Palliative and End of Life Care in the New Internal Medicine Curriculum
Briefing Paper May 2018

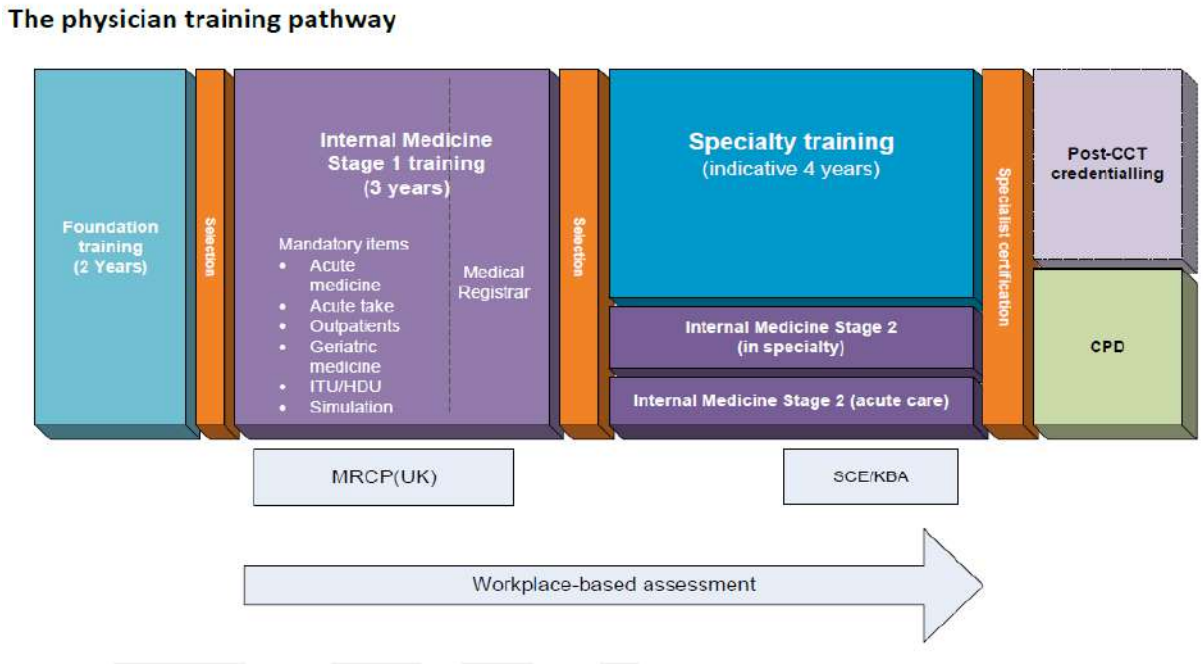
1. Background

The Internal Medicine curriculum has been developed to meet the requirements set out by the Shape of Training Review i.e. to produce doctors with the generic professional and specialty specific capabilities to manage patients presenting with a wide range of general medical symptoms and conditions.

Internal Medicine Stage 1 will form the first phase of specialty training for doctors training in Group 1 physicianly specialties. Palliative Medicine is a new 'Group 1' medical specialty. This means that trainees in Palliative Medicine will continue to train in Internal Medicine and will dual accredit on completion of training.

The new Internal Medicine Stage 1 lasts three years, followed by competitive selection to specialty training, which will last four years. (See Figure 1 below) The first entrants to the new Stage 1 Internal Medicine will be in August 2019. The first entry to specialty training will be August 2022. During their four years of specialty training doctors will be expected to complete a further 12 months of Internal Medicine experience. Details of how this will be delivered remain under discussion.

Figure 1



2. Presentations and Conditions of Internal Medicine by System/Specialty

The Internal Medicine curriculum outlines 'presentations' and 'conditions / issues' by specialty and the scope is broad. Any attempt to list all relevant presentations, conditions and issues would be extensive, inevitably incomplete and rapidly become out of date.

Palliative and end of life care is now a core component of the Internal Medicine curriculum and Table 1 details the key presentations and conditions. We have made them very broad to allow for a wide exposure to a range of conditions where people have palliative care needs or are at high risk of dying.

Table 1 Key Presentations/Conditions for Palliative and End of Life Care		
System/Specialty and subspecialty	**Presentations**	**Conditions/Issues**
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

3. Palliative and End of Life Care experience within Internal Medicine

The Internal Medicine curriculum recommends that trainees undertake a placement in a specialist palliative care environment (hospital advisory team, hospice or community). The curriculum states "Many of the learning objectives and experience in end of life care can be achieved during attachments to routine medical teams (e.g. geriatric medicine, oncology, respiratory medicine) and ICU. However, an attachment with a specialist palliative care service is recommended as it will give a broader perspective in this complex and important area."

The IM curriculum has a section that details the types of exposure trainees need to experience to develop their capabilities in practice. Under section *3.1 Teaching and Learning Methods,* the IM curriculum states that trainees will be expected to gain internal medicine experience in a variety of settings including:

1. Ward rounds with a senior doctor
2. Outpatient clinics
3. Critical care
4. Unselected acute take
5. Post take consultant led ward round
6. Personal ward rounds and provision of ongoing clinical care on specialist medical ward attachments
7. Participation in ward and other (e.g. specialty) MDMs
8. Palliative and end of life care experience

The IM curriculum is not prescriptive as to how the palliative medicine IM experience will be delivered and it is likely that there will be significant local variation. The curriculum does however comment that trainees should have ***significant experience*** of palliative care with the objectives 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 (e.g. 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 DNACPR decisions

Whilst palliative medicine placements are not mandated, we strongly recommend that clinical and educational supervisors in all palliative care settings liaise with local trust core medical training leads to consider how palliative medicine experience can be delivered within the new IM curriculum and how palliative medicine consultants can be involved in trainee development and assessment.

With the creation of the third year of IM there may be local opportunities to push for palliative medicine placements, if there is sufficient supervision available and / or the development of further palliative medicine posts within IM years 1 to 3.

4. Assessment: Capabilities in Practice

The assessment strategy is to drive learning and provide reassurance to GMC and the public re patient safety - but it also needs to be practical. Assessment of the Internal Medicine curriculum is moving away from what has been seen as a "tick-box" focus on specific competencies to assessment in a number of broad areas, termed "capabilities in practice."

Capabilities in Practice (CiPs) describe high level professional tasks or work. 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 the completion of training and award of CCT, the doctor must demonstrate that they are capable of unsupervised practice in all CiPs.

There are six generic CiPs underpinned by the nine GMC General Professional Capabilities. An additional eight clinical CiPs are mandated that describe tasks or activities essential to the practice of Internal Medicine. The clinical CiPs have been mapped to the nine domains of General Professional Capabilities to reflect the professional generic capabilities required to undertake each clinical task.

One of the clinical CiPs is 'Palliative and end of life care skills' (see Table 2). Ideally there should be palliative care input at different stages of training to support the assessment of this CiP.

Table 2 Capabilities in Practice: 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
Generic Professional Capabilities	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
Evidence to inform decision	Multiple Consultant Report; Case based discussions, Multisource feedback, MRCPUK, Mini-CEX; Regional teaching; Reflection

An educational or clinical supervisor will assign a rating for each CiP to inform progression at ARCP and will outline whether doctors in training are below, meeting or above expectations for their year of training. They will also be expected to comment on the doctor's transition to next stage of training.

There are four levels of formal signoff – in which an educational supervisor makes a judgement on the level of supervision required.

Level 1: entrusted to observe only
Level 2: entrusted to act with direct supervision
Level 3: entrusted to act with indirect supervision
Level 4: entrusted to act unsupervised

A doctor in training will be required to be at Level 4 for all 14 CiPs in order to achieve a CCT in Internal Medicine. Figure 3 below outlines the expected progression through the two stages of IM training:

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	Internal Medicine Stage 2 + Specialty				CCT
Specialty CiP	IM1	IM2		IM3		ST4	ST5	ST6	ST7	
Managing an acute unselected take		3	CRITICAL PROGRESSION POINT	3	CRITICAL PROGRESSION POINT				4	CRITICAL PROGRESSION POINT
Managing an acute specialty-related take		2		2			3		4	
Providing continuity of care to medical in-patients		3		3					4	
Managing outpatients with long term conditions		2		3					4	
Managing medical problems in patients in other specialties and special cases		2		3					4	
Managing an MDT including discharge planning		2		3					4	
Delivering effective resuscitation and managing the deteriorating patient		3		4					4	
Managing end of life and palliative care skills		2		3					4	

Specialty Curriculum

Over the next two years the Palliative Medicine Specialty Advisory Committee will be developing a new curriculum for the specialty. This will also be based around capabilities in practice and we will keep members informed on progress

Recommended Next Steps

1. Download a copy of the Internal Medicine curriculum for reference (https://www.jrcptb.org.uk/new-internal-medicine-curriculum). The key points have been summarised in this document
2. Palliative and end of life care is now a core component of the Internal Medicine curriculum. All palliative care services need to engage with Deaneries and LETBs and local education providers, via the Core Medical Training Specialty Training Committees and Programmes. The focus should be on ways to increase the exposure to palliative care for doctors in training to meet their curriculum and training requirements.
3. There is no mandated minimum time for Palliative Medicine placements within the IM curriculum, so there may be opportunities to bid for palliative medicine posts within Internal Medicine (as part of the reorganisation of core medical training to allow the creation of posts for the IM3 year). These post could include (or not) Palliative Medicine on-call and could be for 3 or 4 months or shorter depending on available resources. Other options could be explored such as simulation training. This should be achieved by a coordinated approach:

a. Training Programme Directors and STC chairs should make contact with counterparts in Core Medical Training at deanery level to start exploring options for the delivery of the palliative care components of the curriculum
b. Consultants in hospices and hospitals should make contact with local acute trust core medical training programme directors to start exploring local options for the delivery of the palliative care components of the curriculum.
It is important that this involvement is well coordinated in each training locality with the TPD in Palliative Medicine and the STC to avoid duplication and confusion.

4. Future developments for delivery of stage 2 IM training could involve training slot swaps with other medical specialties as part of the combined Palliative Medicine Specialty and IM training.

If you have any concerns, comments or questions please feel free to contact us via the emails below. The APM website will have regular updates on Shape over the next year

Polly Edmonds, SAC vice Chair (Curriculum Lead) polly.edmonds@nhs.net

Alison Coackley, SAC Chair alison.coackley@nhs.net

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