

The future of internal medicine: a new curriculum for 2019

ABSTRACT

A new 3-year curriculum for training in internal medicine was approved by the General Medical Council in December 2017. This will replace core medical training in August 2019. It mandates specific experiences and introduces a novel assessment strategy that hopefully will lessen the perceived 'burden of assessment' on trainees (and trainers). It is hoped that it will improve the experience of and enthusiasm for training in internal medicine.

Since August 2007, UK trainee doctors aspiring to become consultant physicians have begun postgraduate medical education by entering core medical training after completing foundation jobs. This 2-year training programme was introduced as part of the Modernising Medical Careers programme. For the first time trainee physicians had a structured curriculum that was designed to prepare them for higher specialist training in general internal medicine and/or many other medical specialties, including several not under the auspices of the Joint Royal Colleges of Physicians Training Board.

A syllabus enumerates the knowledge, skills and attitudes that a learner is to acquire during the educational process whereas a curriculum, while including the syllabus, additionally defines the whole educational environment, and most importantly, the assessment strategy. The core medical training curriculum introduces the idea of specific competencies that a trainee has to acquire during his/her period of training and describes the workplace-based assessments to allow those competencies to be demonstrated. It is a spiral curriculum encouraging topics to be revisited at increasing levels of difficulty as competency increases (Laskaratos et al, 2014). In common with other curricula it is competency rather than time based and although 2 years is the 'indicative time' for completion, very able trainees have the facility to complete in 18 months while others may take longer. Passing the whole of the MRCP(UK) diploma is essential in order to complete core medical training.

Drivers for change

Although the core medical training curriculum was regularly updated, it became increasingly apparent that a major rethink was necessary. The principal drivers were:

- The independent review into the shape of medical training (led by the economist, David Greenaway), published in October 2013, acknowledged the changing demography of both medical workforce and patient population. It articulated the need for increased generalism in early medical careers and curriculum writers were challenged to reflect this in future iterations
- Many of these views were largely congruent with those expressed by the Future Hospital Commission established by the Royal College of Physicians of London (Royal College of Physicians, 2013)
- The General Medical Council (2017) has developed a framework of generic professional capabilities and expects them all to be embedded within specialist curricula by 2020
- There was increasing realization that the present core medical training curriculum imposes a heavy 'burden of assessment' on both trainees and trainers. Moreover, the requirement to have individual competencies 'signed off' and all supported by individual items of evidence (including workplace-based assessments) was felt to have led to a 'tick-box mentality'. There was concern that progression of capable trainees was being unnecessarily hampered by a bureaucratic exercise whereas less able ones were not being identified

- A review of core medical trainees in 2013 showed considerable dissatisfaction with training and specifically demonstrated that many trainees felt unconfident to enter the role of medical registrar (Tasker et al, 2014). While not all these concerns can be addressed by a new curriculum it was felt that this would help to drive improvement, while some of the other issues have been addressed by the development of the quality criteria for core medical training (Joint Royal Colleges of Physicians Training Board, 2015).

Process of change

The Joint Royal Colleges of Physicians Training Board is the arm of the Federation of Physician Royal Colleges (Edinburgh, Glasgow and London) that oversees and develops training. It currently leads training in 30 specialties, three sub-specialties and core medical training with the support of its specialty advisory committees. The Internal Medicine Committee was established by the Joint Royal Colleges of Physicians Training Board and met for the first time in 2015 to develop a new curriculum for an (indicative) 3-year training in internal medicine.

The internal medicine committee had wide representation from trainers and trainees, together with educational and curriculum experts, examination experts (MRCP(UK)) and NHS Employers. It established three sub-groups that focussed on the curriculum itself, the assessment strategy and the practical implementation of the changes. At every stage of the curriculum development there was widespread consultation with

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appropriate stakeholders. A new assessment strategy was piloted in a 'proof of concept study'. The new curriculum was approved by the General Medical Council on 8 December 2017 to commence in August 2019.

Capabilities in practice

One of the major changes has been the development of capabilities in practice that replace the old core medical training individualised 'atomised' competencies with a more holistic view about what a trainee can safely do. Instead of saying that a trainee can look after a patient with heart failure, we say that a trainee can manage an acute unselected take and thus we reduce over 100 individual competencies to 14 capabilities in practice. The capabilities in practice have similarities with the concept of 'entrustable professional activities' (Ten Cate et al, 2015) but there are important differences.

There are six generic capabilities in practice and eight specialist internal medicine capabilities in practice (Table 1). Each is underpinned by a series of descriptors but crucially these individual descriptors do not need to be 'signed off' but are just a guide to a supervisor who is making

an overall assessment. Each capability is mapped to the General Medical Council Generic Professional Capabilities framework and the evidence that can help to inform the decision on the capabilities in practice (including workplace-based assessments) is also listed. For the generic capabilities in practice the requirement is for the supervisor to document whether the trainee is meeting expectations for his/her particular stage of training. For the specialty internal medicine capabilities in practice, the supervisor has to document the level at which he/she feels the trainee is capable of operating. Level 1 means that the trainee is only observing, level 2 that the trainee can operate with direct supervision, level 3 that the trainee can operate with indirect supervision and level 4 that the trainee can operate independently (Table 2).

The multiple consultant reports that each trainee has to have completed will comment on each capability in practice and these are reviewed and collated by the educational supervisor (along with any other evidence) when the annual report is compiled before the annual review of competence progression (ARCP) (which represents the final

summative capabilities in practice sign off). The curriculum details what level a trainee is to achieve in each capability in practice at the end of each training year.

The syllabus

The presentations and conditions around which a trainee needs to develop the appropriate knowledge, skills and attitudes are listed and this list was developed with input from all the specialties to define those conditions and presentations from their particular specialty that were felt to be either so common and/or so important (from a patient safety or public health perspective) that an internal medicine physician needed to be familiar with them.

Experiential learning

Notwithstanding the move from time-based to competency-based learning (see above), it is widely appreciated that much medical learning occurs by gaining experience on the wards and in the clinics. The indicative time to complete internal medicine stage 1 training is 3 years and each year is focussed around a particular theme (Table 3).

Some experiences are specifically mandated, notably a geriatric attachment, a number of acute unselected takes, a number of outpatient attendances and an

Table 1. Internal medicine capabilities in practice

Generic capabilities in practice	Able to successfully function within NHS organizational 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 capabilities in practice	Managing an acute unselected take
	Managing an acute specialty-related take
	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 multidisciplinary team including effective discharge planning
	Delivering effective resuscitation and managing the acutely deteriorating patient
	Managing end of life and applying palliative care skills

Table 2. Level descriptors

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

Table 3. Internal medicine stage 1 training programme

Training year	Focus of training placements
IM1	Assessment of the acutely ill patient and the management of the acute medical intake of patients
IM2	Experience in outpatient clinics
IM3	Primarily involved in the acute take and functioning as the 'medical registrar'

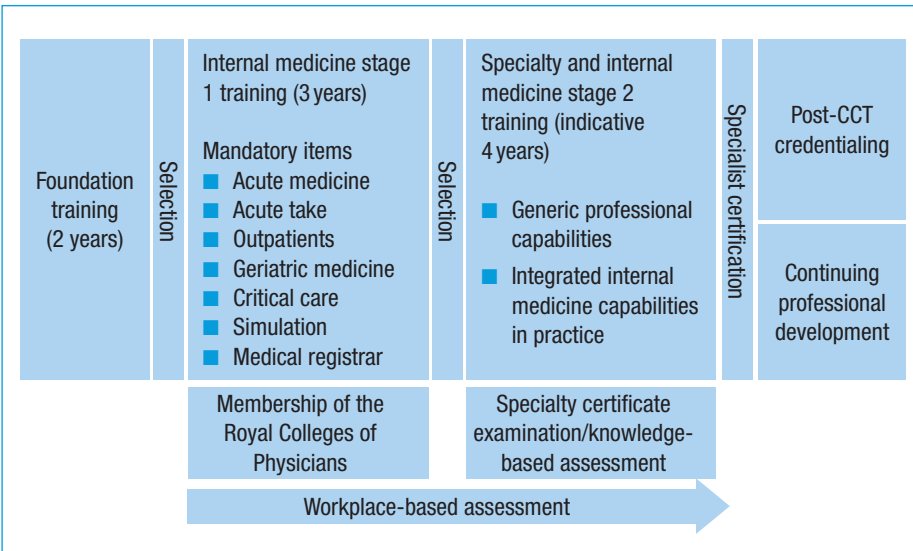


Figure 1. Training pathway for group 1 specialties. CCT = Certification of Completion of Training.

attachment to a critical care unit. Much of this is designed to ensure that the trainee progressing to internal medicine 3 is confident and competent to be the medical registrar.

Moving on

On successful completion of internal medicine training the trainee will hopefully move on to specialty training and for most specialties (known as the group 1 specialties) this will include a further year of internal medicine stage 2 training that will not introduce a new syllabus or capabilities in practice but will allow revisiting of previous acquired capabilities in a spiral fashion. This indicative year will either be integrated within the specialty training or as separate 'blocks' of internal medicine training (some of which must occur in the final year before certificate of completion of training). The internal medicine training will be fully integrated within the specialty training and for group 1 specialties it will not be possible to train in the specialty alone (Figure 1).

Some specialties that are not going to be involved in the acute take will be able to

recruit from the end of internal medicine year 2 (provided the trainee has passed MRCP(UK)) and will not do further internal medicine training (Table 4; Figure 2).

Next steps

Now that the internal medicine stage 1 curriculum has been approved, the priorities are to train trainers and trainees how to use the new assessment strategy, to develop rotations to provide appropriate experience and to write the stage 2 internal medicine and all the specialty curricula. No small challenge! **BJHM**

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Table 4. Group 1 and group 2 specialties

Group 1 specialties	Acute internal medicine
	Cardiology
	Clinical pharmacology and therapeutics
	Endocrinology and diabetes mellitus
	Geriatric medicine
	Gastroenterology
	Genitourinary medicine
	Infectious diseases*
	Neurology
	Palliative medicine
	Renal medicine
	Respiratory medicine
	Rheumatology
	Tropical medicine
Group 2 specialties	Allergy
	Audiovestibular medicine
	Aviation and space medicine
	Clinical genetics
	Clinical neurophysiology
	Dermatology†
	Haematology
	Immunology
	Medical ophthalmology
	Nuclear medicine
Paediatric cardiology	
Pharmaceutical medicine	
Rehabilitation medicine	
Sport and exercise medicine	

* Model for dual training in infectious diseases and medical microbiology/virology to be determined.
 † Programme for dermatology to be determined.
 Medical oncology is not included in this table as discussions are ongoing with the UK Shape of Training Steering Group regarding the future training model for this specialty.

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KEY POINTS

- A 3-year training programme in internal medicine replaces the current 2-year core medical training from August 2019.
- A holistic assessment system based on capabilities in practice will replace individualized competencies.
- In group 1 specialties completion of internal medicine training will be mandatory.

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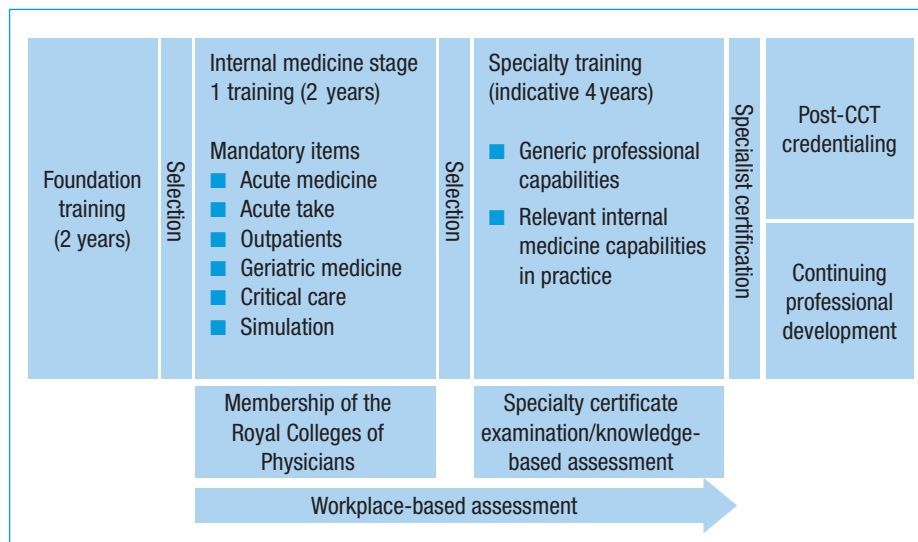


Figure 2. Training pathway for group 2 specialties. CCT = Certification of Completion of Training.

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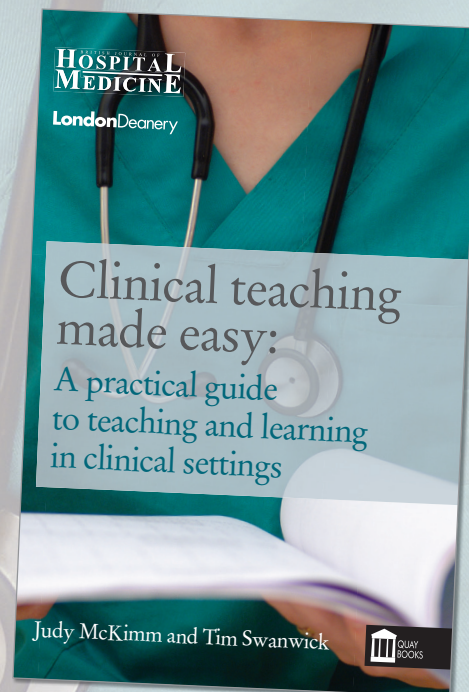
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