**A flexible curriculum for Internal Medicine – a proposal**

**Introduction**

The Shape of Training Review (SoT) suggests post graduate training of all doctors should be more patient focused, more general (especially in the early years) and with more flexibility of career structure. It should lead to a certificate of specialist training (CST) after which, further training could take place with credentialing.

As far as training of physicians is concerned, these views are broadly congruent with the view expressed by the Future Hospital Commission and will address many of the failings identified by the Francis report. The increasing number of elderly patients with multiple comorbidities faced by acute medical services needs a different approach to training. Discussions at the Councils of all three Physicianly Colleges have confirmed agreement with this overall concept.

JRCPTB on behalf of the Federation of Royal Colleges of Physicians has suggested that an appropriate model for physician training should consist of a 7 year (minimum) training period leading to a CST in internal medicine with a specialty. The 7 years starting from Foundation training should consist of 3 years training in basic internal medicine during which increasing responsibility for the acute medical take would be experienced in year 3 and MRCP(UK) would be achieved. After these 3 years, there should be competitive entry into specialty training for a minimum of 4 years. During this period, an indicative 3 years will be spent training for the CST specialty and a further year of internal medicine either as a “stand alone year” or integrated flexibly within the specialty training to ensure that CST holders are competent to practice at post CST consultant independent level. This approach garnered general support at a recent JRCPTB sponsored “Development Day” (appendix 2). The details of the implementation of this overarching plan will need to be flexible enough to encompass the range of physicianly specialties and the changing demands of the demographic of the trainee workforce in each specialty.

**A FLEXIBLE INTERNAL MEDICINE CURRICULUM**

This development will require restructuring of the curricula for General internal Medicine (GIM), Core Medical Training (CMT) and for the specialties. This curriculum would also cover all the GMC generic professional capabilities to be launched in 2015. Despite broad support for this model, it remains to be established whether it is relevant for all JRCPTB managed specialties.

One definition of Internal medicine is the knowledge and skills to care for patients with common acute and long-term medical conditions, including management of comorbidities, recognising the circumstances where specialist input is required.

**ASSESSMENT OF A COMPETENT PHYSICIAN**

The present curricula for physician training are based on achieving a large number of individual identifiable competencies that are assessed throughout training by a variety of different assessment strategies. The perceived ‘burden of assessment’ led to the Specialty Trainee Assessment and Review (STAR) recommendations that greater emphasis be given to individual clinical and educational supervisors’ reports rather than on the multiple ‘box-ticking’ that had become the normal practice.

An improved and simplified option for reviewing progress through the new curricula could be by looking at ‘competencies in practice’ – the ability to perform the professional activities of a competent physician. The key to success for both trainees and trainers will be to produce a flexible model in particular for the integrated ‘ 4th year’. They are not an alternative to competency based education but a way to translate competency into clinical practice.

**AdvantageS of ASSESSMENT OF competencies in practice**

* Enhance patient safety by ensuring that a trainee to whom a task has been ‘TRUSTED’ has demonstrated proficiency in that task. (see level 4 below)
* Encourages curriculum developers to focus on the desired outcomes of training
* Needs an assessment by an experienced supervisor (much less ‘tick box’ than individual competency assessments)
* Assess actual performance (‘does’ rather than ‘shows how’)

**COMPETENCIES IN PRACTICE:** **Graded supervision allow for:**

Level 1 - observations of the activity – no execution

Level 2 - acting with direct, practice supervision

Level 3 - acting with supervision available quickly

Level 4 - acting unsupervised (with clinical oversight within training)

No further assessment would normally be expected once a level 4 “Trusted Decision” is made. Doctors then have a professional obligation and expectation to maintain competence.

**A POTENTIAL MODEL for A flexible INTERNAL MEDICINE Curriculum (see Appendix 1)**

* It sets out the overall competencies in practice that must be achieved at the various stages of training
* It is flexible in how these competencies can be achievedin each specialty, in particular the integrated ‘4th year’ of Internal Medicine.
* It is based on 3 years of basic internal medicine before selection.
* It will require specialty curriculum to be written for training in specialty, post selection.
* It maintains the central importance of MRCP(UK). It may require a new SCE in generic capabilities and Internal Medicine, or extension of current SCE’s.
* Inevitably some content of current specialty curriculum will need to move post CST, using the credentialing model.
* Critically it must not lead to another level of ‘tick box’ competencies but be based on clinical judgment.

**Professor David Black**

**Medical Director**

**JRCPTB**

**30 April 2015 V16**

**EXAMPLE FRAMEWORK FOR THE** **ASSESSMENT OF A COMPETENT PHYSICIAN (To be integrated with individual specialties based on negotiation with SAC and curriculum working groups)**

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|  | **COMPETENCIES IN PRACTICE LEADING TO A ‘TRUSTED DECISION’** | **relevant competencies from the current GIM and CMT curricula. also the gmc generic PROFESSIONAL capabilities (2015)** |
| **1.** | **Managing the acute unselected take over a standard shift** | * clinical skills * knowledge of common medical presentations (‘top’) and other important presentations * underlying causes and comorbidities * therapeutics and self-prescribing * communication and shared decision making * time management and decision making * patient as a central focus of care * team working and patient safety * leadership * handover * breaking bad news * prioritisation * personal behaviour |
| **2.** | **Overall management of all aspects of a selected acute take, either within specialty or as part of the unselected take** | System specific competencies of the main specialty and related specialties as needed for practice:   * clinical skills * knowledge of common (‘top’) medical presentations other important presentations and relevant system specific competencies * underlying cause and comorbidities * therapeutics and self-prescribing * communication and shared decision making * time management and decision making * patient as a central focus of care * team working and patient safety * handover * prioritisation * personal behaviour |
| **3.** | **Providing continuity of care to medical in-patients, including management of comorbidities and cognitive impairment** | * underlying causes and comorbidities * communication and shared decision making * personal behaviour * clinical skills * knowledge of common(‘top’) medical presentations, other important presentations and relevant system specific competencies * therapeutics and self-prescribing * breaking bad news * time management and decision making * patient as a central focus of care * team working and patient safety * handover * prioritisation * management of chronic conditions |
| **4.** | **Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions** | * clinical skills * knowledge of common (‘top’) medical presentations, other important presentations and relevant system specific competencies * underlying causes and comorbidities * therapeutics and self-prescribing * time management and decision making * personal behaviour * clinical reasoning * delegation, health promotion and public health * relationship with patient, shared decision making and communications within a consultation * managing long term conditions and promoting self-care * breaking bad news * patient as the central focus of care |
| **5.** | **Managing medical problems in patients in other specialties** | * communication with colleagues and cooperation * medical problems in pregnancy, surgery and adolescence * Interface and community based medicine * Underlying causes and conditions * Knowledge of common (‘top’) medical presentations, other important presentations and relevant system specific competencies |
| **6.** | **Managing a multi-disciplinary team including effective discharge planning** | * decision making * clinical reasoning * personal behaviour * patient as the central focus of care * team working and patient safety * communication with colleagues and cooperation * relationships with patients and communications within a consultation * communication and shared decision making * time management and decision making * leadership |
| **7.** | **Delivering effective resuscitation, and managing the acutely deteriorating patient** | * Emergency presentations * Advanced resuscitation |
| **8.** | **Managing end of life and palliative care skills** | * relationships with patients and communications within a consultation * breaking bad news * patient as the central focus of care * decision making and clinical reasoning * medical ethics * personal behaviours |
| **9.** | **Delivering effective quality improvement in patient care** | * quality improvement including audit, evidence and guidelines * principles of quality and safety improvement * prioritisation of patient safety in clinical practice * patient as the central focus of care |
| **10.** | **Carrying out research and managing data appropriately** | * ability to understand principles of research and academic writing * ability to carry out critical appraisal of the literature * understanding of public health epidemiology and global health patterns |
| **11.** | **Acting as a Clinical Supervisor** | * able to supervise less experienced trainees in their clinical assessment and management of patients * able to supervise less experienced trainees in carrying out appropriate practical procedures * able to act a Clinical Supervisor to the standard required by the GMC * teaching and training |
| **12.** | **Dealing with ethical and legal issues related to specialty clinical practice** | * decision making * clinical reasoning * legal framework for practice * principles of medical ethics and confidentiality * evidence and guidelines * patient safety |
| **13.** | **Working with NHS organisational and management systems** | * leadership * personal behaviour * management, NHS structure, the independent sector and the communities they serve * evidence and guidelines * valid consent * complaints and medical error * communication with colleagues and cooperation * infection control * principles of quality, safety improvement (patient safety) * legislation * self-learning |
| **14.** | **Competent in all procedural skills as defined by the curriculum** | * Procedural competencies * Team working and patient safety * Communication and shared decision making * Legal framework for practice |

**Appendix 1**

**BLUEPRINT for a flexible INTERNAL MEDICINE Curriculum**

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**Appendix 2**

**JRCPTB Development Day**

**Held on Friday 30 January 2015**

**JRCPTB, Royal College of Physicians, 11 St Andrews Place, London**

**Background**

Responses to the Shape of Training report as well as ‘The Future Hospital’, by the three physicianly colleges and the Federation via JRCPTB, evolved a model that emphasises the need to train future Consultants in both Internal Medicine and a Specialty. Whilst the design of such a programme is very much in its infancy, it would be underpinned by a new spiral curriculum in internal medicine. Such a curriculum would see a change to the way training is currently planned and delivered at both Core and Higher levels in many(possibly all), physicianly specialties is delivered (see APPENDIX 1).

To facilitate the next stages of these discussions, representatives from all the Specialty Advisory Committees (SACs), all Heads of School, also senior officers and Trainee Committees members of the three physicianly colleges were invited to consider the following; ‘what do we mean by the “Junior Registrar” year?’ and ‘ the fourth year of internal medicine training in specialty training’.

Presentations were given by trainee, specialty and internal medicine representatives (see attached presentations) before group discussion.

**Summary**

Several key themes emerged, in particular in response to the first question of what is meant by the so-called ‘junior registrar year’. The second question around a ‘fourth year in Internal Medicine’ produced slightly less consensus, with firm principles more difficult to define.

What do we mean by the junior registrar year?

There was widespread consensus on what could be key principles for what will become basic training in internal medicine including;

* The term ‘junior registrar’ must not be used to describe trainees on this programme, instead ‘registrar’ (year3 and possibly 1&2) and ‘senior registrar’ (years 4-7) were preferred
* It is essential that the new 3-year programme is not perceived as the existing CMT programme + 1 year. It should be an integrated internal medicine training programme, where attainment of competence (both clinical and non-clinical) and expertise is incremental
* A focus should be found for each year of training, this could be quality improvement or clinical leadership skill. In year 3 specifically, the focus must be on progress from readiness, to competence in leading the Acute Take
* Increased exposure to outpatient clinics is essential, but this may be ‘front-loaded’ in year 1 or 2 to appropriately balance staged exposure to this and acute environments
* Procedural exposure should be increased with the attainment of competence graded throughout the programme, clearly defining the need to be ‘simulation competent’ versus being able to independently practice a procedure
* The selection process for higher training should take place at the end of this programme i.e. during ST3. Trainees should not be required to apply for the 3rd year of the new programme in open competition
* It would not be necessary to have completed MRCP(UK) by the end of year 2; however trainees must have at least attempted PACES in order to pass from year 2 into year 3. The attainment of full MRCP(UK) would be an essential requirement for entry into ST4
* In year 3 trainees should spend a minimum of 6 months in a single site. 12 months would be preferred to ensure continuity in assessment of internal medicine in this year.

The fourth year of internal medicine training in specialty training

This subject was found by the group to be more challenging, and there were fewer consensuses. The entire group were in agreement that it would not be possible to implement a ‘one size fits all’ approach. The nature, size and current clinical practice of some specialties would make this impossible.

For some specialties integration of internal medicine and delivery of the model appeared straightforward. In others the importance of knowledge and skills in internal medicine was accepted but supporting the acute take in other ways than managing unselected admissions seemed a more likely requirement for the service and therefore clinical practice. So in designing the “4th year”

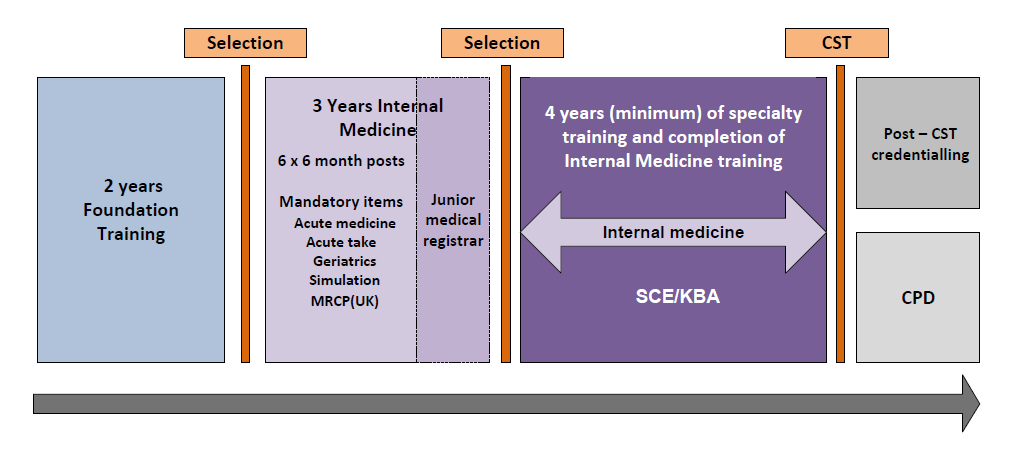
* The aim of the programme must be to ensure that upon completion, the new consultant must be sufficiently trained to support or lead the acute take as required by the service.
* In order to quality manage this programme it would be necessary for a trainee to have both an internal medicine and specialty Training Programme Director to ensure that internal medicine training is appropriately delivered
* Further consideration should be given to specific internal medicine knowledge based assessment. It may be appropriate to introduce an SCE in internal medicine.
* Internal medicine should be integrated throughout the programme, rather than being delivered in year 4 and then revisited at the end of year 7. This would ensure all trainees were able to effectively manage acute medical issues within their specialty area.
* Single or dual training/CCT/Curriculum: There were compelling arguments presented for both a single CCT in ‘specialty + internal medicine’, delivered via a single curriculum, and for the need to maintain the distinction between the two (effectively dual-training). It was noted that from a professional recognition point of view it may be necessary to define further the standard of competence reached in either the internal medicine or specialty aspect of the programme. One possibility would be a single spine for all physicians that encapsulated internal medicine and all generic competences with a separate curriculum for the additional speciality specific competences.

**Next steps**

In order to progress the models of training discussed it was agreed by the group that it was first necessary to start to develop the internal medicine curriculum for the entirety of the programme i.e. ‘years 1-3’ and ‘4-7’. This would enable definition of a core set of competences in internal medicine on top of which specialties could develop their specific internal medicine components, considering the needs of their patients. It would be imperative to ensure that there is no duplication between the competences required for internal medicine and the specialty.

**APPENDIX 1**

Proposed model for physicianly training under Shape of Training



**Event host:** David Black, Medical Director, JRCPTB

**Invited speakers**

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| Brian Bourke | Chair, GIM SAC |
| Jonathan Corne | Head of School of Medicine, HE East Midlands |
| John Corcoran | Deputy Chair, Trainees Committee, RCP London |
| Rosemary Hollick | Chair, Trainees Committee, RCP Edinburgh |
| Tom Hughes | Vice Chair, Neurology SAC |
| Mike Jones | Chair, AIM SAC |
| Giles Major | Chair, Trainees Committee ,RCP London |
| Alastair Miller | Deputy Medical Director, JRCPTB |
| David Smith | Vice Chair, Respiratory SAC (unable to attend in person, see submitted comments) |
| Stacy Smith | Deputy Chair, Trainees Committee, RCPS Glasgow |
| Mike Stewart | Curriculum Lead, Cardiology SAC |
| Emma Vaux | Associate Medical Director, JRCPTB |
| Zoe Wyrko | Workforce Lead, Geriatric SAC |

**Attendees**

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| James Adams | Clinical Lead, Quality Management, JRCPTB |
| John Firth | Curriculum Lead, GIM SAC |
| Miriam Armstrong | Policy officer, JRCPTB |
| Dawn Ashley | Head of School of Medicine, HE North East |
| James Barrett | Head of School of Medicine, HE North West – Mersey |
| Tim Battcock | Clinical Lead, Post CCT Fellowship |
| Arup Chattopadhyay | Chair, Clinical Neurophysiology SAC |
| Bob Coward | Head of School of Medicine, HE North West |
| Ella Edgington | Policy Advisor, RCP London |
| Andrew Elder | Medical Director, MRCP(UK) |
| Zoe Fleet | Project Manager, Curriculum & Assessment |
| Margot Gosney | Head of School of Medicine, HE Thames Valley |
| Stephen Harding | SRO Manager, JRCPTB |
| Andrew Jeffrey | Senior College Censor, RCP London |
| Warren Lynch | Quality Management Officer, JRCPTB |
| Abigail Moore | Clinical Fellow, RCP London |
| Rak Nandwani | Chair, Genitourinary Medicine SAC |
| Rachael O'Flynn | Head of JRCPTB |
| Alan Patrick | Vice President, Education and Training, RCP Edinburgh |
| Gerrard Phillips | Vice President, Education & Training, RCP London |
| Deepti Radia | Chair, Haematology SAC |
| Ananthakrishnan Raghuram | Representing HE South West, Severn |
| Tanya Rehman | Head of Development & Recruitment, JRCPTB |
| Hazel Scott | Honorary Secretary, RCPS Glasgow |
| Callum Totten | Adviser (stakeholder relationships, health sector) RCP London |
| Michael Trimble | Head of School of Medicine, NIMDTA |
| Winnie Wade | Director of Education, RCP London |
| Louise Wheaton | Policy Officer, MRCP(UK) |
| Nick Withers | Head of School of Medicine, HE South West – Peninsula |