

# New Internal Medicine Curriculum & GU Medicine training

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# Implications

- NB This is about training  
NOT service delivery



# Drivers

- UK Shape of Training (October 2013!)
- Generic Professional Capabilities (GPCs)
- Future hospital, Francis etc etc
- Burden of assessment

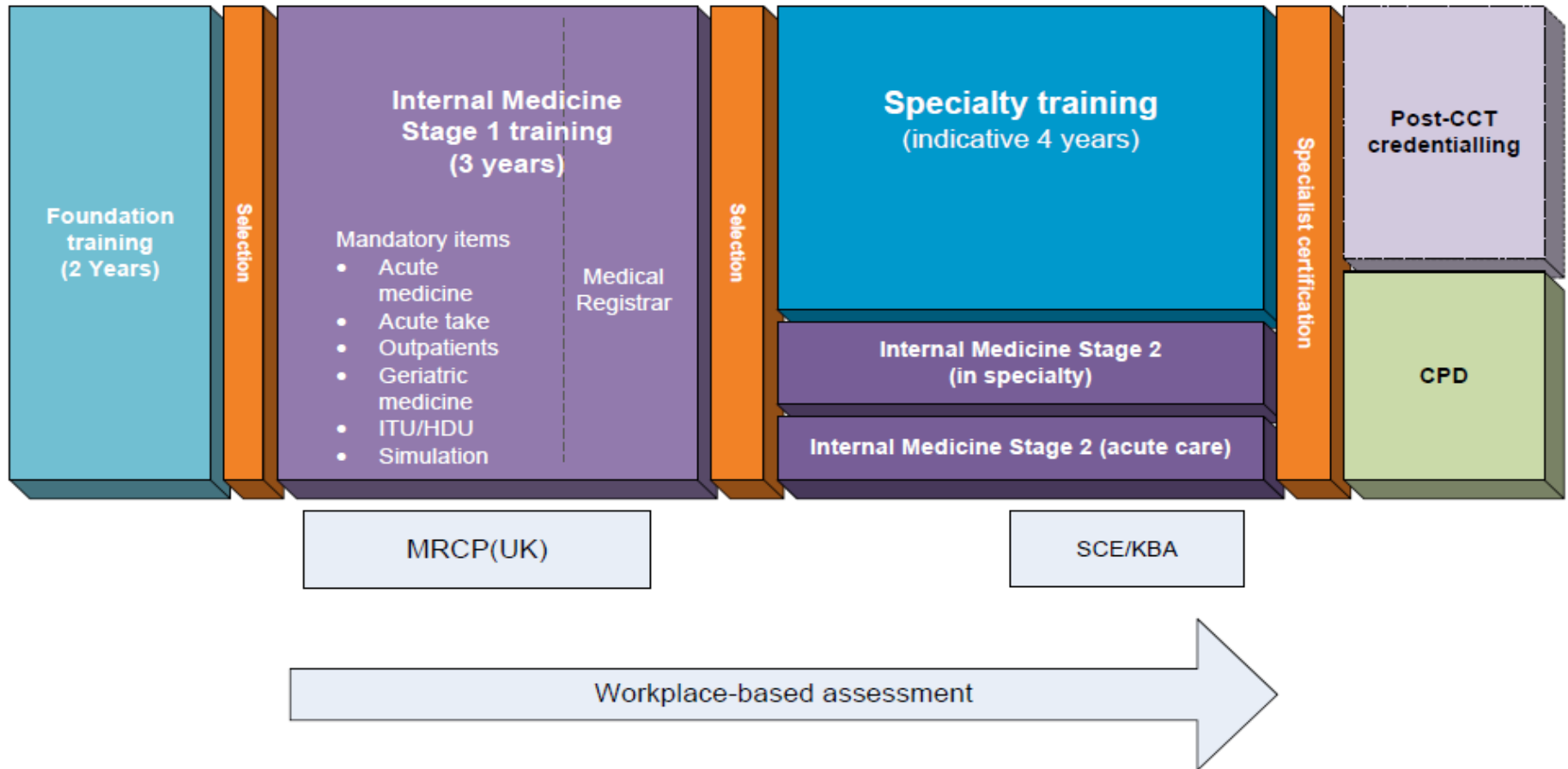
# Major aims

- More generalism without threatening specialism
- More flexibility
- No effect on duration of training
- Reduce burden of assessment

# Internal Medicine Curriculum

- Internal Medicine Committee (IMC)(First met August 2015)
  - Curriculum (Syllabus)
  - Assessment
  - Implementation

# Proposed physician training pathway



# Non acute specialties

- Some specialties that will not play a role in acute unselected care may wish to recruit from IM2 (eg SEM, clinical genetics)
- They will not get a CCT in IM
- This is because of edict that training cannot be increased

# Content of learning

- Good Medical Practice
- Generic outcomes based on GPCs
- Competencies in practice (CiPs)
- Key presentations and conditions that are common or serious (syllabus)
- Practical procedures



# Presentations and conditions

- Presentations and conditions / issues are listed either because they are common or serious
- Trainees should develop the knowledge, skills and attitudes around managing patients with these conditions and presentations
- Not a finite list

# Competencies in Practice (CiPs)

- Similar to Entrustable Professional Activities (EPAs)
- Alternative NOT additional to individual (atomised) competencies
- More holistic
  - Managing an acute unselected take
  - Managing an MDT

# Programme of assessment

- More holistic, authentic assessment based on competencies in practice (CiPs)
- Expected requirements set out for each stage of training
- Workplace-based and knowledge-based assessment mapped to learning outcomes
- Existing assessment methodology

# Demonstration of GPCs

- CiPs will allow the trainee to demonstrate acquisition of GPCs within a clinical context

# Level descriptors

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

# Outline grid of level of supervision

	Internal Medicine Stage 1				Internal Medicine Stage 2 + Specialty				CCT			
Competency in Practice (CiP)	IM1	IM2	KEY PROGRESSION POINT	IM3	KEY PROGRESSION POINT	ST4	ST5	ST6	ST7	KEY PROGRESSION POINT		
Managing acute unselected take		3				3					4	
Managing an acute specialty-related take		2				2		3	4			
Providing continuity of care to medical in-patients		3				3			4			
Managing outpatients with long term conditions		2				3			4			
Managing medical problems in patients in other specialties and special cases		2				3			4			
Managing an MDT including discharge planning		2				3			4			
Delivering effective resuscitation and managing the deteriorating patient		3				4			4			
Managing end of life and palliative care skills		2				3			4			
Delivering effective quality improvements in patient care		2				3			4			
Carrying out research and managing data appropriately		2				2		3				4
Acting as a clinical teacher and clinical supervisor		2				2		3				4
Dealing with ethico-legal issues		2				3						4
Working with NHS systems		2				3					4	

# Timeline

- Subject to four nation and GMC approval
- Implementation of IM stage 1 training in August 2018
- Implementation of IM stage 2 in August 2021
- Implementation of revised specialty programmes August 2021
  - Or 2020 for specialties selecting after 2 years IM

# Questions???

The JRCPTB is part of the Federation of the  
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