Internal Medicine Training & Becoming a Medical Registrar

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Outline of talk

- IMT
  - What is it? Why change from CMT?
  - How does it differ to CMT
  - Advantages + challenges

- Becoming a medical registrar
  - What is a medical registrar
  - Roles + responsibilities
  - Other tips

- Questions

Internal Medicine Training

IMT – why change the curriculum

Trainer + trainee dissatisfaction

Burden of assessment - tick box mentality
Anxiety about being a medical registrar
Many CMTs don't feel ready
Approx. 30% CMTs need to extend CMT training (2017)

Increasing age / complexity of patients

Change in workforce

Geographical disparity
Role changes (specialist nurses; physician associates)
Rota gaps
Changing demography of trainees (50% female)

IMT – why change the curriculum

- Huge consultation exercise
  - Trainees – RCP trainee committees very involved
  - GMC; Heads of Schools; CMTAC; specialty committees; NHS employers; Deans; development days
  - Proof of concept study 2016

- Response to ‘Shape of Training Report’ October 2013
- GMC framework of Generic Professional Capabilities: embedded in all curricula by 2020
- New model for future physician training
- Led by JRCPTB for Federation of Physician Royal Colleges

Main changes

- First 3 years of post-foundation training
  - 3 years vs 2 years of CMT
  - Supervised ST3 year

- Greater preparation for management of acutely unwell patients
- Increased focus on chronic diseases management, comorbidity + complexity

- 14 ‘holistic’ Capabilities in Practice
- New Generic professional capabilities embedded in curricula

- Defined levels of supervision
- Specific experiences mandated - Clinics, critical care, geriatrics
- More specialties doing IMT

What’s not changed

- Supervision process
- ARCP process
- Workplace Based Assessments
- MRCP
- No additional exams for internal medicine
- Person specification for recruitment

Timeline

- First cohort of IMTs started August 2019
- Group 2 specialties start Aug 2021
- Group 1 specialties start Aug 2022

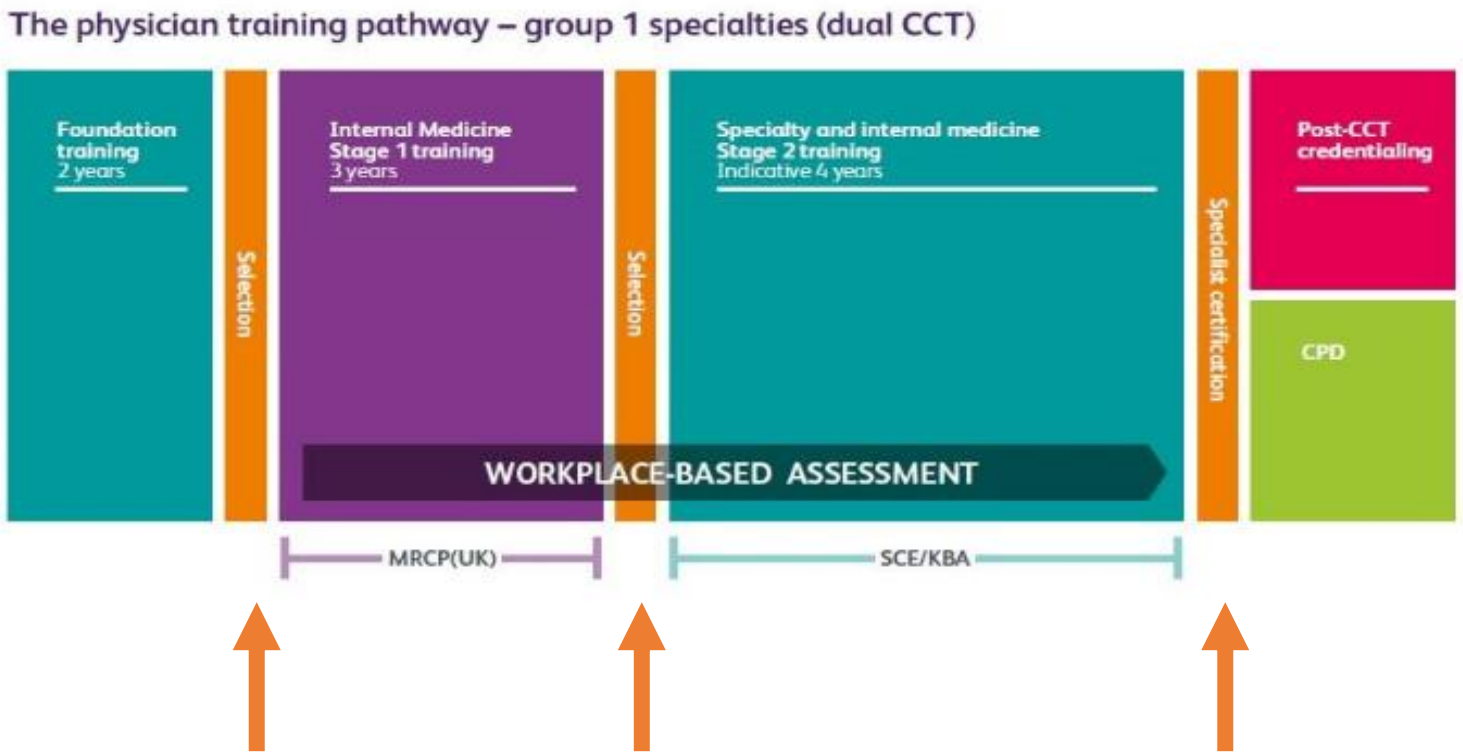
*Trainees will have a training needs analysis to determine the training and experience required to meet the IM stage 1 curriculum capabilities. This will be arranged by the HEE local office/deanery

†Completing IMY3 will not preclude trainees from applying for a group 2 specialty

Academic trainees will be required to complete IMY3 training from 2021 if in a group 1 specialty

Group 1 specialties

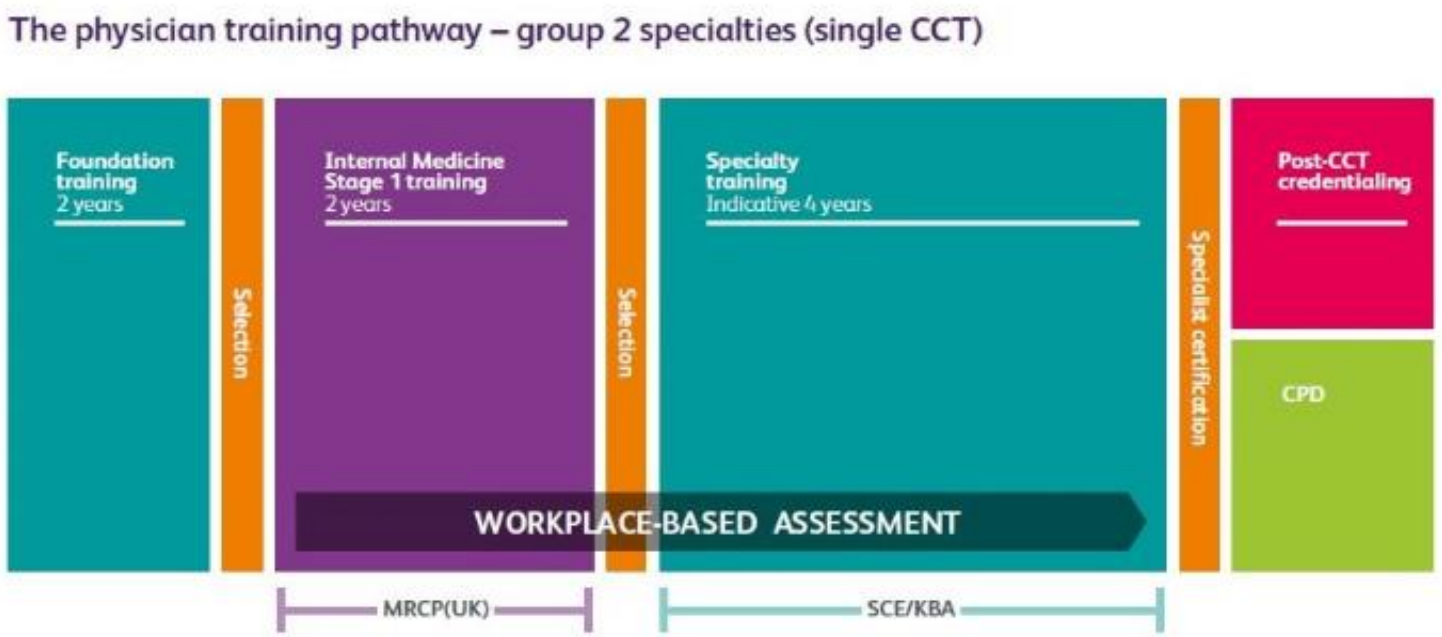
- Have to complete IMY3
- Dual training with internal medicine



- Acute Internal Medicine
- Cardiology
- Clinical Pharmacology & Therapeutics
- Endocrinology & Diabetes Mellitus
- Gastroenterology
- Genitourinary Medicine
- Geriatric Medicine
- Infectious Diseases (except if dual with Medical microbiology or virology)
- Neurology
- Palliative Medicine
- Renal Medicine
- Respiratory Medicine
- Rheumatology

Group 2 Specialties

- Non-acute, primarily outpatient-based services
- Will **NOT** dual train in internal medicine
- Recruit from IMY2 but can come from IMY3 + other routes
- Need full MRCP by IMY2
- Need to check each specialty for recruitment requirements



- Allergy
- Audiovestibular Medicine
- Aviation & Space Medicine
- Clinical Genetics
- Clinical Neurophysiology
- Dermatology
- Haematology
- Immunology
- Infectious Diseases (if dual with Medical microbiology or virology)
- Medical Oncology
- Medical Ophthalmology
- Nuclear Medicine
- Paediatric Cardiology
- Pharmaceutical Medicine
- Rehabilitation Medicine
- Sport and Exercise Medicine

Clinical Oncology, Medical Microbiology, Medical Virology & Occupational Medicine will also recruit trainees who have completed the first two years of IMT.

IMT structure: in more detail

- IMT years 1+2
  - 3x4 month or 2x 6 month blocks
- IMT year 3
  - 2x 6 month blocks (1 likely acute take; 1 likely specialty medicine of your choosing)
- 4 months Geriatrics
- 10 weeks minimum critical care e.g. ICU, HDU, specialty ICU
- Specialty ward experience
- Acute medicine (unselected take)
- Simulation
  - Procedural
  - Human skills
- >80 outpatient clinics – e.g. geriatric day unit, DVT clinics

- Variation in structure across deaneries
  - E.g. 1 year in DGH; 1 year in tertiary hospital
  - Some regions offer 3 years in 1 setting

IMY3 – medical registrar year

- Need sign off of level 3 entrustment for clinical CiP 1: managing acute unselected take prior to starting this year
  - Based on ≥3MCRs - *mandatory*
  - Satisfactory MSF - *mandatory*
  - ACATS showing progression + maturation - *mandatory*
  - Satisfactory ‘acting up’ – supportive + supervised environment in IMY2
  - Progress with MRCP

- ARCP outcomes - 3 main groups:
  - On track, no problems. ARCP 1 - progress to IMY3
  - Some concerns, around clinical CiP 1 in particular, from ES or trainee. Careful + detailed decision making + planning by ARCP panel. ARCP 2 or 3
  - More concerns. Remain at IMY2 for at least 6 months. ARCP 3

Assessment

- WBPAs – ACAT, CBD, mini-cex, DOPS, Teaching observation
- MSF + MCRs
- ES report
- PDP
- Teaching attendance
- Clinic attendance
- Reflections
- QIPAT
- ALS

- MRCP
  - IMT 1 – part 1 written
  - IMT 2 – part 2 written + ≥ 1 attempt PACES
  - IMT 3 – full MRCP UK PACES
- Number of patients seen on acute unselected take
- Critical care + geriatric care

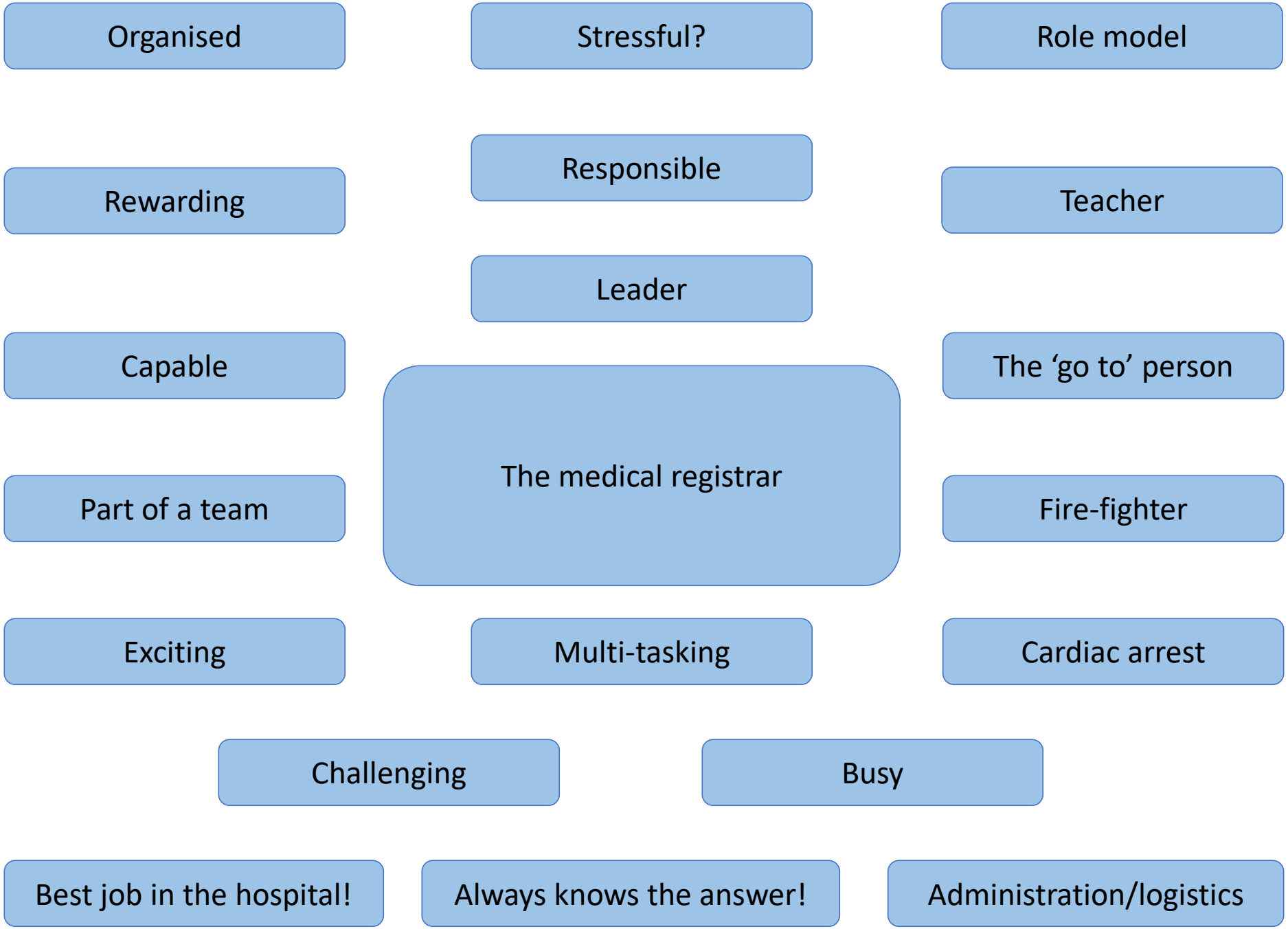
Advantages

- Clear themes of each training year
- Less tick box demand + more pragmatic assessment
- Mandated activities:
  - 10 weeks critical care
  - Geriatrics rotation
  - 80 clinics in 3 years (with focus on OP in year 2)
- Time + extra support (if needed) for MRCP
- Supported 1st SpR year managing acute unselected take – less of a big jump
- ‘Soft’ stop before progression to managing the unselected take in Yr3
- Learning on-call skills before having to develop specialty skills
- Time to consider professional direction

Challenges

- Assessment changes are likely to take a period of time to adjust to
- Teething issues with introduction of new curriculum
- Phase 2 is still in development

Becoming a medical registrar


Organised
Stressful?
Role model
Rewarding
Responsible
Teacher
Leader
Capable
The ‘go to’ person
The medical registrar
Part of a team
Fire-fighter
Exciting
Multi-tasking
Cardiac arrest
Challenging
Busy
Best job in the hospital!
Always knows the answer!
Administration/logistics

Roles of the medical registrar

- Leadership + supervision
- Being a senior medical clinical decision maker
- Training
- Non-priority roles

Leadership + supervision

- Leadership of the medical take team
- Supervise + support the juniors
- Lead handover process
- Communication + escalation to the medical consultant on call
- Communication with senior members of the wider team

Leadership of the medical take team

- Running the take - overarching responsibility.
  - Who is unwell + needs prioritising?
  - Which team member has seen which patient?
  - Who is still waiting to be seen?
  - ‘Eyeball’ each referral

- Know your juniors
  - Know their names, where they are + how they're getting on - look after them

- Awareness of the sickest patients on the take/ward - how they are, their plans/ceilings of care

Supervise + support juniors

- Know your juniors – know their names, where they are + how they're getting on - look after them

- Supervision of clinical procedures

Lead handover process

- Leading handover
  - Morning handover/hospital at night
  - Know your team + skill set
  - Ensure appropriate handover of jobs
  - Know which patients are unwell; what are their plans/ceilings?

- Cardiac arrest team
  - Huddle morning handover/hospital at night
  - Know team member’s names + skill set
  - Assign roles

Communication & escalation to medical consultant on call

- Leading the post-take ward round
- Let them know about the most unwell patients early
- ITU admissions
- Difficult medical decisions
- When telephoning, start by saying why you are calling – just for information, member of staff admitted, need you to come in…
- They want to know! The patient is under their care.

Communication with senior members of the wider team

- Site manager
  - Flow through ED, AMU beds, downstream beds, monitored beds, ITU beds
- Senior nurses
  - Beds, other dilemmas – complaints, DOLS, sections etc
- Other specialties
  - Specialty reviews, specialty beds

Being a senior medical clinical decision maker

- Awareness of and supervision of care for the most acutely unwell +/or complex medical patients
- Clinical support + advice to other specialties e.g. ED, GP, surgery, O&G, psychiatry
- Be confident with other scenarios that arise – e.g. family complaints, mental health sections, mental capacity + DOLS processes

Training

- Be proactive - seek training opportunities + ensure ongoing professional development
- Train junior doctors (+ wider members of the MDT)
- Supervise practical clinical procedures

Non-priority roles

- Roles that are more appropriately designated to less experienced or less skilled members of the MDT
  - Routine clerking of unselected medical specialty admissions
  - Basic clinical tasks incl. venepuncture, cannulation…
  - Routine administrative tasks
  - Facilitating routine bed moves

Worried about the responsibility?

- The medicine will come with time + training
  - If you consider the most likely diagnosis & the most dangerous to miss…you've got it!
- Difficult things in ST3 are soft skills
  - People management, team leadership, stepping-up + decision-making
- Know that there is support, even at 3am!
  - Consultant on call, ICU, anaesthetics, other specialties
- The buck doesn't stop with the med reg the majority of times!
- Remember consultants are paid to make decisions so ask them if you are worried or don't know. Don't be scared to ask.
- Flag up rota gaps + any concerns re staffing levels & patient safety – to the responsible consultant + your supervisor

Be kind to others…

- Always be kind to colleagues - no-one came to work to annoy you; nor is it their fault that you're busy – we all want the same outcome for the patient
- Take a deep breath; answer everything properly + kindly
- If you have a bad day + aren't very kind to someone – say sorry + be kind to yourself
- Be collaborative with ED + other specialties – don't be obstructive + refuse referrals
- 'I can't believe they didn't know….' – remember the times you were in that position + teach them
- Encourage breaks; bring snacks for the office

Be kind to yourself…

- Take breaks - eat, drink + pee! Most things can wait a few minutes!
- Be organized
  - whatsapp groups
  - keep your list up to date so you know who is seeing who
  - write everything down + document in a timely fashion
  - Know local polices + protocols regarding admission - who takes what; referral pathways
- Take a step back - it’s often better to deal with the bleep + review patients if it’s busy
  - But clerking is fun! Plus it’s good for team morale to see the SpR clerking. But take the simple ones, you will be bleeped!
- Don’t expect to always be on top of the take – it’s ok to handover patients
- Be visible + nice to everyone - don't underestimate how much easier life is in a hospital if people recognise + like you
- Don’t carry the weight of every patient you see outside of your own take/team - you are not solely responsible for a patient just because you have provided a medical review

- And remember - you can only do what you can with your 2 hands + one head - everything else will have to wait!

Any questions?

More information

- JRCPTB website
  - IMT webinars
  - Rough guide
  - FAQ
- You tube videos on IMT
- IMT Recruitment website
- RCP Acute care toolkit
- ARCP decision aid

FAQs on IMT

- When will I see which programmes are on offer?
  - All schools need to supply full rotation information for 1st 2 years incl. specialty + duration;
  - IMY3 will be in the same region
- How will I be allocated to IMY3?
  - Locally-run process
  - Interim reviews held to see who will undertake IMY3
  - IMY3 specialty rotations will not be taken into consideration for ST4 specialty recruitment
  - Rotation based on trainee preferences
  - If highly competitive rotation – may consider ARCP outcome at end of IMY1; progress in MRCP; QIPS; recruitment scores; reasons stated in personal statement
- When do I decide if I apply to a group 1 or 2 specialty?
  - All trainees are appointed to 3 year programme – then have interim review during IMY2 + can leave at this stage
- What about ACCS trainees?
  - Under review – aim for 2 years of ACCS training (ED, ICU, AIM + anaesthetics; then IMY2 + IMY3 – so 4 years of training
- What about academic trainees?
  - ACF – remains run through training
  - Length of training depends on group of speciality – check each individual programme
  - If academic CMT & not started higher training by 2021 – will need to do IMY3
- Transition for current CMTs
  - If you won't start specialty training until Aug 2022 – you will need to do IMY3 but guaranteed to do this is same region as CMT
- LTFT
  - You can do LTFT in IMT
- Can trainees in group 1 specialties also train in intensive care medicine?
  - Under review currently

JRCPTB website

14 Capabilities in Practice

- 6 generic CiPs

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

- 8 clinical CiPs

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

Capabilities in practice (CiPs)

Generic CiPs

1. Able to successfully function within NHS 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 to be assessed by DOPS

Clinical 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

Practical procedures in IMT

Practical procedures – minimum requirements	IMY1	IMY2	IMY3
Advanced cardiopulmonary resuscitation (CPR)	Skills lab or satisfactory supervised practice	Participation in CPR team	Leadership of CPR team
Temporary cardiac pacing using an external device	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Ascitic tap	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a]
Lumbar puncture	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a]
Nasogastric (NG) tube	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a]

Practical procedures – minimum requirements	IMY1	IMY2	IMY3
Pleural aspiration for fluid (diagnostic) It can be assumed that a trainee who is capable of performing pleural aspiration of fluid is capable of introducing a needle to decompress a large symptomatic **pneumothorax**. Pleural procedures should be undertaken in line with the British Thoracic Society guidelines[b]	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a]
Access to circulation for resuscitation (femoral vein or intraosseous) 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	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Central venous cannulation (internal jugular or subclavian)	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Intercostal drain for pneumothorax	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Intercostal drain for effusion Pleural procedures should be undertaken in line with the British Thoracic Society guidelines[b]	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Direct current (DC) cardioversion	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a]
Abdominal paracentesis	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice