

The future of internal medicine: a new curriculum for 2019

Sir

I was interested to read the article on the new curriculum for internal medicine (<https://doi.org/10.12968/hmed.2018.79.4.225>) which clearly represents a very significant body of work. Of particular interest is the move to 'capabilities in practice' based upon the concept of entrustable professional activities. This emphasis, with descriptors providing four levels of entrustment, may provide something more intuitive for assessors. This might work particularly well if assessors had indeed entrusted a task to a trainee rather than just declaring that they would do so. This action would put their own judgement on the line.

The list of presentations (provided in the main document) is a welcome advance on lists of diseases.

The article does not cover the assessment and progression issues which are also in the main document. Progression decisions are made by the annual review of competence progression (ARCP) and are based on all the assessment evidence that is available. Large amounts of evidence are a strength in many ways (do we really need 12 methods?) but converting it all to a cut decision is not easy. In general the data available seem to lack metrics so the usual psychometric tests of reliability and validity will be difficult. We must be careful not to go back to an opaque process with poor defensibility. Entrustability may provide a new dimension but is it a sufficiently finely-honed tool?

Much of the evidence for a progress decision is classified as formative while a progress decision is summative. This will

turn the formative evidence into summative at least in the minds of the trainees. This may reduce the value of the portfolio.

It will be interesting to follow the roll out of this programme.

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Sir,

We thank Professor Cookson for his interest in and his helpful comments on our article. We accept that evidence from formative assessments will be part of the combined information that the educational supervisor will use to make his/her expert judgement on the trainee's progress and that the annual review of competence progression panel will use to make a summative outcome decision. We believe that the programme of assessment in the new curriculum maximizes assessment for learning and allows for robust decisions about trainees' progress. There is evidence that aggregated data points can be used for higher stakes assessment decisions and that assessment methods that rely heavily on judgement require less data points than most standardized methods (van der Vleuten et al, 2012).

This assessment methodology and strategy provides a compromise between the old approach of saying 'this is a good trainee and therefore they can do anything' and the artificial breakdown of individualized

competencies that said 'this trainee can look after heart failure but not pneumonia'. We feel that the more holistic approach of capabilities in practice steers that middle line.

Clearly in an article of this length we cannot go into great detail of the process for making entrustment decisions and we would urge Professor Cookson and other readers to examine the full curriculum available on the Joint Royal Colleges of Physicians Training Board website (www.jrcptb.org.uk/new-internal-medicine-curriculum). Additionally we are currently working on training the trainer resources and a practical guide to implementation of the new curriculum and assessment strategy and we would welcome further comments from readers about how this should be developed.

Once again, we are grateful to Professor Cookson for his helpful correspondence.

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van der Vleuten CP, Schuwirth LW, Driessen EW, Dijkstra J, Tigelaar D, Baartman LK, van Tartwijk J. A model for programmatic assessment fit for purpose. *Med Teach.* 2012;34(3):205–214. <https://doi.org/10.3109/0142159X.2012.652239>

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