

Guidance for implementation of Internal Medicine Training during higher specialty training in new Group 1 specialties

Introduction

This paper provides guidance for the organisation and delivery of Internal Medicine training integrated with higher specialty training in new group 1 specialties (Palliative Medicine, Genitourinary Medicine and Neurology). Separate guidance has been developed for established Group 1 specialties.

Background

For many years, most physicians have trained in a physician specialty and concurrently in general internal medicine (GIM). There has always been tension between how much training and experience is orientated towards GIM and how much towards specialty and there was a feeling in some quarters that general experience was losing out to the increasing complexity of specialty and super-specialty training. This may have prompted the Shape of Training (2013) review to try and redress that imbalance. In response to Shape of Training and other reports, JRCPTB introduced a large-scale review and reform of physician curricula with the first of these (Internal Medicine Stage 1) being implemented in August 2019. The major changes relevant to this paper included

- The two year Core Medical Training (CMT) programme has been replaced by a three year Internal Medicine Stage 1 (IMS1) programme. The curriculum for IMS1 includes certain mandated experiences such as critical care and geriatrics that were not specified in CMT.
- Specialty training programmes have been categorised as Group 1 specialties that dual train in Internal Medicine and specialty and Group 2 specialties that train in specialty alone (Group 2 specialties may recruit trainees who have completed two years of IMS1 whereas the entry criteria for Group 1 specialties is to complete the entire three years of IMS1 or equivalent). The curricula for Group 1 specialties have their learning outcomes for Internal Medicine and specialty inextricably linked so it is not possible to complete training in specialty without completing training in Internal Medicine. Higher specialty training in Group 1 specialties mandates a further indicative year of Internal Medicine training to fulfil the requirements of the Internal Medicine Stage 2 (IMS2) curriculum.
- Three specialties that previously did not previously dual train in Internal Medicine became Group 1 specialties (Palliative Medicine, Genitourinary Medicine and Neurology). These specialties will recruit trainees who complete the full (three year) IMS1 programme, and they will complete IMS2 concurrently with their higher specialty training. These specialties are referred to as the new Group 1 specialties for the purposes of this paper. A separate document deals with IMT during HST in the established Group 1 specialties.

Aim of training

The aim of training in a Group 1 specialty is that, on completion of training with issue of CCT and entry into the specialist register, the individual is capable of practising as a consultant physician in independent practice both in their specialty and in Internal Medicine (including, but not confined to, being able to supervise the acute unselected medical intake and provide continuity of care to general patients outside their own specialty). They need to be able to practise in a small remote and rural hospital with limited colleague support or in a large academic centre. Clearly, they are likely to go on and develop further specialist interests via post CCT experience and training.

Therefore, training must equip the trainee to develop expertise in both their specialty and in internal medicine.

A further aim of the Shape of Training reforms is to ensure that there is an adequate number of appropriately trained “Medical Registrars” on the ground to run the acute unselected take (AUT) in all hospitals where it takes place. Although this is really a service issue rather than a training one, JRCPTB feels that it is important from the training perspective that all trainees in Group 1 specialties continue to be involved with the acute unselected medical take throughout the whole of their higher specialty training. The frequency and intensity of involvement in the AUT will be predicated on reasonable service requirements and how many trainees of appropriate grades are available to support AUT. Trainees should report to their educational supervisor if they feel that their commitment to the AUT is unduly onerous and is having a detrimental impact on their specialty training. The educational supervisor should also raise concerns with both specialty and IM training programme directors if the AUT commitment is adversely affecting specialty training

We recommend that from a service and a training perspective, trainees should be involved in AUT at least once a month. However, we recognise that there may be periods of specialty training when AUT involvement is not appropriate because of requirement for on call emergency care within specialty. In general, trainees should be involved in the AUT for at least four years except where the curriculum recommends participation in a specialty on call rota in which case the requirement may be reduced to an indicative minimum of three years. Schools should negotiate the AUT engagement for trainees with each provider to ensure service delivery is supported but specialty training is not adversely impacted. Trainee who have been away from the AUT for more than six months will need to have a plan to reskill them in both the delivery of clinical care and the management aspects of the medical registrar role.

This stipulation will

- Help ensure an adequacy of middle and higher-grade trainees to support the AUT.
- Ensure that general internal medical capabilities are acquired, maintained and demonstrated throughout higher specialty training.
- Promote equity between Group 1 specialties in their commitment to support the AUT.
- Enhance training opportunities for all Group 1 trainees and ensure that CCT holders are well versed and confident in Internal Medicine at the time of CCT.

The flexibility for trainees to spend periods of time without involvement in AUT is recommended from a training perspective and there may, of course be an employer and service delivery imperative for higher trainees to support AUT throughout the whole of HST. The new Group 1 specialties have to do nine months of full immersion Internal Medicine training as their wards are less likely to have general patients within them.

Accepted principles

- We are in the era of competency-based medical education and therefore both the JRCPTB and the GMC are clear that the duration of any suggested/required experiential learning can only be indicative for the purposes of programme planning and general guidance. Acquisition of capabilities will depend both on the trainee’s general ability, the training and learning opportunities made available to them and the educational support available. Most trainees will acquire capabilities within the suggested indicative period; some, however, may require extra time and others may progress more rapidly and accelerate through the programme.

- In some ways the distinction between Internal Medicine placements and specialty placements is rather artificial and needs to be interpreted with pragmatism and common sense. It is quite clear that both generic and Internal Medicine clinical capabilities can be acquired during specialty placements and that specialty capabilities can be acquired during placements labelled as Internal Medicine.
- However, an important principle of training in internal medicine is that trainees should acquire a perspective on patient management that is not delivered by their own parent specialty consultants. This includes the acute, post-acute and chronic management of conditions.
- However, for the purposes of programme planning, IMS2 is felt to require an indicative 12 months of experience of IM during the HST programmes. This could be done as a separate block of (for example) 9 months during the early part of HST and 3 months in the final year (to ensure that the CCT holder is capable of managing the acute take) or 4 blocks of 3 months during each year of HST.
- The IMS2 curriculum requires that trainees are involved in the acute unselected medical take and have had involvement in the admission of at least 750 patients presenting with acute unselected medical problems during IMS2 training. It also requires that trainees spend a minimum of 12 months experience and training in the continuing ward care of patients admitted with acute medical problems.
- The IMS2 curriculum also mandates that over the whole period of higher specialty training, a minimum of 20 outpatient clinics are done in a specialty (or several specialties) other than the parent one to ensure that trainees understand approaches that are out with their own specialty. It is important that these clinic attachments are well supervised and discussed with the Internal Medicine educational supervisor in advance to ensure that appropriate learning outcomes are set and achieved.

Issues for the new Group 1 specialties

The requirements for training in internal medicine (IMS2) present particular challenges to the new Group 1 specialties. Some of these are unique to each specialty and others are germane to all three. JRCPTB recognises these challenges, welcomes the new specialties to IM training and wishes to do everything possible to ease the transition into Group 1. However, this cannot be allowed to compromise the aim of training expressed above.

It therefore seems reasonable to allow some recognition of specialty curricular experience to count towards IM experience and it is felt that 3 months of this would be appropriate for the new Group 1 specialties. Thus

- Stroke medicine subspecialty training is now included in the neurology curriculum, but it is felt that up to 3 months of experience in a hyperacute stroke unit could count towards internal medicine experience for Neurology trainees. Neurology trainees have a particular challenge as in future they will be training to 3 curricula – neurology, stroke and internal medicine.
- HIV medicine is in the Genitourinary Medicine curriculum but up to 3 months of HIV experience could count towards IM experience for GUM trainees
- In Palliative Medicine, up to 3 months of acute in-patient hospital palliative medicine could count towards IM experience. The PM curriculum mandates 3 months of acute hospital experience in Palliative Medicine so this should not cause undue problems to PM programmes.

All the new Group 1 specialties will have to fulfil the learning outcomes of IMS2 and demonstrate achievement of level 4 (unsupervised practice) in all the IM clinical Capabilities in Practice. They will also have to fulfil the minimum requirements for acute take and care of in-patients as described above (750 patients and 12 months respectively). They must also spend a minimum of 12 months in IMS2 when they are involved in the acute unselected take. This may mean that they continue to do acute take when they are doing the 3 month blocks described above or they participate in acute take during another 3 month block of their specialty training. Furthermore, continued engagement with the AUT across the span of training is recommended unless the trainee is taking part in a specialty on call rota. The frequency is not specified as it will depend on the size of the units and the number/case-mix of admissions and reviews and other local factors. However, it is suggested that at least one AUT a month would be appropriate.

It is appreciated that some will feel that this does not go far enough and will continue to put pressure on specialty training whereas others will feel that this change risks trainees not being fully Internal Medicine capable at CCT. However, JRCPTB feels that this way forward represents a reasonable compromise to allow the new Group 1 specialties to become fully assimilated into IM training.

Summary of requirements

1. Involvement in AUT for at least four years except where the curriculum recommends participation in a specialty on call rota in which case the requirement may be reduced to an indicative minimum of three years. The frequency of involvement is not specified as it will depend on the size of the units and the number/case-mix of admissions and reviews and other local factors. However, it is suggested that at least one AUT a month would be appropriate. The requirement for three months of AUT or a full one month immersion on an acute medical unit during the final year of training remains (as defined in the [IMS2 curriculum](#)).
2. Trainees should undertake an indicative minimum of 12 months training in continuing ward care of patients admitted with acute medical problems. Three months of inpatient care or a full one month immersion on an acute medical unit should occur in the last year of training.
3. At least 20 clinics to be done in non parent specialty context. The choice of clinic / experience should be driven by the educational needs of the trainee, as identified by the trainee and their educational supervisor
4. It is recommended that trainees have an educational supervisor who practises internal medicine for periods of IM stage 2 training. Educational supervisors of IM trainees who do not themselves practise IM must take particular care to ensure that they obtain and consider detailed feedback from clinical supervisors who are knowledgeable about the trainees' IM performance and include this in their educational reports.
5. Where trainees are gaining internal medicine experience in another specialty, whether this is an immersive placement or spread throughout training, supervisors must ensure that the training experience adequately addresses their training needs

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