The future of Internal Medicine Training – a new curriculum for 2019 (or RIP CMT)

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A little bit of history

• Modernising Medical Careers 2007 (MMC and MTAS !!)

• Core Medical Training August 2007

• A syllabus and a spiral curriculum

• Competency based

• Work place based assessment

• Educational and clinical supervisors
More history 2007

• The orange guide became gold
• RITAs became ARCPs
Drivers for change

• Shape of Training October 2013
• Future Hospital Commission Sept 2013
• Francis report Feb 2013
• GMC framework of Generic Professional Capabilities (GPCs)
  • to be embedded in all curricula by 2020
• GMC standards for Medical Education and Training (including curriculum design)
  • wef January 2016
More drivers

- Trainer and trainee dissatisfaction
  - “Burden of assessment”
  - “Tick box mentality”
  - “Who wants to be a registrar?”

- Increasing age/complexity/numbers of medical emergency admission

- Flexibility of workforce provision
  - Geographical disparity
  - Role changes (specialist nurses etc)
  - New procedures/treatments changing workforce requirements (e.g., cardiac surgery)
  - Changing demography of trainees (50% female)

Process of change

• Led by JRCPTB on behalf of the Federation of Physician Royal Colleges
• Responding to Shape of Training
• Internal Medicine Committee (IMC) established Aug 2015
  • Curriculum/syllabus sub cttee
  • Assessment sub-cttee
  • Implementation sub cttee
• Huge consultation exercise
  • Trainees, trainees, trainees
  • SACs, HoS, CMTAC, NHS employers, Deans, GMC, Development days (6)
  • Proof of concept study
Headline changes

• Internal Medicine Training for 3 years instead of CMT
• 14 “holisitic” Capabilities in Practice replace multiple “atomized” competencies
• A simplified syllabus
• Trainees “entrusted” at defined levels of supervision
• Specific experiences mandated
  • Clinics, ICU, geriatrics etc
• Internal medicine inextricably bound to specialty training
• More specialties doing IMT
What has not changed

• Supervision process
• ARCP process
• Workplace Based Assessment (WBAs)
• MRCP
• No additional SCE for internal medicine
• Medicine!
Training cannot be lengthened

• An absolute requirement
• Therefore if IM training increased higher training must be decreased
• Hence requirement for Group 1 and Group 2 specialties
<table>
<thead>
<tr>
<th>Group 1 specialties (dual train with Internal Medicine)</th>
<th>Group 2 specialties (single CCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Internal Medicine</td>
<td>Allergy</td>
</tr>
<tr>
<td>Cardiology</td>
<td>Audio vestibular Medicine</td>
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<tr>
<td>Clinical Pharmacology and Therapeutics</td>
<td>Aviation and Space Medicine</td>
</tr>
<tr>
<td>Endocrinology and Diabetes Mellitus</td>
<td>Clinical Genetics</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>Clinical Neurophysiology</td>
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<tr>
<td>Gastroenterology</td>
<td>Dermatology</td>
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<tr>
<td><strong>Genitourinary medicine</strong></td>
<td>Haematology</td>
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<tr>
<td>Infectious Diseases*</td>
<td>Clinical Immunology</td>
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<tr>
<td>Neurology</td>
<td>Medical Ophthalmology</td>
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<tr>
<td><strong>Palliative Medicine</strong></td>
<td>Nuclear Medicine</td>
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<tr>
<td>Renal Medicine</td>
<td>Paediatric Cardiology</td>
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<tr>
<td>Respiratory Medicine</td>
<td>Pharmaceutical Medicine</td>
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<tr>
<td>Rheumatology</td>
<td>Rehabilitation Medicine</td>
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<td></td>
<td>Sport and Exercise Medicine</td>
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<td>Medical Oncology</td>
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</table>

*Group 2 if combined with MMMV*
NB these changes are about training only and need not necessarily be reflected in service delivery
Model for physician training – Group 1 specialties (dual CCT)

Foundation training (2 Years)

Internal Medicine Stage 1 training (3 years)
- Mandatory items
  - Acute medicine
  - Acute take
  - Outpatients
  - Geriatric medicine
  - ITU/HDU
  - Simulation

Selection

Medical Registrar

Specialty and Internal Medicine Stage 2 training (indicative 4 years)
- Generic professional capabilities (GPCs)
- Integrated internal medicine capabilities in practice (ICPs)

Specialist credentialing

Post-CCT credentialing

MRCP(UK)

SCE/KBA

Workplace-based assessment

CPD
Model for physician training – Group 2 specialties (single CCT)

Foundation training (2 Years)
- Selection
- Internal Medicine
  - Stage 1 training (2 years)
    - Mandatory items
      - Acute medicine
      - Acute take
      - Outpatients
      - Geriatric medicine
      - ITU/HDU
      - Simulation

Specialty training (indicative 4 years)
- Selection
- Specialised certification
- Generic professional capabilities (GPCs)
- Relevant internal medicine capabilities in practice (CIPs)

Post-CCT credentialing

MRCP(UK)

SCE/KBA

Workplace-based assessment

CPD
Internal Medicine Training (IMT)

- IMT Stage 1 approved by GMC 8 December 2017
- Implementation August 2019
- IMT Stage 2 currently submitted to GMC
  - 1 year integrated within specialty training
  - 3 years as “stand alone” – but few (any) will do

- Outcomes based curriculum
- Will not be possible to “disentangle” from specialty training
- Training in specialty alone – not an option for Group 1 specialties
Assessment strategy

• Strategy needs to drive learning and provide reassurance
  BUT needs to be practical to implement in a workplace setting without upsetting
  • Trainers
  • Trainees
  • Patients
  • Service delivery
Capabilities in Practice (CiPs)

‘A unit of professional practice identified as a task or responsibility to be entrusted to a learner to execute unsupervised once sufficient competence has been demonstrated’

*Similar to the concept of “Entrustable Professional Activities” (EPAs)*
Compromise

“This is a good trainee who can therefore do anything”

versus

“This is a trainee who can look after heart failure but cannot look after pneumonia”

↓

“This is a trainee who can do the acute take”
Internal medicine CiPs

• 14 CiPs describe the professional tasks or work within the scope of internal medicine
• 6 generic. 8 clinical IM
• Each CiP has descriptors of observable skills and behaviours
• Mapped to GPC domains and subsections
• Each CiP has a list of evidence that MAY be used to inform entrustment decisions
Generic CiP 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 (e.g., cognitive impairment, speech and hearing problems, capacity issues)  
|             | Demonstrates effective consultation skills including effective verbal and nonverbal interpersonal skills  
|             | Shares decision making by informing the patient, prioritising the patient’s wishes, and respecting the patient’s beliefs, concerns and expectations  
|             | Shares decision making with children and young people  
|             | Applies management and team working skills appropriately, including influencing, negotiating, re-assessing priorities and effectively managing complex, dynamic situations |

| 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 teamwork |

| Evidence to inform decision | MCR  
|                            | MSF  
|                            | PS  
|                            | MRCP(UK)  
|                            | End of placement reports  
|                            | ES report |
### IM CiP 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
- MRCP(UK)
- Letters generated at outpatient clinics
## CiP entrustment levels (for Clinical CiPs)

<table>
<thead>
<tr>
<th>Level</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Entrusted to observe only – no provision of clinical care</td>
</tr>
<tr>
<td>Level 2</td>
<td>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</td>
</tr>
<tr>
<td>Level 3</td>
<td>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</td>
</tr>
<tr>
<td>Level 4</td>
<td>Entrusted to act unsupervised</td>
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Syllabus

• List of presentation and conditions that an IM trainee needs to be familiar with either because
  • They are common and/or
  • They are important from a patient or public health perspective

• Developed with SAC input

• No specific definition of knowledge, skills etc
Experiential learning

• Acute (unselected take)
  • 100 patients/year and 500 over 3 years minimum

• Critical care
  • 10 weeks over 3 years (max of 2 blocks)

• Clinics
  • “Active involvement” in 80 clinics
  • Learning objectives defined

• Geriatrics

• Simulation
As usual it is a compromise

Too prescriptive makes it impossible to deliver

Too flexible...nothing changes and poor practice persists
MRCP(UK)

• Trainees will be expected to achieve full MRCP by the end of IMY2 but failure to achieve this is not a bar to progression *per se*
• MRCP is not an assessment of the ability to lead the acute take (Level 3 CiP1) but
• It is a substantial piece of evidence
Next steps

• Train the trainers (and trainees!)
• Develop rotations
• Develop eportfolio
• Recruit
• Stage 2 IM training
• Specialty curricula
And it’s (still) a long road ahead
Grateful thanks to Mike Jones, Zoe Fleet, David Black, Winnie Wade, Lynne Katz, John Firth, Andy Elder, Phil Bright and all the many trainees, SAC Chairs, HoS, Deans, NHS employers etc who have contributed to the development of IMT