JRCPTB

Joint Royal Colleges of Physicians Training Board

Curriculum for Internal Medicine Stage 2 Training

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ROYAL COLLEGE of PHYSICIANS of EDINBURGH
ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
Royal College of Physicians

Contents

1. Introduction

Training in Internal Medicine (IM) stage 2 will take trainees who have completed IM stage 1 (or equivalent) to the level at which they have the capabilities required to acquire a certificate of completion of training (CCT) in Internal Medicine and are thereby deemed capable of working as independent practitioners in this specialty. Most trainees will undertake training in IM stage 2 in combination with training in a second physician specialty managed by JRCPTB.

This curriculum defines the purpose, content of learning, process of training and the programme of assessment for the Internal Medicine stage 2 training. It only includes the learning outcomes for a CCT in IM stage 2 and not the specialty requirements for acquiring a CCT in a second specialty.

2. Purpose

2.1 Purpose of the curriculum

The purpose of the Internal Medicine (IM) stage 2 curriculum is to produce doctors with the generic professional and clinical capabilities needed to take overall responsibility for management of patients presenting with a wide range of general medical symptoms and conditions. They will be particularly skilled in diagnostic reasoning, differential diagnosis, management of co- morbidities, dealing with uncertainty, recognising when specialist care would (or would not) be appropriate, and determining when care should be palliative. Doctors who complete training satisfactorily will be eligible for a CCT (or CESR CP) and can be recommended to the GMC for inclusion on the specialist register. At completion of training they will be capable of independent unsupervised practice and will be eligible for appointment as an NHS consultant.

The Shape of Training (SoT) review[1] 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[2] and the Francis report[3]. With an ageing population, elderly patients exhibit co-morbidities and increasing complexity so acute medical services need a different approach to training the physician of the future.

A further driver for change was the GMC's review of the curricula and assessment standards[4] and introduction of the GMC's generic professional capabilities (GPC)

[1] Shape of Training: Securing the future of excellent patient care
[2] Future hospital: Caring for medical patients
[3] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
[4] Standards and guidance for postgraduate curricula

framework[5]. From May 2017, all postgraduate curricula should be based on higher level learning outcomes and must incorporate the generic professional capabilities. A fundamental component of the GPCs is ensuring that the patient is at the centre of any consultation and decision making. To this end, communication skills are emphasised in the learning outcomes and evidenced through all work based assessments (particularly multi-source feedback – MSF).

JRCPTB, on behalf of the Federation of Royal Colleges of Physicians, has produced a model for physician training leading to a CCT in a specialty and internal medicine. There will be competitive entry into specialty training plus internal medicine dual training. This will ensure that CCT holders are competent to practice independently at consultant level in both specialty (group 1) and internal medicine.

The IM curriculum, usually combined with a specialty curriculum, will produce a workforce that reflects the current trends of increasing patient attendances to both Primary Care and Emergency Departments. This workforce will be trained to manage complex multi-morbidity in an ageing population, and be able to manage many conditions in an ambulatory capacity. There is a growing need from a service perspective for specialists with generalist skills to manage the acute unselected take and care of acutely ill patients.

The curriculum for IM Stage 2 has been developed with input of trainees, consultants actively involved in delivering teaching and training across the UK, service representatives and lay persons. This has been through the work of the JRCPTB and the (General) Internal Medicine Specialist Advisory Committee.

The purpose of this curriculum is to ensure that the trainee develops the full range of generic professional capabilities and underlying knowledge and skills, specifically their application in the practice of internal medicine.
The objectives of the curriculum are:

- to set out a range of specific professional capabilities that encompass all knowledge, skills and activities needed to practise internal medicine at consultant level;
- to set expected standards of knowledge and performance of various professional skills and activities at each stage;
- to suggest indicative training times and experiences needed to achieve the required standards.

The model for physician training and the IM curriculum will:

- Ensure trainee physicians can provide safe and effective care for patients presenting with acute medical problems

[5] Generic professional capabilities framework

- Ensure that internal medicine doctors develop and demonstrate the essential capabilities for ongoing management of patients with both acute and long-term conditions
- Ensure that trainee physicians can acquire and demonstrate all of the GMC mandated GPCs including communication skills
- Allow flexibility between specialties through GPCs and higher level learning outcomes
- Further develop the attributes of professionalism, particularly recognition of the primacy of patient welfare that is required for safe and effective care of those with both acute and long-term conditions, and develop physicians who ensure patients' views are central to all decision making
- 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
- Build on the knowledge, skills and attitudes that were acquired during undergraduate and foundation training

Following IM stage 1 training, most trainees will acquire the capabilities necessary for a CCT in Internal Medicine within a four-year dual CCT training programme. An indicative 12 months will be spent in dedicated IM training which will be integrated flexibly into specialty training. Stand-alone IM programmes will be indicative three years in duration to reflect that many generic skills necessary for IM practice are acquired during the course of specialty training.

There will be a critical progression point at the end of higher specialist training to ensure trainees have the required capabilities for a CCT in IM. On completion of training the trainee will be entrusted to manage the acute unselected take and all IM capabilities in practice (CiPs) unsupervised.

Competitive entry into IM stage 2 will take place following trainees successfully completing Internal Medicine stage 1 or Acute Care Common Stem - Acute Medicine/Internal Medicine. The curriculum will be managed by the Joint Royal College of Physicians Training Board (JRCPTB).

Scope of practice

Internal Medicine has a broad scope. Physicians trained in Internal Medicine have the generic professional and specialty specific capabilities needed to take overall responsibility for management of patients presenting with a wide range of general medical symptoms and conditions. They are particularly skilled in diagnostic reasoning, differential diagnosis, management of co- morbidities, dealing with uncertainty, recognising when specialist care would (or would not) be appropriate, and determining when care should be palliative. They need the ability to work within, or as leaders of, teams and systems involving other healthcare professionals to effectively provide optimal patient care. They generally work

primarily as hospital-based specialists, needing to integrate their work with community based primary care colleagues and other hospital-based services (including specialist medical and surgical services). Demonstration of involvement with multidisciplinary and multi-professional working throughout training will be required.

Doctors in training will learn in a variety of settings using a range of methods, including workplace-based experiential learning, formal postgraduate teaching and simulation-based education. All aspects of the curriculum can be adapted to facilitate less than full time training.

2.2 High level curriculum outcomes - capabilities in practice

The internal medicine curriculum is spiral in nature and the high level learning outcomes and knowledge, skills and behaviours of the IM stage 1 curriculum are further developed to achieve higher levels of entrustment.

The capabilities in practice (CiPs) describe the professional tasks or work within the scope of internal medicine. These are articulated in six generic CiPs and eight clinical CiPs, which have been mapped to the relevant GPC domains and subsections to reflect the professional generic capabilities required.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made. By the completion of training and award of CCT, the doctor must demonstrate that they are capable of unsupervised practice in all generic and clinical CiPs.

Learning outcomes – capabilities in practice (CiPs)
Generic CiPs
1. Able to successfully function within NHS organisational and management systems 2. Able to deal with ethical and legal issues related to clinical practice 3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement 4. Is focussed on patient safety and delivers effective quality improvement in patient care 5. Carrying out research and managing data appropriately 6. Acting as a clinical teacher and clinical supervisor
Clinical CiPs
1. Managing an acute unselected take 2. Managing the acute care of patients within a medical specialty service

3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment
4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions
5. Managing medical problems in patients in other specialties and special cases
6. Managing a multi-disciplinary team including effective discharge planning
7. Delivering effective resuscitation and managing the acutely deteriorating patient
8. Managing end of life and applying palliative care skills

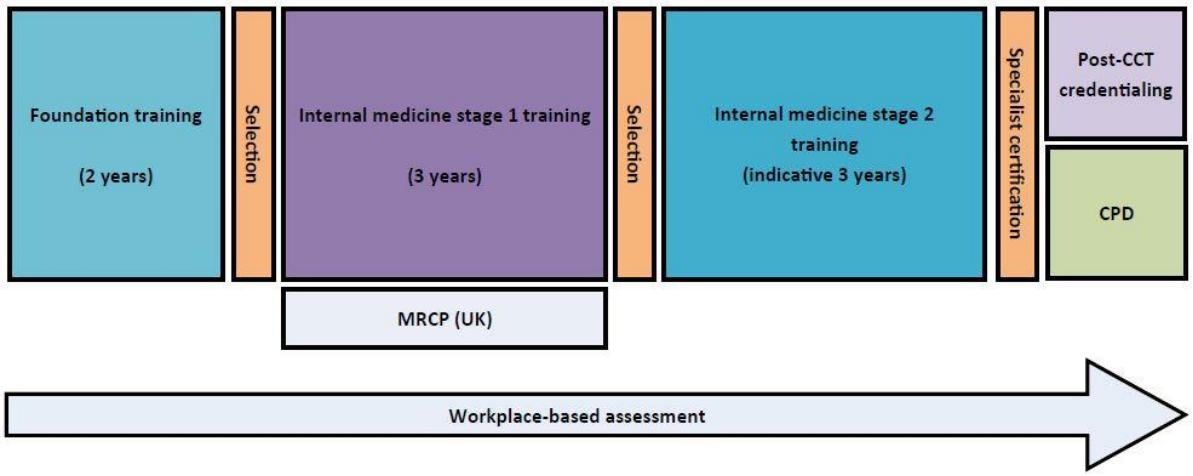
2.3 Training pathway

IM stage 2 training is entered on completion of the IM stage 1 or ACCS-AM/IM programme following selection to ST4.

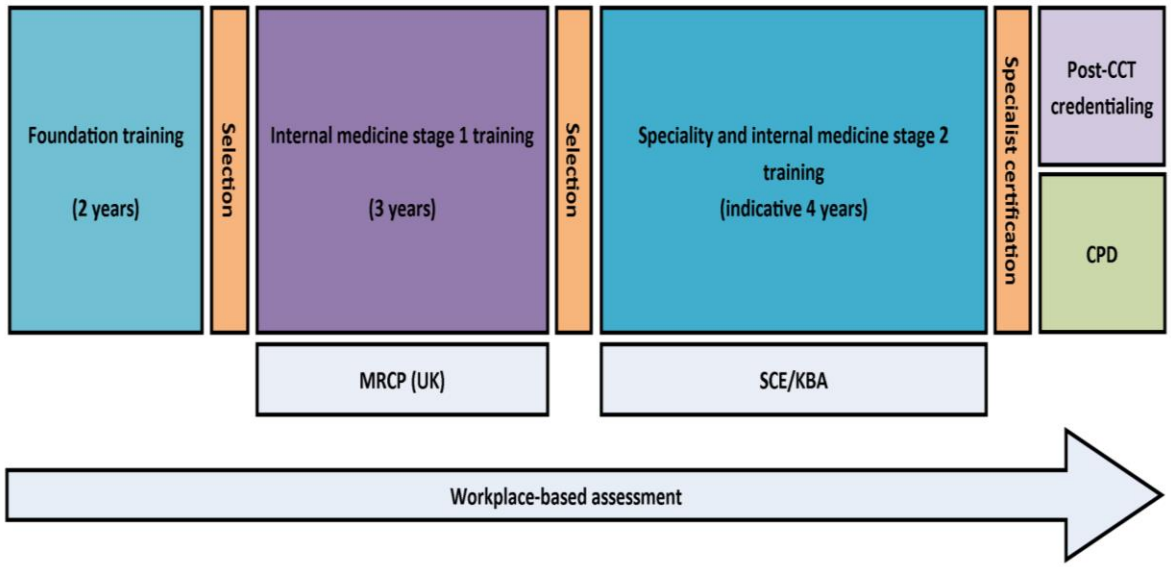
Most trainees will undertake IM stage 2 training in combination with training in a group 1 specialty . This programme will include an indicative one year of IM stage 2 training. The IM training will be integrated flexibly within the specialty training programme (some programmes will choose to run this as a separate year whilst others will integrate it within the specialty training). Internal medicine training will include supporting the acute unselected and the acute specialty take. As skills and experience in internal medicine are gained from specialty training, it is expected that training in IM alone will take an indicative period of three years to acquire the necessary capabilities.

A number of specialties managed by JRCPTB will continue to deliver non-acute, primarily outpatient-based services (group 2 specialties). These specialties will not undertake IM stage 2 training. Alternative core training pathways may be accepted for some physician specialties and will be defined in the relevant curricula.

Training pathway for single CCT training in Internal Medicine



Training pathway for dual training with group 1 specialties



2.4 Duration of training

Stage 2 Internal Medicine alone will usually be completed in an indicative three years of full time training. The overall indicative time with IM1 is five to six years. The duration of specialty training and completion of IM stage 2 training to CCT will vary by specialty. There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training more rapidly than the indicative time. Such trainees may have had previous experience in the specialty as it is recognised that clinical experience is a fundamental aspect of development as a good physician (guidance on completing training early will be available on the JRCPTB website). There may also be a small number of trainees who develop more slowly and will require an extension of training in line the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide)[6].

2.5 Flexibility and accreditation of transferrable competencies

This curriculum will allow flexibility between specialties through GPCs and higher-level learning outcomes.

It will allow trainees to train in academic medicine alongside their acquisition of generic and clinical capabilities, and these skills will be transferable across other specialties

[6] A Reference Guide for Postgraduate Specialty Training in the UK

The key interdependency will be with all Group 1 specialties which will dual train in internal medicine: many of the generic and clinical CiPs learnt will be both acquired in and transferable to these curricula.

GPCs will promote flexibility in postgraduate training as these common capabilities can be transferred from specialty to specialty. The IM generic CiPs will be shared across all physician curricula and the clinical CiPs shared across all group 1 specialties, supporting flexibility for trainees to move between the specialties. The generic capabilities and mapping of the curriculum to the GMC's Generic Professional Capabilities (GPC) framework will facilitate transferability of learning outcomes across other related specialties and disciplines.

2.6 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 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 the Gold Guide.

2.7 Generic Professional Capabilities and Good Medical Practice

The GMC has developed the Generic professional capabilities (GPC) framework[7] with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a common language. GPCs also represent a system-wide, regulatory response to the most common contemporary concerns about patient safety and fitness to practise within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

[7] Generic professional capabilities framework

The nine domains of the GMC's Generic Professional Capabilities

Good medical practice (GMP)[8] 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 describes nine domains with associated descriptors outlining the 'minimum common regulatory requirement' of performance and professional behaviour for those completing a CCT or its equivalent. These attributes are common, minimum and generic standards expected of all medical practitioners achieving a CCT or its equivalent.

The nine domains and subsections of the GPC framework are directly identifiable in the IM curriculum. They are mapped to each of the generic and clinical CiPs, which are in turn mapped to the assessment blueprints. This is to emphasise those core professional capabilities essential to safe clinical practice that must be demonstrated at every stage of training as part of the holistic development of responsible professionals.

This approach will allow early detection of issues most likely to be associated with fitness to practise and to minimise the possibility that any deficit is identified during the final phases of training.

This purpose statement has been endorsed by the GMC's Curriculum Oversight Group and confirmed as meeting the needs of the health services of the countries of the UK.

[8] Good Medical Practice

3 Content of Learning

The practice of Internal Medicine requires the generic and specialty knowledge, skills, attitudes and procedural skills 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.

The internal medicine curriculum is spiral and topics and themes will be revisited to expand understanding and expertise. The level of entrustment for capabilities in practice (CiPs) will increase as an individual progresses from 'competent' to 'expert'.

3.1 Capabilities in practice

CiPs describe the professional tasks or work within the scope of internal medicine. CiPs are based on the concept of entrustable professional activities[9] which use the professional judgement of appropriately trained, expert assessors. This is as a key aspect of the validity of assessment and a defensible way of forming global judgements of professional performance.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the knowledge, skills and attitudes which should be demonstrated by 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.

Many of the CiP descriptors refer to patient centred care and shared decision making. This is to emphasise the importance of patients being at the centre of decisions about their own treatment and care, by exploring care or treatment options and their risks and benefits and discussing choices available.

Additionally, the clinical CiPs repeatedly refer to the need to demonstrate professional behaviour with regard to patients, carers, colleagues and others. Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability. Appropriate professional behaviour should reflect the principles of GMP and the GPC framework.
In order to complete training and be recommended to the GMC for the award of CCT and entry to the specialist register, the doctor must demonstrate that they are capable of unsupervised practice in all generic and clinical CiPs. Once a trainee has achieved level 4 sign off for a CiP it will not be necessary to repeat assessment of that CiP if capability is maintained (in line with standard professional conduct).

[9] Nuts and bolts of entrustable professional activities

This section of the curriculum details the 14 generic and clinical CiPs for Internal Medicine stage 2 with expected levels of performance, mapping to relevant GPCs and the evidence that may be used to make an entrustment decision. The list of evidence for each CiP is not prescriptive and other types of evidence may be equally valid for that CiP.

3.2 Generic capabilities in practice

The six generic CiPs cover the universal requirements of all specialties as described in GMP and the GPC framework. Assessment of the generic CiPs will be underpinned by the descriptors for the nine GPC domains and evidenced against the performance and behaviour expected at that stage of training. Satisfactory sign off will indicate that there are no concerns. It will not be necessary to assign a level of supervision for these non-clinical CiPs.

In order to ensure consistency and transferability, the generic CiPs have been grouped under the GMP-aligned categories used in the Foundation Programme curriculum plus an additional category for wider professional practice:

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

For each generic CiP there is 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.

KEY

ACAT	Acute care assessment tool	ALS	Advanced Life Support
CbD	Case-based discussion	DOPS	Direct observation of procedural skills
GCP	Good Clinical Practice	MRCP (UK)	Membership of the Royal Colleges of Physicians Diploma
Mini-CEX	Mini-clinical evaluation exercise	MCR	Multiple consultant report
MSF	Multi source feedback	PS	Patient survey
QIPAT	Quality improvement project assessment tool	TO	Teaching observation

Generic capabilities in practice (CiPs)	
Category 1: Professional behaviour and trust	
1. Able to function successfully within NHS organisational and management systems	
Descriptors	• Aware of and adheres to the GMC professional requirements

	• Aware of public health issues including population health, social detriments of health and global health perspectives • Demonstrates effective clinical leadership • Demonstrates promotion of an open and transparent culture • Keeps practice up to date through learning and teaching • Demonstrates engagement in career planning • Demonstrates capabilities in dealing with complexity and uncertainty • Aware of the role of and processes for operational structures within the NHS • Aware of the need to use resources wisely
GPCs	Domain 1: Professional values and behaviours Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF Active role in governance structures Management course End of placement reports
2. Able to deal with ethical and legal issues related to clinical practice	
Descriptors	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups • Behaves in accordance with ethical and legal requirements • Demonstrates ability to offer apology or explanation when appropriate • Demonstrates ability to lead the clinical team in ensuring that medico legal factors are considered openly and consistently
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF CbD DOPS Mini-CEX MRCP(UK) ALS certificate End of life care and capacity assessment End of placement reports
Category 2: Communication, teamworking and leadership	
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	
Descriptors	• Communicates clearly with patients and carers in a variety of settings

	• Communicates effectively with clinical and other professional colleagues • Identifies and manages barriers to communication (eg 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
GPCs	Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR MSF PS MRCP(UK) End of placement reports ES report
Category 3: Safety and quality	
4. Is focussed 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 • Avoids organising unnecessary investigations or prescribing poorly evidenced treatments
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)*

	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries 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 • patient safety • quality improvement
Evidence to inform decision	MCR MSF QIPAT End of placement reports
Category 4: 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 the role of evidence in clinical practice and demonstrates shared decision making with patients • Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry • Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice • Follows guidelines on ethical conduct in research and consent for research • Understands public health epidemiology and global health patterns • Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 7: Capabilities in safeguarding vulnerable groups Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF MRCP(UK) GCP certificate (if involved in clinical research) Evidence of literature search and critical appraisal of research Use of clinical guidelines Quality improvement and audit 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 • 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 provide clinical supervision to doctors in earlier stages of training
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 Clinical capabilities in practice

The eight IM clinical CiPs describe the clinical tasks or activities which are essential to the practice of Internal Medicine. The clinical CiPs have been mapped to the nine GPC domains to reflect the professional generic capabilities required to undertake the clinical tasks.

Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

Clinical CiPs – Internal Medicine	
1. Managing an acute unselected take	
Descriptors	• Demonstrates 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
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty

	clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries 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 • patient safety • quality improvement
Evidence to inform decision	MCR MSF CbD ACAT Logbook of cases Simulation training with assessment
2. Managing the acute care of patients within a medical specialty service	
Descriptors	• Able to manage patients who have been referred acutely to a specialised medical service as opposed to the acute unselected take (eg cardiology and respiratory medicine acute admissions) • Demonstrates 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 a medical specialty setting • Refers patients appropriately to other specialties as required
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements

	• national legislation • the health service and healthcare systems in the four countries 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 • patient safety • quality improvement
Evidence to inform decision	MCR MSF CbD ACAT Logbook of cases Simulation training with assessment
3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment	
Descriptors	• Demonstrates 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 inpatients 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 medial inpatients (unselected take, selected acute take or specialty admissions) • Demonstrates awareness of the quality of patient experience
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries 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 • patient safety • quality improvement
Evidence to inform decision	MCR MSF ACAT Mini-CEX

	DOPS
4. Managing patients in an outpatient clinic, ambulatory or community setting (including management of long term conditions)	
Descriptors	• Demonstrates 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
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR ACAT mini-CEX PS Letters generated at outpatient clinics
5. Managing medical problems in patients in other specialties and special cases	
Descriptors	• Demonstrates effective consultation skills (including when in challenging circumstances) • Demonstrates management of medical problems in inpatients under the care of other specialties • Demonstrates appropriate and timely liaison with other medical specialty services when required
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 7: Capabilities in safeguarding vulnerable groups

Evidence to inform decision	MCR ACAT CbD
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 • Ensures continuity and coordination of patient care through the appropriate transfer of information demonstrating safe and effective handover • Effectively estimates length of stay • Delivers patient centred care including shared decision making • Identifies appropriate discharge plan • Recognises the importance of prompt and accurate information sharing with primary care team following hospital discharge
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR MSF ACAT 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 knowledge of 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
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries

	Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR DOPS ACAT MSF ALS certificate Logbook of cases Reflection Simulation training with assessment
8. Managing end of life and applying 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 • Demonstrates effective consultation skills in challenging circumstances • Demonstrates compassionate professional behaviour and clinical judgement
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries
Evidence to inform decision	MCR CbD Mini-CEX MSF Regional teaching Reflection

3.4 Presentations and conditions

The scope of Internal Medicine is broad and cannot be encapsulated by a finite list of presentations and conditions. Any attempt to list all relevant presentations, conditions and 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. In this spiral curriculum, trainees will expand and develop the knowledge, skills and attitudes around managing patients with these conditions and presentations. The patient should always be at the centre of knowledge, learning and care.

Trainees must demonstrate core bedside skills, including information gathering through history and physical examination and information sharing with patients, families and colleagues.

Treatment care and strategy covers how a doctor selects drug treatments or interventions for a patient. It includes discussions and decisions as to whether care is focused mainly on curative intent or whether the main focus is on symptomatic relief. It also covers broader aspects of care, including involvement of other professionals or services.

Particular presentations, conditions and issues are listed either because they are common (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. Specifically, many if not most of these presentations and conditions will be highly relevant to the specialty of Acute Internal Medicine (AIM) but we have not listed AIM as a specialty because to do so would merely produce repetition of much of this list of presentations and conditions/issues, many of which have both acute and chronic disease implications.

The table of systems/specialties, presentations and conditions of Internal Medicine is to be interpreted with common sense. The number of times each condition and presentation appears in the syllabus has been limited to avoid repetition, 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, for each condition/presentation, trainees will need to be familiar with such aspects as aetiology, epidemiology, clinical features, investigation, management and prognosis. Our approach is to provide general guidance and not exhaustive detail, which would inevitably become out of date.

Presentations and conditions of Internal Medicine by system/specialty

System/Specialty and subspecialty	Presentations	Conditions/Issues
Emergency presentations	Cardiorespiratory arrest Shocked patient Unconscious patient Anaphylaxis	
Allergy	Acute and chronic allergic symptoms Anaphylaxis Angioedema Asthma Nose and sinus symptoms Urticaria	Allergy – food, latex, insect venom, transfusion Anaphylaxis Asthma Drug – allergy and intolerance Rhinitis / sinusitis / conjunctivitis Skin disorders Urticaria and angioedema
Cardiology	Breathlessness Chest pain Limb pain Limb swelling Palpitations Syncope and pre-syncope	Cardiac arrhythmias Cardiac failure Cardiac involvement in genetic disease Cardiac involvement in infectious disease Congenital heart disease in the adult Coronary heart disease Diseases of heart muscle Diseases of the arteries, including aortic dissection Diseases of the pulmonary circulation Heart valve disease Hypertension Hyperlipidaemia Oedema Pericardial disease Tumours of the heart Venous thromboembolism
Clinical genetics	Familial condition Interpretation of a genetic test Possibility of genetic diagnosis Request for genetic testing	Common single gene disorders in the adult
Clinical pharmacology and therapeutics	Poisoning Drug side effects Drug allergy Hypertension	Adverse drug reactions Practice safe / rational prescribing and medicines optimisation Use national or local guidelines on appropriate and safe prescribing
Dermatology	Mouth ulcer Pruritus Rash Skin lesions	Blood and lymphatic vessel disorders Cutaneous reactions to drugs Cutaneous vasculitis, connective tissue diseases and urticaria Dermatitis / eczema

System/Specialty and subspecialty	Presentations	Conditions/Issues
		Disorders of pigmentation Hair and nail disorders Infections of the skin and soft tissues Inherited skin diseases Papulosquamous diseases Photosensitivity Sebaceous and sweat gland disorders Skin in systemic disease Tumours of the skin Blistering disorders
Endocrinology and diabetes mellitus	Amenorrhoea Hirsutism Hyperglycaemia Hypoglycaemia Obesity Polydipsia Polyuria Sick day rules Weight gain Weight loss	Adrenal disorders Benign breast diseases Diabetes mellitus Disorders of growth Disorders of male reproduction Disorders of puberty Disorders of the anterior pituitary Disorders of the posterior pituitary Electrolyte disorders Ovarian disorders Pancreatic endocrine disorders (other) Parathyroid disorders Sexual dysfunction Thyroid disorders
Gastroenterology and Hepatology	Abdominal mass / hepatosplenomegaly Abdominal pain Abdominal swelling Anaemia (iron deficiency) Constipation Diarrhoea Dyspepsia Haematemesis and melaena Jaundice Nausea and vomiting Rectal bleeding Swallowing difficulties Weight loss	Acute abdominal pathologies Alcohol related liver disease including the withdrawal syndrome Chronic liver diseases Congenital abnormalities of the GI tract Diet and nutritional support Diseases of the colon Diseases of the gall bladder, pancreas and biliary tree Diseases of the mouth and salivary glands Diseases of the oesophagus Diseases of the small bowel Diseases of the stomach Functional bowel disorders Gastrointestinal infections Inflammatory bowel diseases Malabsorption Nutrition and malnutrition Refeeding The acute abdomen Vascular disorders of the GI tract

System/Specialty and subspecialty	Presentations	Conditions/Issues
Genitourinary medicine	Genital discharge and ulceration Genital rash Erectile dysfunction, genital lumps, rectal discharge, post coital and intermenstrual bleeding, pelvic pain, dyspareunia	HIV infection Prevention of conditions related to sexual behaviour Sexually transmitted infections and systemic complications Reproductive health (incl contraception)
Geriatric medicine	Delirium Deterioration in mobility Falls Fragility fractures Frailty Hypothermia Incontinence Memory loss Unsteadiness / balance disturbance	Continence – faecal and urinary Dementias Depression Malnutrition Movement disorders Osteoporosis Pharmacology Subarachnoid haemorrhage Stroke Transient ischaemic attack Pressure ulcers
Haematology	Anaemia Bruising and spontaneous bleeding Coagulation test abnormality Full blood count abnormality Lymphadenopathy Neutropenic fever Paraproteinaemia Splenomegaly Transfusion reactions	Anaemia Blood transfusion and alternatives Common haematological malignancies Bone marrow failure Haemoglobinopathies Haemolysis MGUS (monoclonal gammopathy of uncertain significance) Thrombosis and anticoagulant therapy
Immunology		Autoimmune systemic disorders Primary immunodeficiency disorders
Infectious diseases	Fever Genital discharge and ulceration Sepsis syndrome Weight loss	Anti-microbial drug monitoring Anti-microbial resistance and stewardship Bacterial infections Evaluation of the unwell returning traveller Fever of unknown origin Fungal infections Helminth infections HIV infection Infections in the immune-compromised host Protozoal infections Viral infections Traveller and migrant health
Medical ophthalmology	Diplopia Optic disc swelling	Cranial nerve palsy Glaucoma

System/Specialty and subspecialty	Presentations	Conditions/Issues
	Painful eye Red eye Vision loss	Inflammatory eye disease TIA/stroke Retinal vascular disease
Neurology	Abnormal sensation (paraesthesia and numbness) Abnormal behaviour Acute confusion Bladder, bowel and sexual dysfunction Breathlessness Dizziness and vertigo 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	Acute stroke and transient ischaemic attacks Chronic neurological disability Dementia and cognitive disorders Delirium Epilepsy Functional illness Head injury Meningitis and encephalitis Migraine and other headache syndromes Motor neurone disease Multiple sclerosis Myasthenia gravis Myopathies (acute and chronic) Parkinson's disease and other movement disorders Peripheral neuropathy (acute and chronic) Subarachnoid haemorrhage and cerebral venous sinus thrombosis Tumours involving the brain and spinal cord
Oncology	Weight loss	Common cancers Hypercalcaemia Neutropenic sepsis Paraneoplastic conditions Premalignant conditions Spinal cord compression SVC obstruction
Palliative medicine and end of life care	Pain Physical symptoms other than pain Psychosocial concerns including spiritual care and care of family The dying patient	Advanced malignancy End stage organ failure Frailty Multiple comorbidity
Public health and health promotion		Alcohol Exercise Mental health Non-communicable diseases Nutrition Obesity Occupation Sexual behaviour Smoking

System/Specialty and subspecialty	Presentations	Conditions/Issues
		Social deprivation Substance abuse UK and global health
Psychiatry	Aggressive or disturbed behaviour Alcohol and substance dependence Anxiety or panic Physical symptoms unexplained by organic disease Self-harm Treatment refusal	Alcohol and substance misuse Anxiety disorders Bipolar disorder Delirium Dementias Depression Eating disorders Personality disorder Phobias Psychoses Schizophrenia Somatic symptom disorders Stress disorders Suicide and self-harm
Renal medicine	Dysuria Electrolyte abnormality Fluid balance abnormality Haematuria Hypertension Loin pain Micturition difficulties Polyuria Proteinuria Raised serum creatinine	Acute kidney injury Chronic kidney disease Drugs and the kidney Electrolyte disorders Fluid balance disorders Genetic disorders affecting the kidneys Glomerular diseases Malignant disease of the urinary tract Nephrotic syndrome Renal replacement therapy Renal tubular disorders Systemic disorders affecting the kidneys Tubulointerstitial diseases Urinary tract infection Urinary tract obstruction
Respiratory medicine	Breathlessness Pleuritic chest pain Cough Haemoptysis Hoarseness Stridor Pleural effusion Wheeze	Asthma Bronchiectasis Chronic obstructive pulmonary disease Cystic fibrosis Diseases of the pulmonary circulation Disorders of the thoracic cage and diaphragm Disorders of the upper respiratory tract Immune mediated respiratory diseases Interstitial lung diseases Malignant diseases of the respiratory system

System/Specialty and subspecialty	Presentations	Conditions/Issues
		Pleural diseases including pneumothorax Occupational lung diseases Pulmonary embolism Sarcoidosis Sleep related breathing disorders Respiratory infections Respiratory failure Tuberculosis
Rheumatology	Back pain Joint pain and swelling Neck pain Rash and weakness	Multisystem rheumatic disorders Spinal pain and regional disorders Crystal-related arthropathies Infection and arthritis Metabolic bone diseases Monitoring and toxicity of immunosuppressive drugs including biologics Osteoarthritis Osteoporosis Rheumatoid arthritis Spondyloarthritides
Other / all - clinical	Incidental findings Medical problems following surgical procedures Medical problems in pregnancy Physical symptoms unexplained by organic disease Pre-operative assessment	Chronic fatigue syndrome

3.5 Practical procedures

There are a number of internal medicine procedural skills in which a trainee must become proficient.

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 help when appropriate. For all practical procedures the trainee must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary.

Trainees should receive training in procedural skills in a clinical skills lab if required. Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool. 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 IM stage 2. Trainees are expected to maintain procedural competencies achieved during IM stage 1 training.

Obtaining independence in all of these practical procedures is desirable but not essential for the completion of IM stage 2. Sites that require trainees to be able to perform particular procedures independently for service reasons will need to put in place mechanisms to provide training and assure competence for independent practice. Trainees working in sites that do not provide such training are required to have skills lab training on a minimum of two occasions in Internal Medicine stage 2 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. It is a matter of professional conduct and probity that all doctors maintain the appropriate skills to perform the practical procedures required by their scope of practice. In accordance with clinical governance the trust/health board should ensure that no doctor performs procedures that they are not competent to carry out.

Internal medicine practical procedures

Internal Medicine stage 2	
Procedure	**Minimum level**
Advanced cardiopulmonary resuscitation (CPR)	Leadership of CPR team
Direct current (DC) cardioversion	Competent to perform unsupervised
Temporary cardiac pacing using an external device	Skills lab or satisfactory supervised practice
Central venous cannulation (internal jugular or subclavian)	Skills lab or satisfactory supervised practice
Access to circulation for resuscitation (femoral vein or intraosseous)[a]	Skills lab or satisfactory supervised practice
Pleural aspiration for fluid (diagnostic) [b, c]	Competent to perform unsupervised
Pleural aspiration (pneumothorax)[c]	Competent to perform unsupervised
Intercostal drain for pneumothorax	Skills lab or satisfactory supervised practice
Intercostal drain for effusion [b]	Skills lab or satisfactory supervised practice
Nasogastric (NG) tube	Competent to perform unsupervised
Ascitic tap	Competent to perform unsupervised
Abdominal paracentesis	Skills lab or satisfactory supervised practice
Lumbar puncture	Competent to perform unsupervised

Notes

[a] The requirement is for a minimum of skills lab training or satisfactory supervised practice 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] Pleural procedures should be undertaken in line with the British Thoracic Society guidelines. These state that thoracic ultrasound guidance is strongly recommended for all pleural procedures for pleural fluid, also that the marking of a site using thoracic ultrasound for subsequent remote aspiration or chest drain insertion is not recommended. Ultrasound guidance should be provided by a -trained thoracic ultrasound practitioner.

[c] It can be assumed that a trainee who is capable of performing pleural aspiration of fluid is capable of introducing a needle to decompress a large symptomatic pneumothorax

4 Learning and Teaching

4.1 The training programme

The organisation and delivery of postgraduate training is the responsibility of the Health Education England (HEE), NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA) – referred to from this point as 'deaneries'. A training programme director (TPD) will be responsible for coordinating the Internal Medicine stage 2 training programme. In England, the local organisation and delivery of training is overseen by a school of medicine.

Progression through the programme will be determined by the Annual Review of Competency Progression (ARCP) process and the training requirements for each indicative year of training are summarised in the IM stage 2 ARCP decision aid (available on the JRCPTB website).

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 curriculum requirements are met and also that unnecessary duplication and educationally unrewarding experiences are avoided.

The following provides a guide on how training programmes should be focussed in each training year in order for trainees to gain the experience and develop the capabilities to the level required.

When training in IM stage 2 all trainees will have an appropriate clinical supervisor (a senior member of the IM team) and an appropriate educational supervisor in IM. The clinical supervisor and educational supervisor may be the same person. It will be best practice for trainees in IM stage 2 to have an educational supervisor who practises IM themselves. However, educational supervisors of IM trainees who do not themselves practise IM must take particular care to ensure that they obtain and consider detailed feedback from clinical supervisors who are knowledgeable about the trainees' IM performance and include this in their educational reports.

Mandatory training

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

standards. The teaching and learning methods section provides guidance on the learning experiences required.

Acute medical take
Trainees should be involved in the acute unselected medical take and they should be actively involved (have sufficient input for their involvement to be recorded in the patient's clinical notes) in the care of an indicative 750 patients presenting with acute unselected medical problems during the course of IM stage 2 training.

Trainees will need to demonstrate they have the required capabilities to manage the acute unselected take at completion of training, hence it is required that they are involved in the acute unselected take for an indicative three months in the final year of training (e.g. three months of involvement with the acute unselected take as part of dual training with specialty; four weeks of attachment to an acute medicine service with no concurrent specialty duties), during which time they must be involved in the care of an indicative 100 patients presenting with acute unselected medical problems.

Care of medical specialty patients with acute illness
It is recognised that not all specialties will have an acute specialty take but all will receive patients in an unscheduled fashion. The trainee should be able to manage the specialty conditions with which the patient presents and provide management of co-existing acute medical illness.

Inpatients
Trainees in internal medicine must be entrusted to provide continuity of care to medical inpatients without supervision by completion of training (clinical CiP 3). Trainees will have had extensive experience and training in this capability during IM stage 1 and during IM stage 2 they should build on this by undertaking an indicative minimum of 12 months further experience and training in continuing ward care of patients admitted with acute medical problems. In order to confirm that trainees are confident and capable of unsupervised practice at the time of CCT an indicative minimum of three months of inpatient care should occur in the last year of training.

The inpatient setting should provide trainees with experience of the following:

- Assessment of patients during the course of acute medical illness
- Decision making during the course of acute medical illness
- Discussion with patients and relatives during the course of acute medical illness
- Management of the patient who is deteriorating, including decisions about and implementation of plans for escalation of care (to HDU, ICU) or move to palliative care
- Planning discharge of patients along with other members of the MDT.

In addition to the indicative minimum 12 months experience of inpatient care, trainees will acquire relevant skills, knowledge and behaviours (as detailed above and in the CiP descriptors) in specialty settings such as the acute take, outpatients, hospices, community and ambulatory care.

Outpatients
Trainees should attend and be actively involved in an indicative minimum of 20 clinics that occur outside of their main specialty. Reflecting changes in clinical practice, some of this training could be provided as community experience, virtual clinics and work in ambulatory settings. The choice of clinic / experience should be driven by the educational needs of the trainee, as identified by the trainee and their educational supervisor, with the educational objectives as set out in the teaching and learning methods section.

Simulation
Simulation teaching involving human factors and scenarios training should be carried out in IM stage 2 with refresher training for procedural skills where necessary. Simulation can underpin assessment of the GPCs, for example, leadership and teamworking, communication skills and time management.

Recommended training

Palliative and end of life care experience
Trainees should be involved in the management of patients who are approaching the end of their lives and be able to demonstrate that they can recognise such patients and care for them and their families appropriately. Attachments with or experience of working with a palliative care team are strongly recommended.

Working with primary care and the community
Trainees will need to demonstrate that they have an understanding of primary care and community services, and they should be able to interact with them appropriately and effectively. Experience of and training in working across the primary-secondary care divide (e.g. rapid access outpatient clinics, admission avoidance clinics, and ambulatory care) will be markers of good practice.

Working in the manner of a consultant
At the completion of CCT doctors need to be able to function as independent consultant practitioners. It will be a marker of good practice for trainees in their final year to be given up to 3 months of experience 'acting up' (with appropriate supervision) as a consultant in Internal Medicine.

4.2 Teaching and learning methods

The curriculum will be delivered through a variety of learning experiences and will achieve the capabilities 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.

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
The educational objectives of attending clinics are:

- To understand the management of chronic diseases
- Be able to assess a patient in a defined time-frame
- To interpret and act on the referral letter to clinic
- To propose an investigation and management plan in a setting different from the acute medical situation
- To review and amend existing investigation plans
- To write an acceptable letter back to the referrer
- To communicate with the patient and where necessary relatives and other health care professionals.

These objectives can be achieved in a variety of settings including hospitals, day care facilities and the community. 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. Trainees should see a range of new and follow-up patients and present their findings to their clinical supervisor. Clinic letters written by the trainee should also be reviewed and feedback given.

The number of patients that a trainee should see in each clinic is not defined, neither is the time that should be spent in clinic, but as a guide this should be a minimum of two hours.

Clinic experience should be used as an opportunity to undertake supervised learning events and reflection.

Reviewing patients with consultants
It is important that trainees have an opportunity to present at least a proportion of the patients whom they have admitted to their consultant in order to obtain immediate feedback on their performance (that may be supplemented by an appropriate WBA such as an ACAT, mini-CEX or CBD). This may be accomplished when working on a take shift along with a consultant or on a post-take ward round with a consultant.

Personal ward rounds and provision of ongoing clinical care on specialist medical ward attachments
Every patient seen, on the ward or in outpatients, 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.

Ward rounds by more senior doctors
Every time a trainee observes another doctor seeing a patient or their relatives there is an opportunity for learning. Ward rounds (including post-take) should be led by a more senior doctor and 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 inpatients. 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.

Palliative and end of life care
Trainees should have significant experience of palliative care with the objective of:

- Enhancing skills in recognising the patient with limited reversibility of their medical condition and the dying patient
- Enhancing ability to recognise the range of interventions that can be delivered in acute and non-acute settings (eg community, hospice or care home)
- Increasing confidence in managing physical symptoms inpatients and psychosocial distress inpatients and families
- Increasing confidence in developing appropriate advance care plans, including DNACPR decisions

These learning objectives and experience of end of life care can be achieved during attachments to routine medical teams (eg geriatric medicine, oncology, respiratory medicine) and ICU, which will allow a trainee to acquire and demonstrate the necessary capabilities to comply with clinical CiP 8. An attachment with a specific palliative care team and/or consultant would give a broader perspective in this complex and important area, hence training programme directors and those managing both acute medical and palliative care services are encouraged to consider how this might be achieved. This is particularly relevant if a trainee is doing stand alone IM or dual training in a specialty which does not include palliative medicine experience

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 teaching within a training site)
- 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.

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.

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 and leadership courses and communication courses which are particularly relevant to patient safety and experience.

4.3 Academic training

The four nations have different arrangements for academic training and doctors in training should consult the local deanery for further guidance.

Trainees may train in academic medicine as an academic clinical fellow (ACF), academic clinical lecturer (ACL) or equivalent.

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.

4.4 Taking time out of programme

There are a number of circumstances when a trainee may seek to spend some time out of specialty training, such as undertaking a period of research or taking up a fellowship post. All such requests must be agreed by the postgraduate dean in advance and trainees are advised to discuss their proposals as early as possible. Full guidance on taking time out of programme can be found in the Gold Guide.

4.5 Acting up as a consultant

A trainee coming towards the end of their training may spend up to three months “acting-up” as a consultant, provided that a consultant supervisor is identified for the post and satisfactory progress is made. As long as the trainee remains within an approved training programme, the GMC does not need to approve this period of “acting up” and their original CCT date will not be affected. More information on acting up as a consultant can be found in the Gold Guide.

5 Programme of Assessment

5.1 Purpose of assessment

The purpose of the programme of assessment 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 GPCs and meet the requirements of GMP
- 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 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.

5.2 Programme of Assessment

Our programme of assessment refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of training. The purpose of the programme of assessment is to robustly evidence, ensure and clearly communicate the expected levels of performance at critical progression points defined in the curriculum and to demonstrate satisfactory completion of training as required by the curriculum.

The programme of assessment is comprised of several different individual types of assessment. A range of assessments is needed to generate the necessary evidence required for global judgements to be made about satisfactory performance, progression in, and completion of, training. All assessments, including those conducted in the workplace, are linked to the relevant curricular learning outcomes (eg through the blueprinting of assessment system to the stated curricular outcomes).

The programme of assessment emphasises the importance and centrality of professional judgement in making sure learners have met the learning outcomes and expected levels of performance set out in the approved curricula. Assessors will make accountable, professional judgements. The programme of assessment describes how professional judgements are used and collated to support decisions on progression and satisfactory completion of training.

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 continually to 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.

Reflection and feedback should be an integral component to all SLEs and WBPAs. In order for trainees to maximise benefit, reflection and feedback should take place as soon as possible after an event. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently. Feedback should be of high quality and should include an action plan for future development for the trainee. Both trainees and trainers should recognise and respect cultural differences when giving and receiving feedback.

5.3 Assessment of CiPs

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks.

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 and multiple consultant reports will include global assessment anchor statements.

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 their progression for each CiP and record this in the eportfolio with signposting to the evidence to support their rating.

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, with commentary.

For generic CiPs, the ES will indicate whether the trainee is meeting expectations or not using the global 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 clinical CiPs, the ES will make an entrustment decision for each CiP and record the indicative level of supervision required with detailed comments to justify their entrustment decision. The ES will also indicate the most appropriate global anchor statement (see above) for overall performance.

Level descriptors for clinical CiPs

Level	Descriptor
Level 1	**Entrusted to observe only** – no provision of clinical care
Level 2	**Entrusted to act with direct supervision**: The trainee may provide clinical care, but the supervising physician is physically within the hospital or other site of patient care and is immediately available if required to provide direct bedside supervision
Level 3	**Entrusted to act with indirect supervision**: The trainee may provide clinical care when the supervising physician is not physically present within the hospital or other site of patient care, but is available by means of telephone and/or electronic media to provide advice, and can attend at the bedside if required to provide direct supervision
Level 4	**Entrusted to act unsupervised**

The 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. ARCPs will be held for each training year. The final ARCP will ensure trainees have achieved level 4 in all CiPs for the critical progression point at completion of training.

5.4 Critical progression points

There will be a key progression point on completion of IM stage 2 training. Trainees will be required to be entrusted at level 4 in all CiPs in order to achieve an ARCP outcome 6 and be recommended for a CCT in IM.

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 each year of training. The ARCP panel will make the final decision on whether the trainee can be signed off and progress to the next year/level of training [see section 5.6].

The outline grid below sets out the expected level of supervision and entrustment for the clinical CiPs and the critical progression points for the whole of IM training.

Table 1: Outline grid of levels expected for Internal Medicine clinical CiPs at the end of each year of training - single CCT

Level descriptors
Level 1: Entrusted to observe only – no clinical care
Level 2: Entrusted to act with direct supervision
Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

	Internal Medicine stage 1				Selection	Internal Medicine stage 2			CCT
Specialty CiP	**IMY1**	**IMY2**	**CRTICAL PROGRESSION POINT**	**IMY3**	**CRITICAL PROGRESSION POINT**	**ST4**	**ST5**	**ST6**	**CRITICAL PROGRESSION POINT**
1. Managing an acute unselected take		**3**		**3**				**4**	
2. Managing the acute care of patients within a medical specialty service		**2**		**2**				**4**	
3. Providing continuity of care to medical inpatients		**3**		**3**				**4**	
4. Managing outpatients with long term conditions		**2**		**3**				**4**	
5. Managing medical problems in patients in other specialties and special cases		**2**		**3**				**4**	
6. Managing an MDT including discharge planning		**2**		**3**				**4**	
7. Delivering effective resuscitation and managing the deteriorating patient		**3**		**4**				**4**	
8. Managing end of life and applying palliative care skills		**2**		**3**				**4**	

Table 2: Outline grid of levels expected for Internal Medicine clinical CiPs at the end of each year of training - dual CCT

Level descriptors

Level 1: Entrusted to observe only – no clinical care
Level 2: Entrusted to act with direct supervision
Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

	Internal Medicine stage 1				Selection	Internal Medicine stage 2 + specialty training				CCT
Specialty CiP	**IMY1**	**IMY2**	**CRITICAL PROGRESSION POINT**	**IMY3**	**CRITICAL PROGRESSION POINT**	**ST4**	**ST5**	**ST6**	**ST7**	**CRITICAL PROGRESSION POINT**
1. Managing an acute unselected take		**3**		**3**					**4**	
2. Managing the acute care of patients within a medical specialty service		**2**		**2**			**3**		**4**	
3. Providing continuity of care to medical inpatients		**3**		**3**					**4**	
4. Managing outpatients with long term conditions		**2**		**3**					**4**	
5. Managing medical problems in patients in other specialties and special cases		**2**		**3**					**4**	
6. Managing an MDT including discharge planning		**2**		**3**					**4**	
7. Delivering effective resuscitation and managing the deteriorating patient		**3**		**4**					**4**	
8. Managing end of life and applying palliative care skills		**2**		**3**					**4**	

5.5 Evidence of progress

The following methods of assessment will provide evidence of progress in the integrated programme of assessment. The requirements for each training year/level are stipulated in the ARCP decision aid (www.jrcptb.org.uk).

Summative assessment

Examinations and certificates

- Advanced Life Support Certificate (ALS)

MRCP(UK) must be achieved before entry to IM stage 2 training.

Workplace-based assessment (WPBA)

- Direct Observation of Procedural Skills (DOPS) - summative

Formative assessment

Supervised Learning Events (SLEs)

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

WPBA

- Direct Observation of Procedural Skills (DOPS) - formative
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)

These methods are described briefly below. More information and guidance for trainees and assessors are available in the eportfolio and on the JRCPTB website (www.jrcptb.org.uk).

Assessment should be recorded in the trainee's eportfolio. These methods include feedback opportunities as an integral part of the programme of assessment.

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, but may be used in other settings, including outpatient clinic. It is primarily for assessment of their ability to prioritise, to work efficiently, to work with and lead a team, and to interact effectively with nursing and other

colleagues. It can also be used for assessment and feedback in relation to care of individual patients. Any senior doctor who has supervised the trainee during the appropriate patient interaction (as described above) can be the assessor for an ACAT.

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, and discharge summary). A typical encounter might be when presenting newly referred patients in the outpatient 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. DOPS can be undertaken as many times as the trainee and their supervisor feel is necessary (formative). A trainee can be regarded as competent to perform a procedure independently after they are signed off as such by an appropriate assessor (summative). It is the trainee's responsibility to maintain those skills appropriately and to seek additional training should they feel it is necessary. This is a matter of probity and clinical governance.

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. Raters should be agreed with the educational supervisor at the start of the training year. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the Educational Supervisor.

Patient Survey (PS)
A trainee's interaction with patients should be continually observed and assessed. The Patient Survey provides a tool to assess a trainee during a consultation period. The Patient Survey assesses the trainee's performance in areas such as interpersonal skills, communication skills and professionalism.

Quality Improvement Project Assessment Tool (QIPAT)
The QIPAT is designed to assess a trainee's competence in completing a quality improvement project. The QIPAT 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 TO form is designed to provide structured, formative feedback to trainees on their competence at teaching. The TO 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).

Supervisors reports

Multiple Consultant Report (MCR)
The MCR captures the views of consultant supervisors based on observation of a trainee's performance in practice. 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 contribute to the educational supervisor's report.

Educational supervisors report (ESR)
The ES will periodically (at least annually) record a longitudinal, global report of a trainee's progress based on a range of assessment, potentially including observations in practice or reflection on behaviour by those who have appropriate expertise and experience. The ESR will include the ES's summative judgement of the trainee's performance and the entrustment decisions given for the learning outcomes (CiPs). The ESR can incorporate commentary or reports from longitudinal observations, such as from supervisors (MCRs) and formative assessments demonstrating progress over time.

5.6 Decisions on progress (ARCP)

The decisions made at critical progression points should be clear and defensible. They must be fair and robust and make use of evidence from a range of assessments, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise or experience. They can also incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

Periodic (at least annual) review should be used to collate and systematically review evidence about a doctor's performance and progress in a holistic way and make decisions about their progression in training. The annual review of progression (ARCP) process supports the collation and integration of evidence to make decisions about the achievement of expected outcomes.

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks, as do decisions about the satisfactory completion of presentations/conditions and procedural skills set out in this curriculum. The outline grid in section 5.4 sets out the level of supervision expected for each of the clinical CiPs. The table of practical procedures sets out the minimum level of performance expected at the end of each year of training. The requirements for each year of training are set out in the ARCP decision aid (www.jrcptb.org.uk).

The ARCP process is described in the Gold Guide. 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.

The penultimate ARCP prior to the anticipated CCT date will include an external assessor from outside the training programme. This is known as the Penultimate Year Assessment (PYA) and will identify any outstanding targets that the trainee will need to complete to meet all the learning outcomes.

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.

Poor performance will be managed in line with the Gold Guide.

5.7 Assessment blueprint

The table below show the possible methods of assessment for each CiP. It is not expected that every method will be used for each competency and additional evidence may be used to help make a judgement on capability.

KEY

ACAT	Acute care assessment tool	CbD	Case-based discussion
DOPS	Direct observation of procedural skills	Mini-CEX	Mini-clinical evaluation exercise
MCR	Multiple consultant report	MSF	Multi source feedback
PS	Patient survey	QIPAT	Quality improvement project assessment tool
TO	Teaching observation		

Blueprint for WPBAs mapped to CiPs

Learning outcomes	ACAT	CbD	DOPS	MCR	Mini -CEX	MSF	PS	QIPAT	TO
Generic outcomes									
Able to function successfully within NHS organisational and management systems				√		√			
Able to deal with ethical and legal issues related to clinical practice		√	√	√	√	√			
Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement				√		√	√		
Is focussed on patient safety and delivers effective quality improvement in patient care				√		√		√	
Carrying out research and managing data appropriately				√		√			
Acting as a clinical teacher and clinical supervisor				√		√			√
Specialty outcomes									
Managing an acute unselected take	√	√		√		√			
Managing the acute care of patients within a medical specialty service	√	√		√		√			
Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment	√		√	√	√	√			
Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions	√			√	√		√		
Managing medical problems in patients in other specialties and special cases	√	√		√					
Managing a multi-disciplinary team including effective discharge planning	√			√		√			
Delivering effective resuscitation and managing the acutely deteriorating patient	√		√	√		√			
Managing end of life and applying palliative care skills		√		√	√	√			
Practical procedural skills			√						

6 Supervision and feedback

This section of the curriculum describes how trainees will be supervised, and how they will receive feedback on performance. For further information please refer to the AoMRC guidance on Improving feedback and reflection to improve learning[10].

Access to high quality, supportive and constructive feedback is essential for the professional development of the trainee. Trainee reflection is an important part of the feedback process and exploration of that reflection with the trainer should ideally be a two way dialogue. Effective feedback is known to enhance learning and combining self-reflection to feedback promotes deeper learning.

Trainers should be supported to deliver valuable and high quality feedback. This can be by providing face to face training to trainers. Trainees would also benefit from such training as they frequently act as assessors to junior doctors, and all involved could also be shown how best to carry out and record reflection.

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 discuss all cases with a supervisor if appropriate. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

Organisations must make sure that each doctor in training has access to a named clinical supervisor and a named educational supervisor. Depending on local arrangements these roles may be combined into a single role of educational supervisor. However, it is preferred that a trainee has a single named educational supervisor for (at least) a full training year, in which case the clinical supervisor is likely to be a different consultant during some placements.

The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training[11].

Educational supervisor
The educational supervisor is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements. Trainees on a dual training program may have a single educational supervisor

[10] Improving feedback and reflection to improve learning. A practical guide for trainees and trainers
[11] Promoting excellence: standards for medical education and training

responsible for their internal medicine and specialty training, or they may have two educational supervisors, one responsible for internal medicine and one for specialty.

Clinical supervisor
Consultants responsible for patients that a trainee looks after provide clinical supervision for that trainee and thereby contribute to their training; they may also contribute to assessment of their performance by completing a 'Multiple Consultant Report (MCR)' and other WPBAs. A trainee may also be allocated (for instance, if they are not working with their educational supervisor in a particular placement) a named clinical supervisor, who is responsible for reviewing the trainee's training and progress during a particular placement. It is expected that a named clinical supervisor will provide a MCR for the trainee to inform the Educational Supervisor's report.

The educational and (if relevant) clinical supervisors, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. If the service lead (clinical director) has any concerns about the performance of the trainee, or there are issues of doctor or patient safety, these would be discussed with the clinical and educational supervisors (as well as the trainee). 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.

Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles[12]. It is essential that training in assessment is provided for trainers and trainees in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of the WPBAs and the application of standards.

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.

Trainees
Trainees should make the safety of patients their first priority and they should not be practising in clinical scenarios which are beyond their experiences and competencies without supervision. Trainees should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. Trainees would need to plan their WPBAs accordingly to enable their WPBAs to collectively provide a picture of their development during a training period. Trainees should actively seek guidance from their trainers in order to identify the appropriate learning opportunities and plan the appropriate frequencies and types of WPBAs according to their individual learning needs. It is the responsibility of trainees to seek feedback following learning opportunities and WPBAs. Trainees should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

[12] Recognition and approval of trainers

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 eportfolio 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 six 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 eportfolio. 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 eportfolio. 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. Supervisors should also identify areas where a trainee has performed above the level expected and highlight successes.

7 Quality Management

The organisation of training programs for Internal Medicine stage 2 is the responsibility of the deaneries. The deaneries will oversee programmes for postgraduate medical training in their regions. The Schools of Medicine in England, Wales and Northern Ireland and the Medical Specialty Training Board in Scotland will undertake the following roles:

- oversee recruitment and induction of trainees into IM stage 2
- allocate trainees into particular rotations for IM stage 2 appropriate to their training needs
- oversee the quality of training posts provided locally

- 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.

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

Development, implementation, monitoring and review of the curriculum are the responsibility of the JRCPTB via the SAC responsible for IM stage 2. 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 will be the responsibility of the JRCPTB to ensure that curriculum developments are communicated to heads of school, regional specialty training committees and TPDs.

JRCPTB provide their role in quality management by monitoring and driving improvement in the standard of all medical specialties on behalf of the three Royal Colleges of Physicians in Edinburgh, Glasgow and London. Our SACs are actively involved in assisting and supporting deaneries to manage and improve the quality of education within each of their approved training locations. They are tasked with activities central to assuring the quality of medical education such as writing the curriculum and assessment systems, reviewing applications for new posts and programmes, provision of external advisors to deaneries and recommending trainees eligible for CCT or Certificate of Eligibility for Specialist Registration (CESR).

JRCPTB uses data from six quality datasets across its 30 physicianly specialties and three subspecialties to provide meaningful quality management. The datasets include the GMC national Training Survey (NTS) data, ARCP outcomes, MRCP(UK) exam outcomes, New Consultant Survey, Penultimate Year Assessments (PYA)/External Advisor reports and the monitoring visit reports.

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience. These are monitored and reviewed by JRCPTB to improve the provision of training and ensure enhanced educational experiences. The principles of the quality criteria for CMT and GIM will be transferred to the IM curriculum to ensure this continues.

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.

Clinical and educational supervisors should use the curriculum and decision aid as the basis of their discussion with trainees, particularly during the appraisal process. 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.

Recording progress in the eportfolio

On enrolling with JRCPTB trainees will be given access to the eportfolio for IM stage 2. 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 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 used to provide evidence towards acquisition of curriculum capabilities. Trainees should 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 assist 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 capabilities 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.

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
- Deaneries ensuring that educational supervisors have had equality and diversity training (for example, an e-learning module) every three years
- 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 three years
- ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. 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. 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 advantage or 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.