Requirements for Outpatient experience in Internal Medicine (IMS1) Training

The COVID-19 pandemic has resulted in changes in the training experiences that may be available for trainees in Internal Medicine. This has especially affected opportunities in outpatients because the number of face to face out-patient clinics has reduced significantly and some outpatient experience may be telephonic or use a computer interface. Information about how outpatient capabilities may be gained in these circumstances has already been published on the JRCPTB website. Outpatient capabilities are important and thus need to be developed despite the reduction in outpatient work as a result of the pandemic.

The IMS 1 curriculum requires trainees to undertake an indicative 80 clinics over the three years, with a minimum of 20 in each training year. It is recommended that there should be flexibility in assessing the numbers of clinics attended during the COVID-19 pandemic/post-pandemic period with an emphasis on determining whether an individual trainee has indeed acquired the abilities to satisfy CiP4 even if they have not undertaken all the clinic numbers suggested. All trainees must continue to acquire outpatient experiences and demonstrate achievement of the defined learning outcomes. To that end, there must be specific commentary on their capability in outpatient care (CiP 4) within at least two of the multiple consultant reports (MCRs) required in each training year prior to ARCP. To help provide evidence of this capability it is recommended that trainees maintain a logbook to demonstrate the range of clinics that they have attended and to note the numbers of patients seen together with the type of clinic (virtual / face-to-face/telephonic etc). The contents of the logbook should form part of regular discussions with a trainee's supervisor. Trainees must attend an adequate number of clinics to achieve the outpatient learning objectives defined in the curriculum but also to acquire capability in the novel types of outpatient interface that are now being practised. Advice pertaining to this is published in the 'Rough Guide'.

Although there is as yet no specific outpatient assessment we are in the process of attempting to validate such a tool; until then trainees should use existing workplace based assessments especially the mini-CEX to provide evidence of clinical abilities in the outpatient setting. Within the feedback offered after such an assessment there should be a commentary, where possible, from the assessor about the trainee's generic skills including communication both with the patient and back to the referring doctor. This will help with the construction of the ES report covering outpatient capabilities.

Summary of recommendations

- Trainees should aim to complete 80 clinics during the three years of IMS1. To monitor progress the ES should have regular conversations with their trainee. The ES should direct and adapt experiences to maximise learning opportunities that facilitate acquisition of the defined outpatient learning outcomes. The ES report is required to comment on the current level of capability for all CiPs. In the current pandemic context it is especially important that the ESR details what level of capability the trainee has achieved for outpatient clinics (CiP4) and the basis for that judgement (particularly if the trainee has been unable to attend the recommended numbers of clinics).
- Trainees should maintain a logbook of clinic experience. A version of an appropriate logbook may be found on the JRCPTB website

- Assessment and feedback should include a minimum of two MCRs per training year that, in addition to commenting on all required aspects of the trainee's performance, specifically cover in depth outpatient capability (CiP 4). Mini-CEX can be used to give feedback on outpatient capability as well as generic skills (e.g. communication).

October 2020