Marklýsing fyrir kjarnanám í lyflækningum 2.0

Gildir frá 26. ágúst 2019

JRCPTB
Joint Royal Colleges of Physicians Training Board

SAK

LANDSPÍTALI
HÁSKÓLASJÚKRAHÚS

ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

Inngangur að marklýsingu fyrir kjarnanámi í lyflækningum

Marklýsing fyrir sérnám í lyflækningum er nú gefin út í annað sinn frá því námið var endurskoðað í tengslum reglugerð nr. 467 sem tók gildi árið 2015.

Markmiðið er að setja fagmennsku og gæði sérnáms í forgang. Þessi marklýsing gagnast sérnámslæknum, handleiðurum þeirra og yfirmönnum, sem og öðrum fagstéttum sem koma að mati og samvinnu við námslækna. Megináherslan er á sjúklinginn, samskipti og mikilvægt samstarf við fagaðila, sem sinna umönnun og aðhlynningu sjúklinga. Matsblöð sem meta samskiptafærni, kunnáttu, klíníska skráningu og faglega færni verða í notkun. Færnimat á inngripum sem námslæknar þurfa að tileinka sér, verður viðhaft og skráð. Matsblöðin eru lykilatriði í framþróun í sérnáminu.

Sérnámið í lyflækningum á Íslandi er byggt á forskrift frá Bretlandi. Forsendur fyrir því hafa áður verið vel kynntar og uppfylla þau skilyrði sem sett eru fram í reglugerð um menntun, réttindi og skyldur lækna og skilyrði til að hljóta almennt lækningaleyfi og sérfræðileyfi (nr. 467/2015). Þar segir m.a. að við gerð marklýsinga skuli leita alþjóðlegrar ráðgjafar eftir því sem þurfa þykir og að skipulagi sérnáms skuli þannig háttað að alþjóðlegum gæðaviðmiðum sé mætt Samvinnan við „Joint Royal Colleges of Physicians Training Board (JRCPTB)“ í Bretlandi hefur skilað sér í miklum framförum í framhaldsnámi á Íslandi.

Marklýsingin er unnin með hliðsjón af bresku markmiðslýsingunni, þ.e. „Curriculum for Internal Medicine Stage 1 Training“, og staðfærð með hliðsjón af íslenskum aðstæðum. Hún tekur við af marklýsingu „Specialty Training Curriculum for Core Medical Training“. Marklýsingin er á ensku því ekki er talin ástæða til að þýða hana að svo stöddu, sérstaklega þar sem notast er við rafræna skráningu á færnimati á ensku, svokallað ePortfolio. Jafnframt er sérnámið reglulega tekið út af Royal College of Physicians (RCP) og auðveldar marklýsing á ensku það vottunarferli. Mats- og hæfisnefnd skv. íslensku reglugerðinni nr. 467/2015 kemur einnig að vottun sérnámsins með því að samþykkja marklýsinguna og breytingar á henni og gegnum aðkomu að úttekt á sjúkrahúsum og öðrum stofnunum þar sem sérnámið fer fram. Þessi útgáfa af marklýsingunni gildir á öllum námsstöðum sérnámslækna í lyflækningum á Landspítala og á Sjúkrahúsinu á Akureyri sem hefja störf haustið 2019 eða síðar. Þá verður námslæknum sem hafa lokið minna en ári af kjarnanámi í lyflækningum þann 26. ágúst 2019 boðið að skipta yfir í þessa nýju marklýsingu frá þeirri eldri. Aðrir námslæknar sem eru lengra komnir í kjarnanáminu munu fylgja eldri marklýsingunni.

Yfirlestur og staðfærsla bresku markmiðslýsingarinnar var gerð af kennslustjórum í lyflækningum. Aftur fékkst góðfúslegt leyfi „Joint Royal Colleges of Physicians Training Board“ til að staðfæra þeirra marklýsingu, en námið hérlendis hefur verið vottað af þeim. Námið hefur því sömu stöðu og sambærilegt nám sem er í boði í Bretlandi.

Helstu breytingar frá fyrri marklýsingu er að nú er aukin áhersla á starfsnám á göngudeildum og að nú fá námslæknar á þriðja ári fá nú aukna ábyrgð.

Mats- og hæfisnefnd um starfs- og sérfræðinámið, skv. reglugerð nr. 467/2015, hefur samþykkt marklýsinguna og þannig hefur hún öðlast opinbert leiðbeiningargildi. Vonast er til að þessi marklýsing auki gæði starfsnámssársins og faglega færni námslækna.

f.h. kennslustjóra í lyflækningum
Friðbjörn Sigurðsson, framhaldsmenntunarstjóri lyflækninga

Contents

1. Introduction

Internal Medicine stage 1 will form the first stage of specialty training for most doctors training in physician specialties (lyflækningar og undirgreinar lyflækninga), i.e. those specialties managed by the Joint Royal College of Physicians Training Board (JRCPTB). This document only includes the learning outcomes for Internal Medicine Stage 1 and not the further requirements for acquiring a certificate of completion of training (CCT) in a physician specialty.

This curriculum defines the purpose, content of learning, process of training and the programme of assessment for the Internal Medicine Stage 1 training.

2. Purpose

2.1 Purpose statement

The purpose of the Internal Medicine (IM) stage 1 curriculum is to produce doctors with the generic professional and specialty specific capabilities needed to manage patients presenting with a wide range of general medical symptoms and conditions. They will be entrusted to undertake such roles as medical registrar in NHS district general and teaching hospitals and qualified to apply for higher specialist training (sérnámslæknar með aukna ábyrgð (námslæknar MAÁ))

Internal medicine stage 1 will normally be a three year programme that will include mandatory training in geriatric medicine, intensive care, outpatient and ambulatory care, in addition to other rotations in internal medicine.

The scope of internal medicine requires diagnostic reasoning and the ability to manage uncertainty, deal with co-morbidities and recognise when specialty opinion or care is required. There will be a critical progression point at the end of the second year (IM2) to ensure trainees have the required capabilities and are entrusted to 'step up' to the medical registrar role in IM3. For most, the trainee will be entrusted to manage the acute unselected take (bráðainnlagnir) and manage the deteriorating patient with indirect supervision in IM3. For a few this will be for a period of time in a supportive training environment with the supervising physician readily available (please see section 5.3 for the description of supervision levels).

There will be a further critical progression point at completion of IM stage 1 and trainees will be required to meet all curriculum requirements, including passing the full MRCP(UK) diploma examination by time of completion.

Doctors in training will learn in a variety of settings using a range of methods, including workplace-based experiential learning, formal postgraduate teaching and simulation-based education.

IM stage 1 will be the first stage of training in internal medicine and the specialties managed by the Joint Royal College of Physicians Training Board (JRCPTB). Further training in internal medicine and a specialty will be required to achieve a Certificate of Completion of Training (CCT) (sérfræðileyfi) in internal medicine and specialty training.

The IM capabilities in practice (CiPs) will be shared across all physician curricula (sameiginlegur grunnur fyrir undirgreinar lyflækninga í Bretlandi), supporting flexibility for trainees to move between the specialties. The generic capabilities and mapping of the curriculum to the GMC's Generic Professional Capabilities (GPC) framework[1] will facilitate transferability of learning outcomes across other related specialties and disciplines.

2.2 Rationale

The Shape of Training (SoT) review[2] was a catalyst for reform of postgraduate training of all doctors in the UK to ensure it is more patient focused, more general (especially in the early years) and with more flexibility of career structure. For physician training, the views and recommendations of SoT were similar to those of the Future Hospital Commission[3] and the Francis report[4]. With an ageing population, elderly patients exhibit co-morbidities and increasing complexity so acute medical services need a different approach to training the physician of the future.

A further driver for change was the GMC's in the UK review of the curricula and assessment standards[5] and introduction of the GPC framework. From May 2017, all

[1] Generic professional capabilities framework
[2] Shape of Training: Securing the future of excellent patient care
[3] Future hospital: Caring for medical patients
[4] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry
[5] Standards and guidance for postgraduate curricula

postgraduate curricula should be based on higher level learning outcomes and must incorporate the generic professional capabilities. A fundamental component of the GPCs is ensuring that the patient is at the centre of any consultation and decision making. To this end, communication skills are emphasised throughout all of our capabilities in practice (CiPs – see below) and evidenced through all our work based assessments (and especially in our use of multi-source feedback – MSF). Trainees are encouraged to reflect on their communication skills throughout every stage of their training.

JRCPTB, on behalf of the Federation of Royal Colleges of Physicians, has produced a model for physician training that consists of an indicative seven year (dual) training period leading to a CCT in a specialty and internal medicine. Stage 1 training in internal medicine will comprise the first three years post-foundation training, during which there will be increasing responsibility for the acute medical take and the MRCP(UK) Diploma will be achieved. After these three years, there will be competitive entry into specialty plus internal medicine dual training. A minimum of three years will be spent training in the specialty (there will be variation across specialties) and there will be a further one year of internal medicine integrated flexibly within the programme. This will ensure that CCT holders are competent to practice independently at consultant level in both their specialty and internal medicine.

This model will enhance the training in internal medicine for all physicians. In particular, it will promote the management of the acutely unwell patient with an increased focus on chronic disease management, co-morbidity and complexity in the main specialties supporting acute hospital care. This should be in conjunction with appropriate work force transformation to facilitate increased working and collaboration with non-medical healthcare professionals and between hospitals and community environments.

The curriculum for internal medicine incorporates and emphasises the importance of the generic professional capabilities. Common capabilities will promote flexibility in postgraduate training in line with the recommendations set out in the GMC's report to the four UK governments[6]. We believe a flexible approach is essential to deliver a sustainable model for physician training agile enough to respond to evolving patient need.

In summary, the model for physician training and the IM curriculum will:

- Ensure trainee physicians can provide safe emergency and acute care during and on completion of their postgraduate training (as appropriate to their specialty).
- Ensure that internal medicine doctors develop and demonstrate a range of essential capabilities for managing patients with both acute and long-term conditions.
- Ensure that trainee physicians can acquire and demonstrate all of the GMC mandated GPCs including communication skills.
- Allow flexibility between specialties through GPCs and higher level learning outcomes.
- Further develop the attributes of professionalism, particularly recognition of the primacy of patient welfare that is required for safe and effective care of those with both acute and long-term conditions, and develop physicians who ensure patients' views are central to all decision making.

[6] Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training

- Provide the opportunity to develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team and to work towards making independent clinical decisions with appropriate support.
- Provide doctors with a variety of hospital, community and academic workplace experience during their programme. All doctors will have the opportunity to build on community experience gained in foundation training and understand the interface with community care provision.
- Build on the knowledge, skills and attitudes that were acquired during undergraduate and foundation training.
- Ensure the flexibility to allow trainees to train in academic medicine alongside their acquisition of clinical and generic capabilities.

The curriculum for internal medicine has been developed with the support and input of trainees, consultants actively involved in delivering teaching and training across the UK, service representatives and lay persons. This has been through the work of the Internal Medicine Committee and its subgroups and at regular stakeholder engagement events. A 'proof of concept' study[7] was conducted in 2016 and a wide consultation exercise was carried out in 2017, which have led to significant changes and improvements to the draft curriculum.

High level curriculum outcomes: Capabilities in practice

The 14 capabilities in practice (CiPs) (starfshæfni) describe the professional tasks or work within the scope of internal medicine. Each CiP has a set of descriptors associated with that activity or task.

Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made. By the completion of training and award of CCT, the doctor must demonstrate that they are capable of unsupervised practice in all generic and specialty CiPs.

The six generic CiPs cover the universal requirements of all specialties as described in GPC framework. Assessment of the generic CiPs will be underpinned by the GPC descriptors. Satisfactory sign off will indicate that there are no concerns before the trainee can progress to the next part of the assessment of clinical capabilities.

The eight specialty CiPs describe the clinical tasks or activities which are essential to the practice of internal medicine. The clinical CiPs have also been mapped to the GPC domains and subsections to reflect the professional generic capabilities required to undertake the clinical tasks. Satisfactory sign off requires demonstration that, for each of the CiPs, the doctor in training's performance meets or exceeds the minimum expected level of performance expected for completion of this stage of internal medicine training, as defined in the curriculum (see 5.5 outline grid of levels expected for each CiP in each year of training).

[7] Proof of concept study 2016

Learning outcomes – capabilities in practice (CiPs)
Generic CiPs
1. Able to successfully function within the Icelandic health care system and in NHS in the UK organisational and management systems. 2. Able to deal with ethical and legal issues related to clinical practice. 3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement. 4. Is focussed on patient safety and delivers effective quality improvement in patient care. 5. Carrying out research and managing data appropriately. 6. Acting as a clinical teacher and clinical supervisor.
Specialty CiPs
1. Managing an acute unselected take. 2. Managing an acute specialty-related take. 3. Providing continuity of care to medical in-patients, including management of comorbidities and cognitive impairment. 4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions. 5. Managing medical problems in patients in other specialties and special cases. 6. Managing a multi-disciplinary team including effective discharge planning. 7. Delivering effective resuscitation and managing the acutely deteriorating patient. 8. Managing end of life and applying palliative care skills.

2.3 Development

This curriculum was developed by the Internal Medicine Committee (IMC) and its subgroups under the direction of the Joint Royal Colleges of Physicians Training Board (JRCPTB). The members of the IMC have broad UK representation and include consultants who are actively involved in teaching and training, trainees, service representatives and lay persons.

To facilitate consultation and input from the 30 specialties and three sub-specialties that we oversee, JRCPTB held meetings with all the chairs of the specialty advisory committees (SACs). In addition the model has been shared widely with numerous organisations including: councils of the three physician royal colleges and regional advisors, the trainees committees of the three colleges, the medical specialties board based in London, heads of school of medicine and the postgraduate deans. JRCPTB has held a series of consultation events with these stakeholders. In addition, podcasts have been available on YouTube and the JRCPTB website.

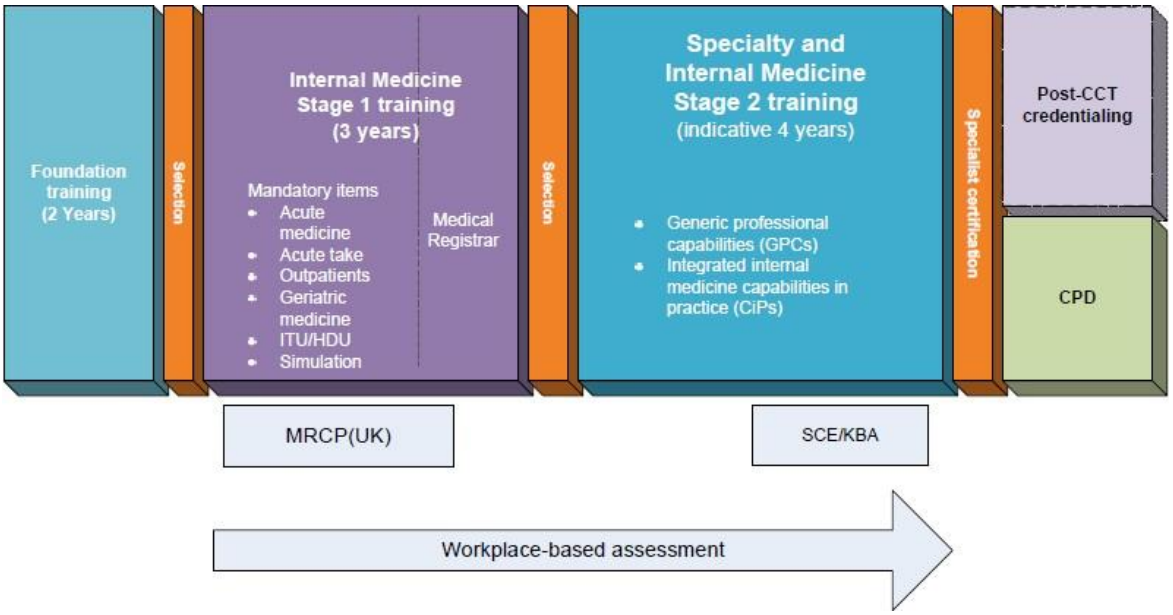
2.4 Training Pathway

Internal medicine (IM) stage 1 training is entered following completion of the foundation programme (starfsnám/kandídatsár) and its purpose is to ensure doctors demonstrate the

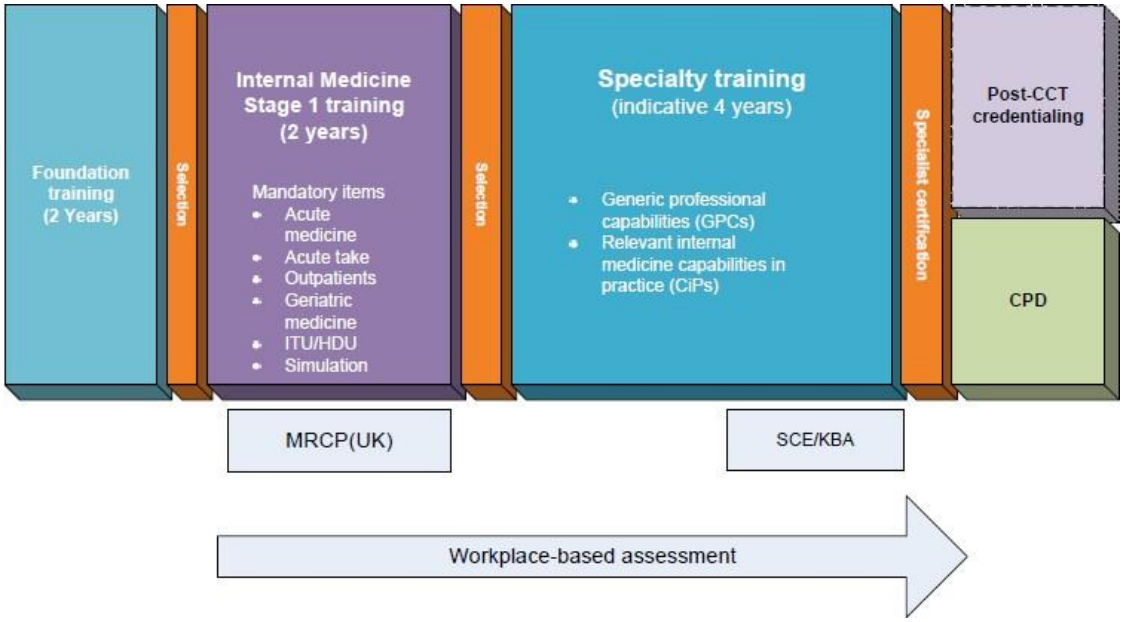
ability to learn in the workplace and develop their clinical and professional skills in readiness for higher specialty training (áframhaldandi sérnám). Internal Medicine stage 1 forms the initial training programme for the physician specialties.

This Icelandic version of the curriculum is based on the programme for group 1 specialties. However there is an option for trainees who wish to enter further training in the UK in group 2 specialties to apply for position in those specialties if they have finished all requirements, including MRCP.

The physician training pathway – group 1 specialties



The physician training pathway – group 2 specialties



2.5 Duration of training

Internal Medicine Stage 1 training will usually be completed in three years of full time training. There may be a small number of trainees who develop more slowly and will require an extension of training in line the Reference Guide for Postgraduate Specialty Training in the Iceland (The Icelandic Gold Guide)[8].

2.6 Flexibility

GPCs will promote flexibility in postgraduate training as these common capabilities can be transferred from specialty to specialty. In addition, the IM CiPs will be shared across all physician curricula, supporting flexibility for trainees to move between these specialties without needing to repeat aspects of training.

Trainees in Internal Medicine Stage 1 training can apply to the Training Programme Director to take part of their training in the UK, preferably as a 6 month rotation. This is based on an agreement between the Icelandic training programme and an individual training programme in the UK. Those trainees will need to apply for a medical licence in the UK.

Accreditation of transferrable competencies

The Internal Medicine stage 1 programme accepts transferable competences from Acute Care Common Stem (ACCS)(Sameiginlegt kjarnanám í bráðagreinum lækninga, SKBL) Anaesthesia and Intensive Care [Anaes] and ACCS Emergency Medicine [EM].

[8] A Reference Guide for Postgraduate Specialty Training in Iceland

Transfer of competences will only be available to doctors who have successfully completed at least one year of an ACCS [Anaesthesia, Emergency Medicine] programme and have obtained ARCP outcome 1. The maximum amount of time that can be credited for competences obtained during ACCS [Anaesthesia, Emergency Medicine] is 12 months towards training in IM Stage 1.

ATCF also applies for trainees who complete ST1-3 of the Emergency Medicine run-through programme.

Approval for the previous experience must be agreed by the relevant Internal Medicine stage 1 training programme director on an individual trainee basis, and must be reviewed and confirmed at the first ARCP.

Details of the maximum duration and a mapping of transferable competences are set out in the table below [NB ACCS Acute Medicine is an approved core programme for all physician specialties so trainees undertaking this pathway can apply at ST3 and ATC does not apply].

1st CCT Programme	Transferring to	Completed component	Expected counted time	Maximum counted time
ACCS [Anaes] [EM]	IM Stage 1	EM, GIM, ICM	6 months GIM 3 months EM 3 months ICM	12 months
ST1-3 EM	IM Stage 1	EM, GIM, ICM	6 months GIM 3 months EM 3 months ICM	12 months

2.7 Less than Full Time Training

Trainees are entitled to opt for less than full time training programmes. Less than full time trainees should undertake a pro rata share of the out-of-hours duties (including on-call and other out-of-hours commitments) required of their full-time colleagues in the same programme and at the equivalent stage. Less than full time trainees should assume that their clinical training will be of a duration pro-rata with the time indicated/recommended, but this should be reviewed in accordance with the Gold Guide.

2.8 Generic Professional Capabilitiesand Good Medical Practice

The GMC has developed the Generic professional capabilities (GPC) framework[9] with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a common language. GPCs also represent a system-wide, regulatory response to the most common contemporary concerns about patient safety and fitness to practise within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

The nine domains of Generic Professional Capabilities

Good Medical Practice (GMP, Góðir starfshættir lækna (https://www.landlaeknir.is/servlet/file/store93/item32436/Godir_starfshaettir_laekna_31.5.2017.pdf))[10] is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

The GPC framework describes nine domains with associated descriptor outlining the 'minimum common regulatory requirement' of performance and professional behaviour for those completing a CCT or its equivalent. These attributes are common, minimum and generic standards expected of all medical practitioners achieving a CCT or its equivalent.

[9] Generic professional capabilities framework
[10] Good Medical Practice

The 20 domains and subsections of the GPC framework are directly identifiable in the IM curriculum. They are mapped to each of the generic and specialty CiPs, which are in turn mapped to the assessment blueprints. This is to emphasise those core professional capabilities that are essential to safe clinical practice and that they must be demonstrated at every stage of training as part of the holistic development of responsible professionals.

This approach will allow early detection of issues most likely to be associated with fitness to practise and to minimise the possibility that any deficit is identified during the final phases of training.

3 Content of Learning

The practice of Internal Medicine requires the generic and specialty knowledge, skills, attitudes and procedural skills to manage patients presenting with a wide range of medical symptoms and conditions. It involves particular emphasis on diagnostic reasoning, managing uncertainty, dealing with comorbidities, and recognising when specialty opinion or care is required.

3.1 Capabilities in practice

Capabilities in practice (CiPs) describe the professional tasks or work within the scope of internal medicine. CiPs are based on the format of entrustable professional activities [11] which are a method of using the professional judgement of appropriately trained, expert assessors as a key aspect of the validity of assessment and a defensible way of forming global judgements of professional performance.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated by stage 1 internal medicine doctors. Doctors in training may use these capabilities to provide evidence of how their performance meets or exceeds the minimum expected level of performance for their year of training. The descriptors are not a comprehensive list and there are many more examples that would provide equally valid evidence of performance.

Many of the CiP descriptors refer to patient centred care and shared decision making. This is to emphasise the importance of patients being at the centre of decisions about their own treatment and care, by exploring care or treatment options and their risks and benefits and discussing choices available.

Additionally, the clinical CiPs repeatedly refer to the need to demonstrate professional behaviour with regard to patients, carers, colleagues and others. Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or

[11] Nuts and bolts of entrustable professional activities

disability. Appropriate professional behaviour should reflect the principles of GMP and GPC (see section 2.6).

In order to complete training and be recommended to the GMC for the award of CCT and entry to the specialist register, the doctor must demonstrate that they are capable of unsupervised practice in all generic and specialty CiPs.

Satisfactory sign off at the end of Internal Medicine stage 1 requires demonstration that, for each of the CiPs, the doctor in training's performance meets or exceeds the minimum expected level of performance expected for completion of this stage of internal medicine training.

This section of the curriculum details the 14 generic and specialty CiPs for Internal Medicine Stage 1 with expected levels of performance, mapping to relevant GPCs and the evidence that may be used to make an entrustment decision.

3.1.1 Generic capabilities in practice

The six generic CiPs cover the universal requirements of all specialties as described in GMP and the GPC framework. Assessment of the generic CiPs will be underpinned by the descriptors for the nine GPC domains and evidenced against the performance and behaviour expected at that stage of training. Satisfactory sign off will indicate that there are no concerns before the trainee can progress to the next part of the assessment of clinical capabilities. It will not be necessary to assign a level of supervision for these non-clinical CiPs.

In order to ensure consistency and transferability, the generic CiPs have been grouped under the GMP-aligned categories used in the Foundation Programme curriculum (Marklýsing fyrir starfsnám lækna (kandídatsár) plus an additional category for wider professional practice:

- Professional behaviour and trust
- Communication, team-working and leadership
- Safety and quality
- Wider professional practice

For each generic CiP a set of descriptors of the observable skills and behaviours which would demonstrate that a trainee has met the minimum level expected. The descriptors are not a comprehensive list and there may be more examples that would provide equally valid evidence of performance.

Generic capabilities in practice (CiPs)	
Category 1: Professional behaviour and trust	
1. Able to function successfully within NHS organisational and management systems	
Descriptors	• Aware of and adheres to the GMC professional requirements • Aware of public health issues including population health, social detriments of

	health and global health perspectives • Demonstrates effective clinical leadership • Demonstrates promotion of an open and transparent culture • Keeps practice up to date through learning and teaching • Demonstrates engagement in career planning • Demonstrates capabilities in dealing with complexity and uncertainty • Aware of the role of and processes for commissioning
GPCs	Domain 1: Professional values and behaviours Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in Iceland Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF Active role in governance structures Management course End of placement reports
2. Able to deal with ethical and legal issues related to clinical practice	
Descriptors	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups • Behaves in accordance with ethical and legal requirements • Demonstrates ability to offer apology or explanation when appropriate • Demonstrates ability to lead the clinical team in ensuring that medical legal factors are considered openly and consistently
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in Iceland Domain 4: Capabilities in health promotion and illness prevention Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF CbD DOPS Mini-CEX MRCP(UK) ALS certificate End of life care and capacity assessment End of placement reports
Category 2: Communication, team working and leadership	
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 (eg 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 team working
Evidence to inform decision	MCR MSF PS MRCP(UK) End of placement reports ES report
Category 3: Safety and quality	
4. Is focussed on patient safety and delivers effective quality improvement in patient care	
Descriptors	• Makes patient safety a priority in clinical practice • Raises and escalates concerns where there is an issue with patient safety or quality of care • Demonstrates commitment to learning from patient safety investigations and complaints • Shares good practice appropriately • Contributes to and delivers quality improvement • Understands basic Human Factors principles and practice at individual, team, organisational and system levels • Understands the importance of non-technical skills and crisis resource management • Recognises and works within limit of personal competence
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 legislative requirements • the health service and healthcare systems in Iceland

	Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF QIPAT End of placement reports
Category 4: Wider professional practice	
5. Carrying out research and managing data appropriately	
Descriptors	• Manages clinical information/data appropriately • Understands principles of research and academic writing • Demonstrates ability to carry out critical appraisal of the literature • Understands the role of evidence in clinical practice and demonstrates shared decision making with patients • Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry • Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice • Follows guidelines on ethical conduct in research and consent for research • Understands public health epidemiology and global health patterns • Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in Iceland Domain 7: Capabilities in safeguarding vulnerable groups Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF MRCP(UK) GCP certificate (if involved in clinical research) Evidence of literature search and critical appraisal of research Use of clinical guidelines Quality improvement and audit Evidence of research activity End of placement reports
6. Acting as a clinical teacher and clinical supervisor	
Descriptors	• Delivers effective teaching and training to medical students, junior doctors and other health careprofessionals • Delivers effective feedback with action plan • Able to supervise less experienced trainees in their clinical assessment and management ofpatients • Able to supervise less experienced trainees in carrying out appropriate practical procedures • Able to act a clinical supervisor to doctors in earlier stages of training

GPCs	Domain 1: Professional values and behaviours Domain 8: Capabilities in education and training
Evidence to inform decision	MCR MSF TO Relevant training course End of placement reports

3.1.2 Specialty capabilities in practice

The eight specialty CiPs describe the clinical tasks or activities which are essential to the practice of Internal Medicine. The clinical CiPs have been mapped to the nine GPC domains to reflect the professional generic capabilities required to undertake the clinical tasks.

Satisfactory sign-off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

Specialty CiPs – Internal Medicine	
1. Managing an acute unselected take	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Takes a relevant patient history including patient symptoms, concerns, priorities and preferences • Performs accurate clinical examinations • Shows appropriate clinical reasoning by analysing physical and psychological findings • Formulates an appropriate differential diagnosis • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately selects, manages and interprets investigations • Recognises need to liaise with specialty services and refers where appropriate
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 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF CbD ACAT MRCP(UK) Logbook of cases Simulation training with assessment
2. Managing an acute specialty–related take	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Takes a relevant patient history including patient symptoms, concerns, priorities and preferences • Performs accurate clinical examinations • Shows appropriate clinical reasoning by analysing physical and psychological findings • Formulates an appropriate differential diagnosis • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately selects, manages and interprets investigations • Demonstrates appropriate continuing management of acute medical illness in patients admitted to hospital on an acute unselected take or selected take
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 Iceland Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and team-working Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF

	CbD ACAT MRCP(UK) Logbook of cases Simulation training with assessment
3. Providing continuity of care to medical in-patients, including management of comorbidities and cognitive impairment	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues andothers • Delivers patient centred care including shared decision making • Demonstrates effective consultation skills • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Demonstrates appropriate continuing management of acute medical illness in patients admitted to hospital on an acute unselected take or selected take • Recognises need to liaise with specialty services and refers where appropriate Appropriately manages comorbidities in medial inpatients (unselected take, selected acute take or specialty admissions) • 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 Iceland Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF ACAT Mini-CEX DOPS MRCP(UK)
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 Iceland Domain 5: Capabilities in leadership and teamworking
Evidence to informdecision	MCR ACAT mini-CEX PS MRCP(UK) Letters generated at outpatient clinics
5. Managing medical problems in patients in other specialties and special cases	
Descriptors	• Demonstrates effective consultation skills (including when in challenging circumstances) • Demonstrates management of medical problems in inpatients under the care of other specialties • Demonstrates appropriate and timely liaison with other medical specialty services when required
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 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR ACAT CbD MRCP(UK)
6. Managing a multi-disciplinary team including effective discharge planning	
Descriptors	• Applies management and team working skills appropriately, including

	influencing, negotiating, continuously re-assessing priorities and effectively managing complex, dynamic situations • Ensures continuity and coordination of patient care through the appropriate transfer of information demonstrating safe and effective handover • Effectively estimates length of stay • Delivers patient centred care including shared decision making • Identifies appropriate discharge plan • Recognises the importance of prompt and accurate information sharing with primary care team following hospital discharge
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 5: Capabilities in leadership and team-working
Evidence to inform decision	MCR MSF ACAT MRCP(UK) Discharge summaries
7. Delivering effective resuscitation and managing the acutely deteriorating patient	
Descriptors	• Demonstrates prompt assessment of the acutely deteriorating patient, including those who are shocked or unconscious • Demonstrates the professional requirements and legal processes associated with consentfor resuscitation • Participates effectively in decision making with regard to resuscitation decisions, including decisions not to attempt CPR, and involves patients and their families • Demonstrates competence in carrying out resuscitation
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 Iceland • Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups

Evidence to inform decision	MCR DOPS ACAT MSF MRCP(UK) ALS certificate Logbook of cases Reflection Simulation training with assessment
8. Managing end of life and applying palliative care skills	
Descriptors	• Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs • Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing at end of life • Demonstrates safe and effective use of syringe pumps in the palliative care population • Able to manage non complex symptom control including pain • Facilitates referrals to specialist palliative care across all settings • Demonstrates effective consultation skills in challenging circumstances • Demonstrates compassionate professional behaviour and clinical judgement
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 (Iceland)
Evidence to inform decision	MCR CbD Mini-CEX MSF MRCP(UK) Regional teaching Reflection

KEY

ACAT	Acute care assessment tool	ALS	Advanced Life Support
CbD	Case-based discussion	DOPS	Direct observation of procedural skills
GCP	Good Clinical Practice	MRCP (UK)	Membership of the Royal Colleges of Physicians Diploma
Mini-CEX	Mini-clinical evaluation exercise	MCR	Multiple consultant report
MSF	Multi source feedback	PS	Patient survey
QIPAT	Quality improvement project assessment tool	TO	Teaching observation

3.2 Presentations and conditions

The scope of internal medicine is broad and cannot be encapsulated by a finite list of presentations and conditions. Any attempt to list all relevant presentations, conditions and issues would be extensive but inevitably incomplete and rapidly become out of date.

The table below details the key presentations and conditions of internal medicine. Each of these should be regarded as a clinical context in which trainees should be able to demonstrate CiPs and GPCs. Trainees will need to become familiar with the knowledge, skills and attitudes around managing patients with these conditions and presentations. The patient should always be at the centre of knowledge, learning and care.

Trainees must demonstrate core bedside skills, including information gathering through history and physical examination and information sharing with patients, families and colleagues.

Treatment care and strategy covers how a doctor selects drug treatments or interventions for a patient. It includes discussions and decisions as to whether treatment should be active or palliative, and also broader aspects of care, including involvement of other professionals or services.

Particular presentations, conditions and issues are listed either because they are common (therefore the internal medicine physician must be familiar with them) or serious (having high morbidity, mortality and/or serious implications for treatment or public health).

Some presentations may be caused by conditions attributed to more than one system, or presenting to more than one specialty, and some conditions may be the rightful province of two or more specialties. Specifically, many if not most of these presentations and conditions will be highly relevant to the specialty of Acute Internal Medicine (AIM) but we have not listed AIM as a specialty because to do so would merely produce repetition of much of this list of presentations and conditions/issues, many of which have both acute and chronic disease implications.

The table of systems/specialties, presentations and conditions of internal medicine is to be interpreted with common sense. Each condition and presentation appears once in the syllabus, or on a limited number of occasions, e.g. chest pain is listed as a cardiology or respiratory medicine presentation. The fact that chest pain is not listed as a rheumatological presentation does not mean that the Internal Medicine curriculum does not require that the trainee recognises that there can be musculoskeletal causes of chest pain. It is not felt necessary to document the specific attributes of each presentation and condition with which trainees need to be familiar as this will vary between conditions and presentations. However, for each condition/presentation, trainees will need to be familiar with such aspects as aetiology, epidemiology, clinical features, investigation, management and prognosis. Our approach is to provide general guidance and not exhaustive detail, which would inevitably become out of date.

Presentations and conditions of Internal Medicine by system/specialty

System/Specialty and subspecialty	Presentations	Conditions/Issues
Emergency presentations	Cardiorespiratory arrest Shocked patient Unconscious patient Anaphylaxis	
Allergy	Acute and chronic allergic symptoms Anaphylaxis Angioedema Asthma Nose and sinus symptoms Urticaria	Allergy – food, latex, insect venom, transfusion Anaphylaxis Asthma Drug – allergy and intolerance Rhinitis / sinusitis / conjunctivitis Skin disorders Urticaria and angioedema
Cardiology	Breathlessness Chest pain Limb pain Limb swelling Palpitations Syncope and pre-syncope	Cardiac arrhythmias Cardiac failure Cardiac involvement in genetic disease Cardiac involvement in infectious disease Congenital heart disease in the adult Coronary heart disease Diseases of heart muscle Diseases of the arteries, including aortic dissection Diseases of the pulmonary circulation Heart valve disease Hypertension Hyperlipidaemia Oedema Pericardial disease Tumours of the heart Venous thromboembolism
Clinical genetics	Familial condition Interpretation of a genetic test Possibility of genetic diagnosis Request for genetic testing	Common single gene disorders in the adult
Clinical pharmacology and therapeutics	Poisoning Drug side effects Drug allergy Hypertension	Adverse drug reactions Practice safe / rational prescribing and medicines optimisation Use national or local guidelines on appropriate and safe prescribing
Dermatology	Mouth ulcer Pruritus Rash Skin lesions	Blood and lymphatic vessel disorders Cutaneous reactions to drugs Cutaneous vasculitis, connective tissue diseases and urticaria Dermatitis / eczema Disorders of pigmentation Hair and nail disorders Infections of the skin and soft tissues

System/Specialty and subspecialty	Presentations	Conditions/Issues
		Inherited skin diseases Papulosquamous diseases Photosensitivity Sebaceous and sweat gland disorders Skin in systemic disease Tumours of the skin Blistering disorders
Endocrinology and diabetes mellitus	Amenorrhoea Hirsutism Hyperglycaemia Hypoglycaemia Obesity Polydipsia Polyuria Sick day rules Weight gain Weight loss	Adrenal disorders Benign breast diseases Diabetes mellitus Disorders of growth Disorders of male reproduction Disorders of puberty Disorders of the anterior pituitary Disorders of the posterior pituitary Electrolyte disorders Ovarian disorders Pancreatic endocrine disorders (other) Parathyroid disorders Sexual dysfunction Thyroid disorders
Gastroenterology and Hepatology	Abdominal mass / hepatosplenomegaly Abdominal pain Abdominal swelling Anaemia (iron deficiency) Constipation Diarrhoea Dyspepsia Haematemesis and melaena Jaundice Nausea and vomiting Rectal bleeding Swallowing difficulties Weight loss	Acute abdominal pathologies Alcohol related liver disease including the withdrawal syndrome Chronic liver diseases Congenital abnormalities of the GI tract Diet and nutritional support Diseases of the colon Diseases of the gall bladder, pancreas and biliary tree Diseases of the mouth and salivary glands Diseases of the oesophagus Diseases of the small bowel Diseases of the stomach Functional bowel disorders Gastrointestinal infections Inflammatory bowel diseases Malabsorption Nutrition and malnutrition Refeeding The Acute abdomen Vascular disorders of the GI tract
Genitourinary medicine	Genital discharge and ulceration Genital rash Erectile dysfunction, genital lumps, rectal discharge, post	HIV infection Prevention of conditions related to sexual behaviour Sexually transmitted infections and systemic complications

System/Specialty and subspecialty	Presentations	Conditions/Issues
	coital and intermenstrual bleeding, pelvic pain, dyspareunia	Reproductive health (incl. contraception)
Geriatric medicine	Delirium Deterioration in mobility Falls Fragility fractures Frailty Hypothermia Incontinence Memory loss Unsteadiness / balance disturbance	Continence – faecal and urinary Dementias Depression Malnutrition Movement disorders Osteoporosis Pharmacology Subarachnoid haemorrhage Stroke Transient ischaemic attack Pressure ulcers
Haematology	Anaemia Bruising and spontaneous bleeding Coagulation test abnormality Full blood count abnormality Lymphadenopathy Neutropenic fever Paraproteinaemia Splenomegaly Transfusion reactions	Anaemia Blood transfusion and alternatives Common haematological malignancies Bone marrow failure Haemoglobinopathies Haemolysis MGUS (monoclocal gammopathy of uncertain significance) Thrombosis and anticoagulant therapy
Immunology		Autoimmune systemic disorders Primary immunodeficiency disorders
Infectious diseases	Fever Genital discharge and ulceration Sepsis syndrome Weight loss	Anti-microbial drug monitoring Anti-microbial resistance and stewardship Bacterial infections Evaluation of the unwell returning traveller Fever of unknown origin Fungal infections Helminth infections HIV infection Infections in the immune-compromised host Protozoal infections Viral infections Traveller and migrant health
Medical ophthalmology	Diplopia Optic disc swelling Painful eye Red eye Vision loss	Cranial nerve palsy Glaucoma Inflammatory eye disease TIA/stroke Retinal vascular disease
Neurology	Abnormal sensation (paraesthesia and numbness) Abnormal behaviour	Acute stroke and transient ischaemic attacks Chronic neurological disability

System/Specialty and subspecialty	Presentations	Conditions/Issues
	Acute confusion Bladder, bowel and sexual dysfunction Breathlessness Dizziness and vertigo Headache Hearing loss Involuntary movements Memory loss and intellectual decline Pain Seizures (epileptic and non-epileptic) Speech disturbance Swallowing difficulties Syncope and pre-syncope Unsteadiness Visual disturbance Weakness and paralysis	Dementia and cognitive disorders Delirium Epilepsy Functional illness Head injury Meningitis and encephalitis Migraine and other headache syndromes Motor neurone disease Multiple sclerosis Myasthenia gravis Myopathies (acute and chronic) Parkinson's disease and other movement disorders Peripheral neuropathy (acute and chronic) Subarachnoid haemorrhage and cerebral venous sinus thrombosis Tumours involving the brain and spinal cord
Oncology	Weight loss	Common cancers Hypercalcaemia Neutropenic sepsis Paraneoplastic conditions Premalignant conditions Spinal cord compression SVC obstruction
Palliative medicine and end of life care	Pain Physical symptoms other than pain Psychosocial concerns including spiritual care and care of family The dying patient	Advanced malignancy End stage organ failure Frailty Multiple comorbidity
Public health and health promotion		Alcohol Exercise Mental health Non-communicable diseases Nutrition Obesity Occupation Sexual behaviour Smoking Social deprivation Substance abuse UK and global health
Psychiatry	Aggressive or disturbed behaviour Alcohol and substance	Alcohol and substance misuse Anxiety disorders Bipolar disorder

System/Specialty and subspecialty	Presentations	Conditions/Issues
	dependence Anxiety or panic Physical symptoms unexplained by organic disease Self-harm Treatment refusal	Delirium Dementias Depression Eating disorders Personality disorder Phobias Psychoses Schizophrenia Somatic symptom disorders Stress disorders Suicide and self-harm
Renal medicine	Dysuria Electrolyte abnormality Fluid balance abnormality Haematuria Hypertension Loin pain Micturition difficulties Polyuria Proteinuria Raised serum creatinine	Acute kidney injury Chronic kidney disease Drugs and the kidney Electrolyte disorders Fluid balance disorders Genetic disorders affecting the kidneys Glomerular diseases Malignant disease of the urinary tract Nephrotic syndrome Renal replacement therapy Renal tubular disorders Systemic disorders affecting the kidneys Tubulo-interstitial diseases Urinary tract infection Urinary tract obstruction
Respiratory medicine	Breathlessness Pleuritic chest pain Cough Haemoptysis Hoarseness Stridor Pleural effusion Wheeze	Asthma Bronchiectasis Chronic obstructive pulmonary disease Cystic fibrosis Diseases of the pulmonary circulation Disorders of the thoracic cage and diaphragm Disorders of the upper respiratory tract Immune mediated respiratory diseases Interstitial lung diseases Malignant diseases of the respiratory system Pleural diseases including pneumothorax Occupational lung diseases Pulmonary embolism Sarcoidosis Sleep related breathing disorders

System/Specialty and subspecialty	Presentations	Conditions/Issues
		Respiratory infections Respiratory failure Tuberculosis
Rheumatology	Back pain Joint pain and swelling Neck pain Rash and weakness	Multisystem rheumatic disorders Spinal pain and regional disorders Crystal-related arthropathies Infection and arthritis Metabolic bone diseases Monitoring and toxicity of immunosuppressive drugs including biologics Osteoarthritis Osteoporosis Rheumatoid arthritis Spondyloarthritides
Other / all - clinical	Incidental findings Medical problems following surgical procedures Medical problems in pregnancy Physical symptoms unexplained by organic disease Pre-operative assessment	Chronic fatigue syndrome

3.3 Practical procedures

There are a number of procedural skills in which a trainee must become proficient to the level expected by the end of Internal Medicine stage 1.

Trainees must be able to outline the indications for these procedures and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthetics, minimisation of patient discomfort, and requesting for help when appropriate. For all practical procedures the trainee must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary.

Trainees should ideally receive training in procedural skills in a clinical skills lab before performing these procedures clinically, but this is not mandatory. Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool.

The table below sets out the minimum competency level expected for each of the practical procedures at the end of each year of training in IM stage 1. The expectation at higher levels of internal medicine training is included for reference.

Obtaining independence in these procedures is desirable. Sites that require trainees to perform these procedures for service reasons will need to put in place mechanisms to

provide training and assure competence. Trainees working in sites that do not provide such training are required to have skills lab training on a minimum of three occasions in Internal Medicine stage 1 training.

When a trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure, unless they or their educational supervisor think that this is required (in line with standard professional conduct). This also applies to procedures that have been signed off during Foundation Year training or in other training programmes (e.g. ACCS).

Internal medicine practical procedures

	Internal Medicine stage 1			**IM stage 2**
Procedure	**IM1**	**IM2**	**IMT3**	**ST4-7**
Advanced cardiopulmonary resuscitation (CPR)	Skills lab or satisfactory supervised practice	Participation in CPR team	Leadership of CPR team	Maintain
Direct current (DC) cardioversion	Skills lab or satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain
Temporary cardiac pacing using an external device	Skills lab or satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain
Central venous cannulation (internal jugular or subclavian)	Skills lab or satisfactory supervised practice	Maintain	Maintain	Maintain
Access to circulation for resuscitation (femoral vein or intraosseous)[a]	Skills lab or satisfactory supervised practice	Maintain	Maintain	Maintain
Pleural aspiration for fluid (diagnostic)[b]	Skills lab or satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain
Pleural aspiration (pneumothorax)[c]	Skills lab or satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain
Intercostal drain for pneumothorax	Skills lab or satisfactory supervised practice	Maintain	Maintain	Maintain
Intercostal drain for effusion[b]	Skills lab or satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain
Nasogastric (NG) tube	Skills lab or satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain
Ascitic tap	Skills lab or satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain

	Internal Medicine stage 1			IM stage 2
Procedure	**IM1**	**IM2**	**IMT3**	**ST4-7**
Abdominal paracentesis	Skills lab or satisfactory supervised practice	Maintain	Maintain	Maintain
Lumbar puncture	Skills lab or satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain

Notes

[a] The requirement is for a minimum of skills lab training or satisfactory supervised practice in one of these two mechanisms for obtaining access to the circulation to allow infusion of fluid in the patient where peripheral venous access cannot be established.

[b] Pleural procedures should be undertaken in line with the British Thoracic Society guidelines. These state that thoracic ultrasound guidance is strongly recommended for all pleural procedures for pleural fluid, also that the marking of a site using thoracic ultrasound for subsequent remote aspiration or chest drain insertion is not recommended, except for large effusions. Ultrasound guidance should be provided by a pleural-trained ultrasound practitioner.

[c] The requirement is for the trainee to be able to decompress a large symptomatic pneumothorax. This is a relatively uncommon clinical scenario, and it is not expected that all trainees will encounter it during their training. A trainee who can satisfactorily perform pleural aspiration of fluid can be regarded as having the necessary competency.

4 Learning and Teaching

4.1 The training programme

The organisation and delivery of postgraduate training is outlined in the Icelandic Gold Guide[8].

Progression through the programme will be determined by the ARCP process (section 5.6) and the training requirements for each indicative year of training are summarised in the Internal Medicine Stage 1 ARCP decision aid (available on the JRCPTB website). The successful completion of Internal Medicine Stage 1 will be dependent on achieving the expected level in all CiPs, GPCs and procedural skills. The programme of assessment will be used to monitor and determine progress through the programme. Training will normally take place in a range of District General Hospitals and Teaching Hospitals.

The sequence of training should ensure appropriate progression in experience and responsibility. The training to be provided at each training site is defined to ensure that,

during the programme, the entire syllabus is covered and also that unnecessary duplication and educationally unrewarding experiences are avoided. However, the sequence of training should ideally be flexible enough to allow the trainee to develop a special interest.

The following provides a guide on how training programmes should be focussed in each training year in order for trainees to gain the experience and develop the capabilities to the level required. Clearly, it is not intended that trainees in IM1 will spend all their time in acute care but it should be the central focus for the year. Similarly, trainees in IM2 will continue to do in-patient and acute care (including "on-call") but it just means that their primary focus is on acquiring essential out-patient consultation skills.

Irrespective of the year of training and its focus, each trainee will be attached to a "parent" team/firm and it is anticipated that their clinical supervisor will be a senior member of that team.

There has been much discussion about what is the optimum duration of any particular attachment. Longer attachments foster team relationships and ensure that trainees feel more involved and valued and develop enhanced support networks. However shorter attachments mean that a trainee may be exposed to more specialties. The exact pattern of individual rotations will remain a matter for Training Programme Director (TPD) as long as all the curricular objectives are fulfilled. However, attachments to the main specialties should be at least 4 months in IM1 and IM2 and a minimum of six months in IM3.

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 out-patient clinics
IM3	Primarily involved in the acute take and functioning as the 'Medical Registrar'

4.1.1 Mandatory training

All training should be conducted in institutions which meet the relevant JRCPTB Quality Criteria, GMC standards for training and education and the relevant Health and Safety standards. Please see section 4.2 for guidance on methods of teaching and learning.

Acute medical take

Trainees should be involved in the acute unselected medical take in each year of the internal medicine stage 1 training programme, but it is recognised that this will not be a feature of all attachments, and that their greatest involvement will be in IM3. In each year of the internal medicine stage 1 training programme they should be actively involved (have sufficient input for their involvement to be recorded in the patient's clinical notes) in the

care of at least 100 patients presenting with acute medical problems, and at least 500 patients by the end of the internal medicine stage 1 training programme.

Inpatients
Trainees should be involved in the day-to-day management of acutely unwell medical inpatients for at least 24 months of the internal medicine stage 1 training programme.

Outpatients
Trainees should attend and be actively involved in a minimum of 80 clinics over the internal medicine stage 1 training programme. It is accepted that there may be some attachments (eg ICU, acute medicine) where there is little scope to attend out-patient clinics but there are other attachments where it should be a regular weekly or twice weekly commitment. It is expected that trainees will do clinics in all three years of IM training but as noted above the main focus on clinics will be in IM2. These may be in the parent specialty of their attachment but also in other departmental clinics and it will be up to TPDs and Educational Supervisors to construct imaginative clinic attendances in order for the trainee to have a satisfactory educational experience (see teaching and learning methods section below for guidance on clinics).

Geriatric medicine
With an increasing elderly population it is essential that all trainees in IM have adequate exposure to and experience of geriatric medicine. It is felt that a four month attachment to a team led by a consultant geriatrician during the training programme is an absolute minimum.

Critical care experience
It is accepted that for a trainee physician to be able to recognise, assess and care for an acutely unwell patient they need a significant experience in a critical care environment and the learning objectives for such an experience are detailed below. Discussions with trainees and the Faculty of Intensive Care Medicine would suggest that the optimum method of achieving these learning objectives would be by a 3 month attachment to an intensive care unit where the trainee is fully integrated within all aspects of the ICU team's work including the delivery of out of hours care. Ideally this attachment should occur within the IM2 year as the trainee will have acquired an appropriate level of medical skills to maximise their learning opportunities and will be able to enter IM3 with the confidence to manage acutely unwell patients.

It is recognised that such an ideal experience may not be immediately implementable within all LEPs and therefore the curriculum mandates a 10 week minimum period of placement in a of critical care (ICU or HDU) settings over the 3 years in not more than two separate blocks. However, it is recommended that Schools of Medicine and Anaesthesia collaborate to implement the 3 month blocks as soon as possible.

Simulation
All practical procedures in the Internal Medicine stage 1 curriculum should be taught by simulation as early as possible in IM1 with further simulation teaching involving human

factors and scenarios training carried out in either IM1 or IM2. Further years should include refresher training for procedural skills where necessary.

4.1.2 Recommended training

Palliative and end of life care experience
It is recommended that trainees undertake a placement in a specialist palliative care environment (hospital advisory team, hospice or community). Guidance on this is provided in the teaching and learning methods section below.

4.2 Teaching and learning methods

The curriculum will be delivered through a variety of learning experiences and will achieve the capabilities described in the syllabus through a variety of learning methods. There will be a balance of different modes of learning from formal teaching programmes to experiential learning 'on the job'. The proportion of time allocated to different learning methods may vary depending on the nature of the attachment within a rotation.

This section identifies the types of situations in which a trainee will learn.

Learning with peers - There are many opportunities for trainees to learn with their peers. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions. Examination preparation encourages the formation of self-help groups and learning sets.

Work-based experiential learning - The content of work-based experiential learning is decided by the local faculty for education but includes active participation in:

- **Medical clinics including specialty clinics**
  The educational objectives of attending clinics are:
  - To understand the management of chronic diseases
  - Be able to assess a patient in a defined time-frame
  - To interpret and act on the referral letter to clinic
  - To propose an investigation and management plan in a setting different from the acute medical situation
  - To review and amend existing investigation plans
  - To write an acceptable letter back to the referrer
  - To communicate with the patient and where necessary relatives and other health care professionals.

  These objectives can be achieved in a variety of settings including hospitals, day care facilities and the community. The clinic might be primarily run by a specialist nurse (or other qualified health care professionals) rather than a consultant physician. After initial induction, trainees will review patients in clinic settings, under direct supervision. The degree of responsibility taken by the trainee will increase as competency increases. Trainees should see a range of new and follow-up patients and present their

findings to their clinical supervisor. Clinic letters written by the trainee should also be reviewed and feedback given.

The number of patients that a trainee should see in each clinic is not defined, neither is the time that should be spent in clinic, but as a guide this should be a minimum of two hours.

Clinic experience should be used as an opportunity to undertake supervised learning events and reflection.

- **Unselected and specialty-specific takes**
  Trainees will be involved in the acute unselected take on a regular basis throughout the three year training programme. The skills learnt will form the fundamental basis for managing the specialty-specific unselected take. Most trainees will not experience specialty-specific take and it is not mandatory for them to do so.

- **Post-take consultant ward-rounds**
  It is important that trainees have an opportunity to present at least a proportion of the patients whom they have admitted to their consultant for senior review in order to obtain immediate feedback into their performance (that may be supplemented by an appropriate WBA such as an ACAT, mini-CEX or CBD.

- **Personal ward rounds and provision of ongoing clinical care on specialist medical ward attachments**
  Every patient seen, on the ward or in out-patients, provides a learning opportunity, which will be enhanced by following the patient through the course of their illness. The experience of the evolution of patients' problems over time is a critical part both of the diagnostic process as well as management. Patients seen should provide the basis for critical reading and reflection on clinical problems.

- **Ward rounds by more senior doctors**
  Every time a trainee observes another doctor seeing a patient or their relatives there is an opportunity for learning. Ward rounds (including post-take) should be led by a more senior doctor and include feedback on clinical and decision-making skills.

- **Multi-disciplinary team meetings**
  There are many situations where clinical problems are discussed with clinicians in other disciplines. These provide excellent opportunities for observation of clinical reasoning.

  Trainees have supervised responsibility for the care of in-patients. This includes day-to-day review of clinical conditions, note keeping, and the initial management of the acutely ill patient with referral to and liaison with clinical colleagues as necessary. The degree of responsibility taken by the trainee will increase as competency increases. There should be appropriate levels of clinical supervision throughout training, with increasing clinical independence and responsibility.

- **Critical care**

  Trainees should have significant experience of critical care, preferably in a level 3 intensive care unit (ICU) or in a level 2 high dependency unit (HDU). The educational objectives of this are:

  - To become better able to recognise the very sick or rapidly deteriorating patient
  - To be able to work in the multi-disciplinary teams that run critical care units
  - To recognise the limited resource of critical care and gain an understanding of how admission to critical care should be prioritised.
  - To recognise the ceiling of care and when escalation is appropriate
  - To develop enhanced procedural skills such as placement of chest drains and central venous catheters
  - To understand the additional responsibilities and mechanisms of out of hours working in critical care units
  - To experience the way that critical units operate in terms of human factors and technology
  - To develop confidence in being involved with critical care units.

  In addition to these objectives, critical care experience will facilitate acquisition of other capabilities such as communication (particular discussion with family members) and palliative care skills.

- **Palliative and end of life care**

  Trainees should have significant experience of palliative care with the objective of:

  - Enhancing skills in recognising the patient with limited reversibility of their medical condition and the dying patient
  - Enhancing ability to recognise the range of interventions that can be delivered in acute and non-acute settings (eg community, hospice or care home)
  - Increasing confidence in managing physical symptoms in patients and psychosocial distress in patients and families
  - Increasing confidence in developing appropriate advance care plans, including DNA/CPR decisions

  It is accepted that many of these learning objectives and experience of end of life care can be achieved during attachments to routine medical teams (eg geriatric medicine, oncology, respiratory medicine) and ICU, which will allow a trainee to acquire and demonstrate the necessary capabilities to comply with CiP 8. However, it is felt that an attachment with a specific palliative care team and/or consultant will give a broader perspective in this complex and important area so if such an attachment can be arranged that is felt to be desirable.

Formal postgraduate teaching

The content of these sessions are determined by the local faculty of medical education and will be based on the curriculum. There are many opportunities throughout the year for formal teaching in the local postgraduate teaching sessions and at regional, national and international meetings. Many of these are organised by the Royal Colleges of Physicians.

Suggested activities include:

- a programme of formal bleep-free regular teaching sessions to cohorts of trainees (eg a weekly training hour for IM stage 1 teaching within a training site)
- case presentations
- research, audit and quality improvement projects
- lectures and small group teaching
- Grand Rounds
- clinical skills demonstrations and teaching
- critical appraisal and evidence based medicine and journal clubs
- joint specialty meetings
- attendance at training programmes organised on a regional basis, which are designed to cover aspects of the training programme outlined in this curriculum
- educational conferences abroad, as recommended by the Training Programme Director

Independent self-directed learning

Trainees will use this time in a variety of ways depending upon their stage of learning. Suggested activities include:

- reading, including web-based material such as e-Learning for Healthcare (e-LfH)
- maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- audit, quality improvement and research projects
- reading journals
- achieving personal learning goals beyond the essential, core curriculum

Formal study courses

Time to be made available for formal courses is encouraged, subject to local conditions of service. Examples include management courses and communication courses.

Simulation training

Procedural competency training, using simulation aimed at achieving technical competence for IM procedures should be provided as early as possible in IM1. Scenario-based immersive simulation training should be undertaken in IM1 and IM2, with human factors incorporated into the scenarios.

4.3 Academic training

Trainees are encouraged to do research during their training. Trainees can apply for one month paid leave to do research during their second year of training. Subsequently they are required to send in research in progress report and can then opt to apply for a second month of research time during their third year of training, followed by another research in progress report.

Trainees that are seeking a combined training in academic and clinical medicine can apply for a master or a doctoral programme at a collaborating university. This new curriculum should not impact in any way on the facility to take time out of programme for research (OOPR) but as now, such time requires discussion between the trainee, the TPD and the university as to what is appropriate together.

5 Programme of Assessment

5.1 Purpose of assessment

The purpose of the programme of assessment is to:

- assess trainees' actual performance in the workplace
- enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand their own performance and identify areas for development
- drive learning and enhance the training process by making it clear what is required of trainees and motivating them to ensure they receive suitable training and experience
- demonstrate trainees have acquired the GPCs and meet the requirements of GMP
- ensure that trainees possess the essential underlying knowledge required for their specialty
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme;
- inform the ARCP, identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme;
- identify trainees who should be advised to consider changes of career direction.

5.2 Programme of Assessment

Our programme of assessment refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of training. The purpose of the programme of assessment is to robustly evidence, ensure and clearly communicate the expected levels of performance at critical progression points in, and to demonstrate satisfactory completion of training as required by the curriculum.

The programme of assessment is comprised of several different individual types of assessment. These include the MRCP(UK) Diploma examination, summative and formative assessments. A range of assessments is needed to generate the necessary evidence required for global judgements to be made about satisfactory performance, progression in, and completion of, training. All assessments, including those conducted in the workplace, are linked to the relevant curricular learning outcomes (e.g. through the blueprinting of assessment system to the stated curricular outcomes).

The programme of assessment emphasises the importance and centrality of professional judgment in making sure learners have met the learning outcomes and expected levels of performance set out in the approved curricula. Assessors will make accountable, professional judgements. The programme of assessment includes how professional judgements are used and collated to support decisions on progression and satisfactory completion of training.

The assessments will be supported by structured feedback for trainees. Assessment tools will be both formative and summative and have been selected on the basis of their fitness for purpose.

Assessment will take place throughout the training programme to allow trainees to continually gather evidence of learning and to provide formative feedback. Those assessment tools which are not identified individually as summative will contribute to summative judgements about a trainee's progress as part of the programme of assessment. The number and range of these will ensure a reliable assessment of the training relevant to their stage of training and achieve coverage of the curriculum.

Reflection and feedback should be an integral component to all WBPAs. In order for trainees to maximise benefit, reflection and feedback should take place as soon as possible after an event. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently. Feedback should be of high quality and should include an action plan for future development for the trainee. Both trainees and trainers should recognise and respect cultural differences when giving and receiving feedback.

5.3 Assessment of CiPs

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks.

Clinical supervisors and others contributing to assessment will provide formative feedback to the trainee on their performance throughout the training year. This feedback will include a global rating in order to indicate to the trainee and their educational supervisor how they are progressing at that stage of training. To support this, workplace based assessments and multiple consultant reports will include global assessment anchor statements.

Global assessment anchor statements

- Below expectations for this year of training; may not meet the requirements for critical progression point
- Meeting expectations for this year of training; expected to progress to next stage of training
- Above expectations for this year of training; expected to progress to next stage of training

Towards the end of the training year, trainees will make a self-assessment of their progression for each CiP and record this in the ePortfolio with signposting to the evidence to support their rating.

The educational supervisor (ES) will review the evidence in the ePortfolio including workplace based assessments, feedback received from clinical supervisors (via the Multiple Consultant Report) and the trainee's self-assessment and record their judgement on the trainee's performance in the ES report, with commentary.

For **generic CiPs**, the ES will indicate whether the trainee is meeting expectations or not using the global anchor statements above. Trainees will need to be meeting expectations for the stage of training as a minimum to be judged satisfactory to progress to the next training year.

For **specialty CiPs**, the ES will make an entrustment decision for each CiP and record the indicative level of supervision required with detailed comments to justify their entrustment decision. The ES will also indicate the most appropriate global anchor statement (see above) for overall performance.

Entrustability scales are behaviourally anchored ordinal scales based on progression to competence and reflect a judgment that has clinical meaning for assessors[12] .

Level descriptors for specialty CiPs

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

The ARCP will be informed by the ES report and the evidence presented in the ePortfolio. The ARCP panel will make the final summative judgement on whether the trainee has achieved the generic outcomes and the appropriate level of supervision for each CiP. The ARCP panel will determine whether the trainee can progress to the next year/level of training in accordance with the Gold Guide. ARCPs will be held in IM1, IM2 and IM3. Decisions on progress will be of particular importance for the critical progression points at the end of IM2 and IM3.

5.4 Critical progression points

There will be two key progression points during Internal Medicine stage 1 training. The outline grid below sets out the expected level of supervision and entrustment for the specialty CiPs and the critical progression points for the whole of IM training

[12] Entrustability Scales: Outlining Their Usefulness for Competency-Based Clinical Assessment

Critical progression point 1: End of IM2
The first critical progression point will be from IM2 to IM3 as the trainee will be 'stepping up' to become the medical registrar (sérnámslæknar með aukna ábyrgð). It is essential that educational and clinical supervisors are confident that the trainee has the ability to perform in this role.

Trainees will be normally be expected to complete all parts of MRCP(UK) Diploma examination by the end of year 2 of training (IM2) but not holding MRCP(UK) will not in itself be a barrier for progression into IM3. Passing MRCP(UK) is neither necessary nor sufficient to act as medical registrar. If a trainee holds MRCP(UK) by the end of IM2 but in the opinion of their supervisors are not capable of acting as medical registrar they should not progress or should only do so with enhanced supervision. Equally there may be a number of trainees who are performing very well and in whom their supervisors have every confidence, but they have not (for a variety) of reasons yet passed MRCP(UK).

The ARCP at the end of IM2 will play an important role in determining individualised, supportive plans for transition to the medical registrar role. Some trainees may require a period of time in a supportive training environment with the supervising physician readily available.

Trainees applying to group 2 or non-physician specialties after two years of IM stage 1 training should ensure they have the MRCP(UK) full diploma by the published deadline if it is a requirement for entry to the specialty.

Critical progression point 2: End of IM3
The second critical progression point will be at the end of Internal Medicine stage 1 when the trainee must be signed off for all generic and specialty outcomes and practical procedures and must have all parts of the MRCP(UK) diploma in order to complete the stage of training. A satisfactory ARCP outcome will be required for entry to specialty training and further internal medicine training [*currently in the UK General Internal Medicine, Internal Medicine stage 2 curriculum under development].*

There will be a final critical progression point at the end of specialty and internal medicine training. Doctors in training will be required to reach level 4 in all CiPs by the completion of Internal Medicine and specialty training. They will need to meet the appropriate level of entrustment for each CiP for the key progression point between IM2 and IM3 and at completion of Internal Medicine stage 1 and entry to Internal Medicine stage 2/ specialty training as set out in the levels of entrustment grid.

The educational supervisor report will make a recommendation to the ARCP panel as to whether the trainee has met the defined levels for the CiPs and acquired the procedural competence required for each year of training and where relevant, the critical progression points. The ARCP panel will make the final decision on whether the trainee can be signed off and progress to the next year/level of training [see section 5.6].

5.5 Outline grid of levels expected for Internal Medicine specialty capabilities in practice (CiPs)

Levels to be achieved by critical progression points

Level descriptors
Level 1: Entrusted to observe only – no execution
Level 2: Entrusted to act with direct supervision
Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

	Internal Medicine Stage 1				Selection
Specialty CiP	**IM1**	**IM2**		**IM3**	
Managing an acute unselected take		**3**	**CRITICAL PROGRESSION POINT**	**3**	**CRITICAL PROGRESSION POINT**
Managing an acute specialty-related take		**2**		**2**	
Providing continuity of care to medical in-patients		**3**		**3**	
Managing outpatients with long term conditions		**2**		**3**	
Managing medical problems in patients in other specialties and special cases		**2**		**3**	
Managing an MDT including discharge planning		**2**		**3**	
Delivering effective resuscitation and managing the deteriorating patient		**3**		**4**	
Managing end of life and applying palliative care skills		**2**		**3**	

5.6 Evidence of progress

The following methods of assessment will provide evidence of progress in the integrated programme of assessment. The requirements for each training year/level are stipulated in the ARCP decision aid (www.jrcptb.org.uk).

Summative assessment

Examinations and certificates:

- The MRCP(UK) Diploma examination: Part 1, Part 2 Written and Part 2 Clinical (PACES)
- Advanced Life Support Certificate (ALS)

Information about MRCP(UK), including guidance for candidates and how to receive feedback, is available on the MRCP(UK) website www.mrcpuk.org

Workplace-based assessment (WPBA):

- Direct Observation of Procedural Skills (DOPS) - summative

Formative assessment

Supervised Learning Events (SLEs):

- Acute Care Assessment Tool (ACAT)
- Case-Based Discussions (CbD)
- mini-Clinical Evaluation Exercise (mini-CEX)

WPBAs:

- Direct Observation of Procedural Skills (DOPS) - formative
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports:

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)

These methods are described briefly below. More information and guidance for trainees and assessors are available in the ePortfolio, on the website for postgraduate medical training in Iceland (https://www.landspitali.is/fagfolk/menntun/framhaldsnam-laekna/) and on the JRCPTB website (www.jrcptb.org.uk).

Assessment should be recorded in the trainee's ePortfolio. These methods include feedback opportunities as an integral part of the programme of assessment.

SLEs:

Acute Care Assessment Tool (ACAT)
The ACAT is designed to assess and facilitate feedback on a doctor's performance during their practice on the acute medical take. Any doctor who has been responsible for the supervision of the acute medical take can be the assessor for an ACAT. This tool can also be used to assess other situations where a trainee is interacting with a number of different patients (e.g. in a day hospital or a business ward round).

Case-based Discussion (CbD)
The CbD assesses the performance of a trainee in their management of a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should focus on a written record (such as written case notes, out-patient letter, discharge summary). A typical encounter might be when presenting newly referred patients in the out-patient department.

mini-Clinical Evaluation Exercise (mini-CEX)
This tool evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid learning. The mini-CEX can be used at any time and in any setting when there is a trainee and patient interaction and an assessor is available.

WPBAs:

Direct Observation of Procedural Skills (DOPS)
A DOPS is an assessment tool designed to evaluate the performance of a trainee in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development. DOPS can be undertaken as many times as the trainee and their supervisor feel is necessary (formative). A trainee can be regarded as competent to perform a procedure independently after they are signed off as such by an appropriate assessor (summative).

Multi-source feedback (MSF)
This tool is a method of assessing generic skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. 'Raters' are individuals with whom the trainee works, and includes doctors, administrative staff, and other allied professionals. Raters should be agreed with the educational supervisor at the start of the training year. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the Educational Supervisor.

Patient Survey (PS)
The PS addresses issues, including the behaviour of the doctor and effectiveness of the consultation, which are important to patients. It is intended to assess the trainee's performance in areas such as interpersonal skills, communication skills and professionalism by concentrating solely on their performance during one consultation.

Quality Improvement Project Assessment Tool (QIPAT)
The QIPAT is designed to assess a trainee's competence in completing a quality improvement project. The QIPAT can be based on review of quality improvement project documentation or on a presentation of the quality improvement project at a meeting. If possible the trainee should be assessed on the same quality improvement project by more than one assessor.

Teaching Observation (TO)
The TO form is designed to provide structured, formative feedback to trainees on their competence at teaching. The TO can be based on any instance of formalised teaching by the trainee which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).

Supervisor reports:

Multiple Consultant Report (MCR)
The MCR captures the views of consultant supervisors based on observation on a trainee's performance in practice. The MCR feedback and comments received give valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required. MCR feedback will be available to the trainee and included in the educational supervisor's report.

Educational supervisors report (ESR)
The ES will periodically (at least annually) record a longitudinal, global report of a trainee's progress based on a range of assessment, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise and experience. The ESR can incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

5.7 Decisions on progress(ARCP)

The decisions made at critical progression points and upon completion of training should be clear and defensible. They must be fair and robust and make use of evidence from a range of assessments, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise or experience. They can also incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

Periodic (at least annual) review should be used to collate and systematically review evidence about a doctor's performance and progress in a holistic way and make decisions about their progression in training. The annual review of progression (ARCP) process

supports the collation and integration of evidence to make decisions about the achievement of expected outcomes.

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks, as do decisions about the satisfactory completion of presentations/conditions and procedural skills set out in this curriculum. The outline grid in section 5.4 sets out the level of supervision expected for each of the specialty CiPs. The table of practical procedures sets out the minimum level of performance expected at the end of each year or training. The requirements for each year of training are set out in the ARCP decision aid (see website for postgraduate medical training in Iceland (https://www.landspitali.is/fagfolk/menntun/framhaldsnam-laekna/).

The ARCP process is described in the Gold Guide. LETBs/deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee's ePortfolio. As a precursor to ARCPs, JRCPTB strongly recommend that trainees have an informal ePortfolio review either with their educational supervisor or arranged by the local school of medicine. These provide opportunities for early detection of trainees who are failing to gather the required evidence for ARCP.

In order to guide trainees, supervisors and the ARCP panel, JRCPTB has produced an ARCP decision aid which sets out the requirements for a satisfactory ARCP outcome at the end of each training year and critical progression point. The ARCP decision aid is available on the website for postgraduate medical training in Iceland (https://www.landspitali.is/fagfolk/menntun/framhaldsnam-laekna/)

5.8 Assessment blueprints

The tables below show the possible methods of assessment for each learning outcome (competency in practice). It is not expected that every method will be used for each competency and additional evidence may be used to help make a judgement on capability.

Blueprint of MRCP(UK) Diploma examinations mapped to CiPs

Learning outcomes	**Part 1**	**Part 2 written**	**PACES**
Generic outcomes			
Able to function successfully within NHS organisational 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	√	√	

Learning outcomes	Part 1	Part 2 written	PACES
Acting as a clinical teacher and clinical supervisor			
Specialty outcomes			
Managing an acute unselected take	√	√	√
Managing an acute specialty-related take	√	√	√
Providing continuity of care to medical in-patients, 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 multi-disciplinary team including effective discharge planning			√
Delivering effective resuscitation and managing the acutely deteriorating patient	√	√	√
Managing end of life and applying palliative care skills	√	√	√

Blueprint for WPBAs mapped to CiPs

Learning outcomes	ACAT	CbD	DOPS	MCR	Mini -CEX	MSF	PS	QIPAT	TO
Generic outcomes									
Able to function successfully within NHS organisational 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 outcomes									
Managing an acute unselected take	√	√		√		√			
Managing an acute specialty-related take	√	√		√		√			

Learning outcomes	ACAT	CbD	DOPS	MCR	Mini -CEX	MSF	PS	QIPAT	TO
Providing continuity of care to medical in-patients, 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 multi-disciplinary team including effective discharge planning	√			√		√			
Delivering effective resuscitation and managing the acutely deteriorating patient	√		√	√		√			
Managing end of life and applying palliative care skills		√		√	√	√			
Practical procedural skills			√						

KEY

ACAT	Acute care assessment tool	CbD	Case-based discussion
DOPS	Direct observation of procedural skills	Mini-CEX	Mini-clinical evaluation exercise
MCR	Multiple consultant report	MSF	Multi source feedback
PS	Patient survey	QIPAT	Quality improvement project assessment tool
TO	Teaching observation		

6 Supervision and feedback

This section of the curriculum describes how trainees will be supervised, and how they will receive feedback on performance. For further information please refer to the AoMRC guidance on Improving feedback and reflection to improve learning[13].

Access to high quality, supportive and constructive feedback is essential for the professional development of the trainee. Trainee reflection is an important part of the feedback process and exploration of that reflection with the trainer should ideally be a two way dialogue. Effective feedback is known to enhance learning and combining self-reflection to feedback promotes deeper learning.

Trainers should be supported to deliver valuable and high quality feedback. This can be by providing face to face training to trainers. Trainees would also benefit from such training as

[13] Improving feedback and reflection to improve learning. A practi cal guide for trainees and trainers

they frequently act as assessors to junior doctors, and all involved could also be shown how best to carry out and record reflection.

6.1 Supervision

All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. Outpatient and referral supervision must routinely include the opportunity to personally discuss all cases if required. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

Organisations must make sure that each doctor in training has access to a named clinical supervisor and a named educational supervisor. Depending on local arrangements these roles may be combined into a single role of educational supervisor. However, it is preferred that a trainee has a single named educational supervisor for (at least) a full training year, in which case the clinical supervisor is likely to be a different consultant during some placements.

The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training[14].

Educational supervisor
The educational supervisor is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.

Clinical supervisor
The clinical supervisor oversees the doctor's clinical work throughout a placement. The clinical supervisor leads on reviewing the doctor's clinical or medical practice throughout a placement, and contributes to the educational supervisor's report on whether the doctor should progress to the next stage of their training.

The educational supervisor, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents (atvik) involving the trainee. The educational supervisor should be part of the clinical specialty team. If the clinical directorate (clinical director) has any concerns about the performance of the trainee, or there were issues of doctor or patient safety, these would be discussed with the educational supervisor. These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through its management systems.

[14] Promoting excellence: standards for medical education and training

Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles[15]. It is essential that training in assessment is provided for trainers and trainees in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of the WPBAs and the application of standards.

Opportunities for feedback to trainees about their performance will arise through the use of the workplace-based assessments, regular appraisal meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from ARCP.

Trainees

Trainees should make the safety of patients their first priority. Furthermore, trainees should not be practising in clinical scenarios which are beyond their experiences and competences without supervision. Trainees should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. Trainees would need to plan their WPBAs accordingly to enable their WPBAs to collectively provide a picture of their development during a training period. Trainees should actively seek guidance from their trainers in order to identify the appropriate learning opportunities and plan the appropriate frequencies and types of WPBAs according to their individual learning needs. It is the responsibility of trainees to seek feedback following learning opportunities and WPBAs. Trainees should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

6.2 Appraisal

A formal process of appraisals and reviews underpins training. This process ensures adequate supervision during training, provides continuity between posts and different supervisors and is one of the main ways of providing feedback to trainees. All appraisals should be recorded in the ePortfolio.

Induction Appraisal
The trainee and educational supervisor should have an appraisal meeting at the beginning of each post to review the trainee's progress so far, agree learning objectives for the post ahead and identify the learning opportunities presented by the post. Reviewing progress through the curriculum will help trainees to compile an effective Personal Development Plan (PDP) of objectives for the upcoming post. This PDP should be agreed during the Induction Appraisal. The trainee and supervisor should also both sign the educational agreement in the e-portfolio at this time, recording their commitment to the training process.

Mid-point Review
This meeting between trainee and educational supervisor is not mandatory (particularly when an attachment is shorter than 6 months) but is encouraged particularly if either the trainee or educational or clinical supervisor has training concerns or the trainee has been set specific targeted training objectives at their ARCP).At this meeting trainees should

[15] Recognition and approval of trainers

review their PDP with their supervisor using evidence from the e-portfolio. Workplace-based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed. The PDP can be amended at this review.

End of Attachment Appraisal
Trainees should review the PDP and curriculum progress with their educational supervisor using evidence from the e-portfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be recorded. If there are significant concerns following the end of attachment appraisal then the programme director should be informed

7 Quality Management

The organisation of the training program for Internal Medicine Stage 1 is the responsibility of Landspítali University Hospital and Akureyri Teaching Hospital.

- Landspítali University Hospital and Akureyri Teaching Hospital will oversee the programme for postgraduate medical training. They will undertake the following roles:
- oversee recruitment and induction of trainees from Foundation to Internal Medicine stage 1
- allocate trainees into particular rotations for Internal Medicine stage 1 appropriate to their training needs
- oversee the quality of training posts provided locally
- interface with other specialty training faculties (General Practice, Anaesthesia etc.)
- ensure adequate provision of appropriate educational events
- ensure curricula implementation across training programmes
- oversee the workplace-based assessment process within programmes
- coordinate the ARCP process for trainees
- provide adequate and appropriate career advice
- provide systems to identify and assist doctors with training difficulties
- provide flexible training
- recognise the potential of specific trainees to progress into an academic career.

Educational programmes to train educational supervisors and assessors in workplace based assessment may be delivered by Landspítali University Hospital and Akureyri Teaching Hospital, with a help and advice from JRCPTB.

JRCPTB provide their role in quality management by monitoring and driving improvement in the standard of all medical specialties on behalf of the three Royal Colleges of Physicians in Edinburgh, Glasgow and London.

JRCPTB uses data from six quality datasets across its 30 physician specialties and three subspecialties to provide meaningful quality management. The datasets include the GMC national Training Survey (NTS) data, ARCP outcomes, MRCP(UK) exam outcomes, New

Consultant Survey, Penultimate Year Assessments (PYA)/External Advisor reports and the monitoring visit reports.

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience. These are monitored and reviewed by JRCPTB to improve the provision of training and ensure enhanced educational experiences. The principles of the quality criteria for CMT and GIM will be transferred to the IM curriculum to ensure this continues.

8 Intended use of curriculum by trainers and trainees

This curriculum and ARCP decision aid are available on the website for postgraduate medical training in Iceland (https://www.landspitali.is/fagfolk/menntun/framhaldsnam-laekna/)

Clinical and educational supervisors should use the curriculum and decision aid as the basis of their discussion with trainees, particularly during the appraisal process. Both trainers and trainees are expected to have a good knowledge of the curriculum and should use it as a guide for their training programme.

Each trainee will engage with the curriculum by maintaining an eportfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences.

Recording progress in the ePortfolio

On enrolling with JRCPTB trainees will be given access to the ePortfolio for Internal Medicine Stage 1. The ePortfolio allows evidence to be built up to inform decisions on a trainee's progress and provides tools to support trainees' education and development.

The trainee's main responsibilities are to ensure the ePortfolio is kept up to date, arrange assessments and ensure they are recorded, prepare drafts of appraisal forms, maintain their

personal development plan, record their reflections on learning and record their progress through the curriculum.

The supervisor's main responsibilities are to use ePortfolio evidence such as outcomes of assessments, reflections and personal development plans to inform appraisal meetings. They are also expected to update the trainee's record of progress through the curriculum, write end-of-attachment appraisals and supervisor's reports.

Deaneries, training programme directors, college tutors and ARCP panels may use the ePortfolio to monitor the progress of trainees for whom they are responsible.

JRCPTB will use summarised, anonymous ePortfolio data to support its work in quality assurance.

All appraisal meetings, personal development plans and workplace based assessments (including MSF) should be recorded in the ePortfolio. Trainees are encouraged to reflect on their learning experiences and to record these in the ePortfolio. Reflections can be kept private or shared with supervisors.

Reflections, assessments and other ePortfolio content should be used to provide evidence towards acquisition of curriculum capabilities. Trainees should add their own self-assessment ratings to record their view of their progress. The aims of the s elf-assessment are:

- to provide the means for reflection and evaluation of current practice
- to inform discussions with supervisors to help both gain insight and assists in developing personal development plans.
- to identify shortcomings between experience, competency and areas defined in the curriculum so as to guide future clinical exposure and learning.

Supervisors can sign-off and comment on curriculum capabilities to build up a picture of progression and to inform ARCP panels.

9 Equality and diversity

The Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

The Federation of the Royal Colleges of Physicians believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers; as advisers from the medical profession; as members of the Colleges' professional bodies or as doctors in training and examination candidates.

LETBs/deaneries quality assurance will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by GMC. They

should provide access to a professional support unit or equivalent for trainees requiring additional support.

Compliance with anti-discriminatory practice will be assured through:

- monitoring of recruitment processes
- ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post
- LETBs/deaneries ensuring that educational supervisors have had equality and diversity training (for example, an e-learning module) every 3 years
- LETBs/deaneries ensuring that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e-module) every 3 years
- ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. LETBs/deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. LETBs/deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual
- providing resources to trainees needing support (for example, through the provision of a professional support unit or equivalent)
- monitoring of College Examinations
- ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments.