruitment processes
- ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post
- HEE local teams / deaneries ensuring that educational supervisors have had equality and diversity training (for example, an e-learning module) every 3 years
- HEE local teams / deaneries ensuring that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e-module) every 3 years
- ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. HEE local teams / deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. HEE local teams / deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual.
• providing resources to trainees needing support (for example, through the provision of a professional support unit or equivalent)
• monitoring of College Examinations
• ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments.