Introduction to Rajagiri IMT Programme

Postgraduate training programme in medical specialities in NHS of the United Kingdom is designed and managed by the Joint Royal College of Physicians Postgraduate Training Board (JRCPTB). This document has been prepared for guiding the trainees, supervisors both clinical as well as educational and Programme Directors. The main contents included in this document are taken from the "Rough Guide to Internal Medicine Training" by Royal College of Physicians of the United Kingdom. The details are available from the Royal College of Physicians website (www.jrcptb.org.uk).

Rajagiri Hospital at Chunangamvely, Aluva, has been selected as an international site for delivering an accredited UK equivalent IMT Programme in partnership with JRCPTB of the United Kingdom from 2025. The duration of the IMT programme is three years.

Rajagiri Hospital, established in 2014 has created its niche on the map of quality healthcare delivery in South India by touching nearly 2 million lives. Having earned the trust and loyalty of patients through compassion of its caregivers and high-precision medical technology, the institution has emerged as the leading quaternary care facility in the region with a current bed capacity of 570. The hospital is accredited by the Joint Commission International (JCI) with gold seal for complying with the highest international standards on patient safety and quality of care. The hospital is also accredited by the National Accreditation Board for Hospitals and Healthcare Providers (NABH), National Accreditation for Testing and Calibration Laboratories (NABL) and has received ISO22000:2018 certification for its Food and Beverages services.

The current academic activities of Rajagiri Hospital include, DNB post-graduation in Anaesthesiology, General Medicine, Obstetrics and Gynaecology, Pathology, Orthopaedics Surgery, Paediatrics, Respiratory Medicine and Radio Diagnosis. We also have DrNB (Doctorate of National Board) in Critical Care Medicine, Urology, Medical Oncology and Medical Gastroenterology and FNB – Fellowship of National Board in Arthroplasty. All these courses come under the National Board of Examinations in Medical Sciences.

We offer Post-Doctoral Institutional Fellowships in Stroke and Interventional Neurology, Arthroscopy and Arthroplasty, Spine Surgery, Post-Doctoral Fellowship in Rhinology, Paediatric Neurology, Interventional Pulmonology and Hepato-biliary Interventional Radiology.

In addition to these, we provide Post-Doctoral Fellowship Recognised by Professional Bodies in Neonatology, Cranio-Maxillofacial Trauma, Neurocritical care, IDCCM (Indian Diploma in Critical Care Medicine) and a Master of Emergency (MEM) course at our hospital.

The Rajagiri IMT Gold Guide

The Rajagiri IMT Gold Guide sets out the local arrangements in Rajagiri Hospital, Aluva, Kerala, India in agreement with JRCPTB, UK for running the IMT Programme. Rajagiri Hospital is the site where the candidates undergo their IMT Training. This Gold Guide is prepared by Rajagiri IMT Programme Committee for the guidance to all the stake holders of this training programme.

Curriculum and Structure of IMT

Eligibility for the IMT Programme

MBBS degree from any of the recognized national or international medical institutions which are listed in the Indian Medical Council act 1956. Candidates must have completed the mandatory internship and have acquired permanent registration from the National Medical Commission of India or any State Medical Council.

Equivalence of Overseas Postgraduate Qualifications

There are Govt. of India Gazette notifications equating overseas postgraduate qualifications awarded in UK, USA, Canada, New Zealand & Australia to MD/DNB Degrees awarded by the recognized universities and institutions.

Ref: Notifications published in the Gazette of India dated 10.03.2008/ 11.03. 2017 / 22.02.2022 (see below).

MCI-12(1)/2016-Med.Misc./175608

CG-DL-E-23022022-233681

INDIAN MEDICAL COUNCIL ACT, 1956,

The THIRD SCHEDULE-Part II The said Schedule under the heading "Part II Recognition Medical Qualification Granted by Medical Institutions outside India not included in the Second Schedule", after the entries relating to the qualification Doctor of Philosophy (Ph.D.) in Medical Sciences (Dagestan Medical Institute), U.S.S.R.

"All post graduate medical qualification awarded in Australia and recognized for enrolment as medical practitioners in the concerned specialties in that country."

"All post graduate medical qualification awarded in Canada and recognized for enrolment as medical practitioners in the concerned specialties in that country."

"All post graduate medical qualification awarded in New Zealand and recognized for enrolment as medical practitioners in the concerned specialties in that country."

"All post graduate medical qualification awarded in United Kingdom and recognized for enrolment as medical practitioners in the concerned specialties in that country."

"All post graduate medical qualification awarded in United States of America & recognized for enrolment as medical practitioners in the concerned specialties in that country."

Equivalence as a teaching faculty with National Board of Examinations in Medical Science.

Rajagiri Hospital has faculty positions as per the norms of the National Board of Examinations in Medical Sciences. The criteria for a teaching faculty in an NBE accredited institution is as follows:

Senior Consultant: Should have a minimum of 8 years of experience after qualifying MD / MS / DM /MCh / DNB/Fellowships of Royal Colleges (UK / Australia / Canada) / American Board in the specialty concerned.

Junior Consultant: Should have a minimum of 5 years of experience after qualifying MD / MS / DM / MCh / DNB / Fellowships of Royal Colleges (UK / Australia/Canada)/American Board in the specialty concerned.

The Internal Medicine Stage I Curriculum

The purpose of the 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 the role of the medical registrar in NHS district general and teaching hospitals and will be qualified to apply for higher specialist training.

IMT will normally be a three-year programme that will include mandatory training in geriatric medicine, critical care and outpatients (this may include ambulatory care clinics).

At completion of IMT, trainees will be required to meet all curriculum requirements, including passing the full MRCP(UK) examination. 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 is the first stage of training in internal medicine for 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 dual CCT in internal medicine and specialty training.

Capabilities in Practice (CiPs)

The six generic CiPs cover the universal requirements of all specialties as described in the UK General Medical Council (GMC), General Professional Capability (GPC) framework. Assessment of the generic CiPs will be underpinned by the GPC descriptors. Satisfactory sign off will indicate that there are no concerns.

The eight clinical 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.

The 14 CiPs 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 speciality CiPs.

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.

Annual Review of Competence Progression (ARCP)

Assessment: What is required from trainees and trainers?

Introduction

Decisions about a trainee's competence progression will be based on an assessment of how they are achieving their CiPs. For the generic CiPs it will be a straightforward statement as to whether they are operating at, above, or below their anticipated performance for the current year/level of training. However, for the clinical IM CiPs there will be a judgement made at what level of supervision they require (i.e. unsupervised or with direct or indirect supervision). For each clinical IM CiP there is a level that is to be achieved at the end of each year in order for a standard outcome to be achieved at the Annual Review of Competence Progression (ARCP). This level is specified in the curriculum and therefore can only be altered with the agreement of the GMC.

What the trainee needs to do

For IMT, trainees need to do an appropriate number of supervised learning events (SLEs) and workplace-based assessments (WPBAs). The requirements are documented in the ARCP decision aid (see ARCP section below) but it should be appreciated by trainer and trainee that the decision aid sets out the absolute minimums. SLEs and formative DOPS are not pass/fail summative assessments but should be seen by both trainer and trainee as learning opportunities for a trainee to have one to one teaching and receive helpful and supportive feedback from an experienced senior doctor. Trainees should therefore be seeking to have SLEs performed as often as practical. They also must continue to attend and document their teaching sessions and must continue to reflect (and record that reflection) on teaching sessions, clinical incidents and any other situations that would aid their professional development. They should record how many clinics they have attended and how many patients they have been involved with on the Acute Unselected Take in the summary of clinical activity form.

Each trainee must ensure that they have acquired multi-source feedback (MSF) on their performance each year and that this feedback has been discussed with their Educational Supervisor (ES) and prompted appropriate reflection. They also need to ensure that they have received a minimum of four reports from consultants who are familiar with their work and who will contribute to the Multiple Consultant Report (MCR). Each consultant contributing to the MCR will give an advisory statement about the level at which they assess the trainee to be functioning for each clinical CiP.

As the ARCP approaches, trainees need to arrange to see their ES to facilitate preparation of the ES report (ESR). They will have to self-assess the level at which they feel they are operating

at for each CiP. In an analogous fashion to the MSF, this self- assessment allows the ES to see if the trainee's views are in accord with those of the trainers and will give an idea of the trainee's level of insight.

Interaction between trainer and trainee

Regular interaction between trainees and their trainers is critical to the trainee's development and progress through the programme. Trainees will need to engage with their clinical and educational supervisors.

At the beginning of the academic year there should be a meeting with the ES to map out a training plan for the year. This should include;

- how to meet the training requirements of the programme, addressing each CiP separately
- a plan for taking the various stages of the MRCP diploma
- a discussion about what resources are available to help with the programme
- develop a set of SMART Personal Development Plans (PDPs) for the training year
- a plan for using study leave (if available)
- use of the various assessment/development tools

The trainee should also meet with the clinical supervisor (CS) to discuss the opportunities in the current placement including;

- develop a set of SMART PDPs for the placement
- access to clinics and how to meet the learning objectives
- expectations for medical on-call
- expectations for in-patient experience
- expectations to gain experience in end-of-life care

Depending on local arrangements there should be regular meetings for personalised, professional development discussions which will include;

- writing and updating the PDP
- reviewing reflections and SLEs

- reviewing MCR and other feedback
- discussing leadership development
- discussing the trainee's development as a physician and career goals
- discussing things that went well or things that went not so well

Trainees are required to undertake a self-assessment of their engagement with the curriculum and in particular the CiPs. This is not a 'one-off' event but should be a continuous process from induction to the completion of the programme and is particularly important to have been updated ahead of the writing of the ES report and subsequent ARCP. Self- assessment for each of the CiPs should be recorded against the curriculum on the trainee's e-Portfolio account.

The purpose of asking trainees to undertake this activity is:

- To guide trainees in completing what is required of them by the curriculum and helping to maintain focus of their own development. To initiate the process, it is important that the induction meeting with a trainee's ES reviews how the trainee will use the opportunities of the coming academic year to best advantage in meeting the needs of the programme. It will allow them to reflect on how to tailor development to their own needs, over-and-above the strict requirements laid out in the curriculum

- To guide the ES and the ARCP panel as to how the trainee considers they have demonstrated the requirements of the curriculum as set out in the Decision Aid and where this evidence may be found in the trainee's portfolio. This will help the ARCP panel make a more informed judgement as to the trainee's progress and reduce the issuing of outcome 5s as a result of evidence not being available or found by the panel.

What the Educational Supervisor (ES) needs to do

IMT requires trainees and supervisors to plan evidence to be acquired across the training year that can be used by the ES to write an important and substantial ES report (ESR).

The ESR is the central piece of evidence considered by the ARCP Panel when assessing whether the trainee has attained the required standard as set out in the Decision Aid. As such,

both time and planning will need to be given to writing it; this process will need to start at the beginning of the training year.

Educational Supervisor Report (ESR)

The ESR must be written ahead of the ARCP and discussed between the supervisor and the trainee before the ARCP, with any aspects likely to result in a non-standard outcome at ARCP made clear. This conversation should be documented and the final report loaded on to the e-portfolio at least two weeks before the ARCP. The report documents the entrustment decisions made by the supervisor for all the CiPs set out in the curriculum. The decisions should be based on evidence gathered across the training year as planned at the Induction Meeting with the trainee and modified through subsequent, regular, professional development meetings. The evidence should be gathered from several sources as appropriate for the particular CiP. In completing the ESR, assessments are made for each generic CiP using the following 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*

Comments must be made, against all CiP's.

The narration should include;

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

For the clinical CiPs, the ES makes a judgement using the levels of entrustment in the table below.

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. This is the usual level achieved for CiP's at the end of IMT stage 1.

Level 4: Entrusted to act unsupervised.

This means the trainee has achieved the level to work unsupervised as a Consultant. Only the ES makes entrustment decisions. Detailed comments must be given to support entrustment decisions that are below the level expected. As above, it is good practice to provide a narrative for all ratings given.

Important Points

- Plan the evidence strategy from the beginning of the training year
- Write the report in good time ahead of the ARCP
- Discuss the ESR with the trainee before the ARCP
- Give specific, examples and directive narration for each entrustment decision

Types of Evidence

Multi-Source Feedback (MSF)

The MSF provides feedback on the trainee that covers areas such as communication and team working. It closely aligns to the Generic CiPs. Feedback must be discussed with the trainee. If a repeat MSF is required it should be undertaken in the subsequent placement.

Multiple Consultant Report (MCR)

The MCR captures the views of consultant (and other senior staff) based on observation of a trainee's performance in practice. The MCR feedback gives valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required.

The minimum number of MCRs considered necessary is four a year (three of which should reflect performance in the acute take setting). It is advised that more should be obtained to support the entrustment decisions made by the ES especially if the trainee is struggling. All those formally appointed as CS should complete a MCR but any other consultant with whom the trainee has had significant interaction can also complete one.

In completing the MCR assessments are made for each CiP using the global anchor statements [meets, below or above expectations]. If it is not possible for an individual to give a rating for one or more of the CiPs they should record 'not observed'. Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include:

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

Supervised Learning Events

Acute Care Assessment Tool (ACAT)

The ACAT is used to provide feedback on a trainee's performance when undertaking acute care, particularly the acute medical take. Its main focus is on multi- tasking, prioritisation and organisational skills. It should not be used to produce a "multiple Case Based Discussion". The Decision Aid requires a minimum of 4 per year undertaken by consultant assessors, each of which should cover the care of a minimum of five patients.

Case based Discussion (CbD)

This tool is designed to provide feedback on discussions around elements of the care of a particular patient. This can include elements of the particular case and the general management of the condition. It is a good vehicle to discuss management decisions.

Mini-Clinical Evaluation (mini-CEX)

This tool is designed to allow feedback on the directly observed management of a patient and can focus on the whole case or particular aspects.

Direct Observation of Procedural Skill (DOPS)

This tool is designed to give feedback and assessment for trainees on how they have undertaken a procedural skill. This may be in a simulated or real environment. Formative DOPS may be undertaken as many times as the trainee and supervisor feel is necessary. A trainee can be signed off as able to perform a procedure unsupervised using the summative DOPS.

Teaching Observation (TO)

The TO form is designed to provide structured, formative feedback to trainees on their competences at teaching. The TO form 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).

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 a review of quality improvement documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the quality improvement project by more than one assessor. Planning high quality CiP's in conjunction with a hospital's quality is advised.

Reflection

Undertaking regular reflection is an important part of trainee development towards becoming a self-directed professional learner. Through reflection a trainee should develop

SMART learning objectives related to the situation discussed. These should be subsequently incorporated into their PDP. Reflections are also useful to develop 'self-knowledge' to help trainees deal with challenging situations.

It is important to reflect on situations that went well in addition to those that went not so well. Trainees should be encouraged to reflect on their learning opportunities and not just clinical events

Suggested evidence for each CiP

The suggested evidence to inform entrustment decisions is listed for each CiP in the curriculum and e-Portfolio. However, it is critical that trainers appreciate that they do NOT have to supply evidence under each category listed. This list merely suggests the sort of information that could be used to evidence each CiP. For clinical CiP 2 in IM stage 1 it is accepted that experience of the management of specialty patients who have been admitted acutely is more likely than managing an acute specialty take itself. Thus training programmes will vary but all should offer the trainees an opportunity to work within a specialty that admits patients acutely. This should be possible in most hospitals as the consultants in the majority of medical wards have a specialty in addition to internal medicine. Such experience should be counted towards the achievement of clinical CiP 2.

Induction Meeting with ES: Planning the training year

Writing the ESR essentially starts with the induction meeting with the trainee at which the training year should be planned. The induction meeting between the ES and the trainee is pivotal to the success of the training year. It is the beginning of the training relationship

between the two and needs both preparation and time. The induction meeting should be recorded formally in the trainee's e-Portfolio. The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the training year. This is also a time for ES and trainee to start to get to know each other.

Ahead of the meeting review:

- Review Transfers of Information on the trainee.
- Review previous ES, ARCP etc. reports if available.
- Agree with the placement CSs how other support meetings will be arranged. Arrangements for professional development meetings.

At the meeting the following need to be considered:

- Review the placements for the year.
- Review the training year elements of the generic educational work schedule or its equivalent.
- Construct the personalized educational work schedule for the year or its equivalent
- Construct the set of year-level SMART PDPs to include;
  - MRCP PDP
  - QI PDP
  - ALS
- Discuss the trainee's career plans and help facilitate these.
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs.
- Discuss the teaching programme.
- Discuss procedural simulation.
- Discuss procedural skill consolidation.
- Plan additional meetings including the professional development meetings and the interaction with the placement CSs.
- Planning of SLEs and WPBA.
- Arrangements for MSF.
- Review the ARCP decision aid. (Latest version)

- Arrangements for Interim Review of Competence Progression (IRCP). It is suggested this is done about six to eight months into the year.
- Arrangements for ARCP and the writing and discussion of the ESR.
- Pastoral support.
- Arrangements for reporting of concerns.
- Plan study leave.

At the end of the meeting the trainee should have a clear plan for providing the evidence needed by the ES to make the required entrustment decisions.

Important Points

- Prepare for the meeting.
- Make sure that knowledge of the IMS1 curriculum is up-to-date.
- Set up a plan for the training year.

Induction Meeting with Clinical Supervisor (CS)

The trainee should also have an induction meeting with their placement CS (who may also be their ES in some placements). The meeting should be pre-planned and undertaken in a private setting were both can concentrate on the planning of the placement. This is also a time for CS and trainee to start to get to know each other.

Ahead of the meeting review the following should be considered;

- Review Transfers of Information on the trainee.
- Review previous ES, ARCP etc. reports if available.

The following areas will need to be discussed, some of which will reinforce areas already covered by the ES but in the setting of the particular placement:

- Review the training placement elements of the generic educational work schedule or its equivalent.

- Construct the personalized educational work schedule for the placement or its equivalent.
- Construct the set of placement-level SMART objectives in the PDP.
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs.
- Discuss procedural skill consolidation.
- Discuss arrangements for LTFT training if appropriate.
- Plan additional meetings including professional development meetings and the interaction with the placement CSs (depending on whether the ES or CS will be undertaking these).
- Arrangements for MSF.
- Review the ARCP decision aid.
- Pastoral support.
- Arrangements for reporting of concerns.
- Make an exam study plan.

Professional Development Meetings

Trainers and trainees need to meet regularly across the training year.

These meetings are important and should cover the following areas. This list is not

exhaustive. Meet away from the clinical area regularly to:

- Discuss cases.
- Provide feedback.
- Monitor progress of learning objectives.
- Discuss reflections.
- Provide careers advice.
- Monitor and update the trainee's PDP.
- Record meeting key discussion points and outcomes using the Educational Meeting form on the e-Portfolio.
- Record progress against the CiPs by updating the comments in the CiP section of the portfolio (this will make writing the ESR at the end of the year much easier).
- Provide support around other issues that the trainee may be encountering.

At ARCP

The ARCP gives the final summative judgement about whether the trainee can progress into the subsequent year of training (or successfully complete training if in the final year). The panel will review the e-Portfolio (especially the ES report) in conjunction with the decision aid for the appropriate year.

The panel must also review the record of trainee experience to ensure that each trainee has completed (or is on track to complete over ensuing years) the various learning experiences mandated in the curriculum (e.g. outpatient clinics, critical care attachment, geriatrics and acute unselected take).

There are two critical progression points defined within the curriculum. One is the transition from IMY2 to IMY3 when the trainee advances into what was traditionally referred to as the 'Medical Registrar' role and the second is at the end of IMY3 when the trainee has completed IMT Stage 1 and is ready to progress into higher specialty training.

Progression from IMY2 to IMY3

The new GMC approved curriculum for internal medicine training (IMT) states that there is a critical progression point for trainees as they pass from IMY2 to IMY3. This is essentially because part of the trainees' progression is to the important role of the medical registrar, a move that is regarded as a step change in level of responsibility.

For Group 1 specialties in the new curriculum it is not mandatory to have completed MRCP by the end of IMY2 but rather it is "expected". Trainees who have not completed MRCP but who are otherwise continuing to make satisfactory progress will be able to pass into IMY3.

Accepted points

- It is essential from both a patient safety perspective and also for the educational needs and wellbeing of the trainee that only trainees who are competent so to do should lead the acute take.
- MRCP(UK) is not an exam that defines the ability of a doctor to lead the acute unselected take. It provides evidence for various underpinning skills and knowledge but in itself it is neither necessary nor sufficient.
- The summative judgement of whether a trainee is capable of leading the acute take (and therefore acting as medical registrar) is that they have achieved level 3 entrustment (entrusted with indirect supervision) in clinical CiP 1 managing an acute unselected take.
- The curriculum states that a trainee should expect to achieve level 3 in this CiP by the end of IMY2 allowing them to develop into the role of medical registrar with appropriate support during IMY3.

  As noted previously the training programme must provide an adequate opportunity for trainees to acquire clinical CiP 1 by adequate exposure to the acute take within IM2.
- Like all CiPs, that judgement is firstly self-assessed by the trainee, then made by the ES in the ESR and finally scrutinized and ratified at the IMY2 ARCP. A number of information streams may feed into that entrustment decision including personal observation, informal intelligence from colleagues (which must be documented in the ESR), formalised reporting in the form of the MCR, MSF, WPBAs/SLEs (especially ACATs), whether the trainee has undertaken a period of 'acting up' in the medical registrar role (in line with JRCPTB guidance) and the trainee's progress towards completing MRCP. If an ES feels that a trainee with MRCP is not at level 3 on clinical CiP 1 then they need specifically to explain and justify their reasoning. Equally, if an ES feels that a trainee who has attempted but NOT passed MRCP is at level 3 then they will need to justify that entrustment decision fully.

Sign off of Level 3 entrustment for clinical CiP 1: Managing the acute unselected take

The ESR will have a separate box where the ES specifically certifies that in their opinion the trainee has achieved (or by the end of IMY2, is expected to achieve) Level 3 in clinical CiP 1 and is therefore capable of leading acute unselected take with indirect supervision. There

will be an explicit statement that this entrustment decision is made following formal consideration of a number of relevant factors:

1. At least 3 MCRs specifically commenting on acute care and confirming that the trainee is on (or ahead of) track to achieve level 3 in clinical CiP 1 (mandatory)
2. A satisfactory MSF that suggests no problems (mandatory)
3. Relevant ACATs (in line with the decision aid) that demonstrate progression and maturation in the assessment, investigation and treatment of patients with acute medical illness and with no serious concerns documented (mandatory)
4. Satisfactory 'acting up'. This must be performed in a planned mentored, supportive and closely supervised environment and not just for service delivery. Opportunities to acting up may not be available to all so it is not mandatory to have done this in order to achieve level 3 in clinical CiP 1.
5. Progress at achieving MRCP in line with the decision aid.

The first three conditions must all be met. Possession of full MRCP(UK) and periods of 'Acting-up' are not mandatory but are important elements that must be taken into consideration when the overall entrustment recommendation is made.

For some trainees it will be unclear that they have achieved clinical CiP 1 level 3 and some may have personal concerns about their medical registrar role. This is the most important group for the ARCP panel to consider in detail. The key decision is between progression to IMY3 with enhanced supervision and mentoring or remaining at IMY2. For example, it may be appropriate for them to progress to IMY3 but only to lead the acute take during the working day when direct senior supervision is available. This will necessarily limit their time in IMY3 to develop the appropriate skills to complete IMT and it will only be very borderline cases that are likely to progress to IMY3. No trainee should be made to progress to IMY3 if, in their own assessment, they are not ready to take on the medical registrar role. The uncertainty that these trainees express should be explored in detail and arrangements

made for mentoring and probably extra time in training so that confidence for the role can be acquired.

Practical Procedural Skills

The development of practical procedural skills has always been integral to the training of medical registrars. The procedures that are required and the way which they are performed is continuously evolving as new techniques (especially around new imaging) become available to improve patient safety and comfort. Some procedures that were traditionally carried out by a general medical registrar are now frequently performed by specialist services (e.g. temporary transvenous cardiac pacing, pleural drainage etc). It has therefore been difficult to define exactly what procedural skills are required by a trainee in Internal Medicine.

The position adopted in the present IMT Curriculum represents a reasonable compromise between those individuals who feels that IM trainees do not need to develop and demonstrate any procedural skills and those who feel that a medical registrar should be competent to carry out unsupervised, all procedures required in previous medical curricula. It is noted in the decision aid table that several procedures only need to be performed in a skills laboratory as a minimum. This is important so that a trainee at least knows the basics of the procedure and should be able to upskill readily when they are in a post where there are opportunities to learn how to perform the procedure in patients with appropriate supervision and progress to being able to perform independently.

It is stressed that level of competence for each procedure, defined in the curriculum and decision aid, is the minimum required to achieve a standard ARCP outcome for each year and trainees should take every opportunity to increase their level of skill in each procedure and if possible, become capable of performing them unsupervised. Trainees now only need a single summative DOP's assessment in order to be regarded as competent at the appropriate level. They are encouraged to carry out a number of supervised procedures in the way of formative DOPS before submitting themselves for a summative assessment. Trainers need to have a documented, ongoing conversation with trainees about procedures, their practice in them and when they should be undertaking the summative DOPS for each procedure. These conversations should be documented within the portfolio in additional meetings and appraisals.

Candidate Selection

Application Guidelines for Candidates

- The Rajagiri IMT Programme starts on **1st August**.
- The Invitation of application is from **4th of March 2025 to 15th of April 2025.**
- The total number of candidates is limited to **6**. A waiting list will be maintained for a period of six months.
- The selection process will be completed by **15th of May 2025**.

Structure of Application

- Eligibility
- Personal Details
- Fitness
- References
- Competency

Eligibility

- As described in Page no.

Personal Details

- Name
- Address
- Contact Details
- Marital Status
- Number of Children

Fitness

Declaration of:

- Medical Fitness
- Involvement in any Criminal Offence or any pending case against you or history of any conviction.

References

Two references are required.

- Reference from a clinician with whom the candidate has worked for a minimum of three months.
- Reference from a faculty member of the candidate's medical college at or above the rank of an Associate Professor. The referee should have known the candidate for a minimum period of one year and ideally throughout the time spent in the medical college.

Competence

All candidates with a postgraduate degree in Internal Medicine or a pass in MRCP part 1 will automatically be eligible for the interview. The competency of the candidate will be decoded based on the performance in the inhouse selection process.

The number of candidates to be called for interview will be decided by the Rajagiri IMT Selection Committee. Clinical knowledge and skills, communication and ethical skills, aptitude for training, extracurricular abilities, scientific paper publications and presentations are all taken into consideration during the interview process which will be fair and transparent.

Interview Stations

The Structure of the Interview

1. **Portfolio station**
   All documents of the candidate will be verified in this station and marks for other achievements will be awarded.

2. **Clinical scenario station**
   The candidate will be assessed based on a clinical scenario in this station.

3. **Ethical and communication scenario station**
   The ethical consideration and the communication skill will be assessed using an appropriate clinical scenario in this station.

The candidates will have 5 minutes between each station and 10 minutes inside. In those 5 minutes before the clinical and ethical stations (Station 2 & 3), candidate will have a Cue card

to read that will cover the scenario candidate will face inside. The entire process should take 45 minutes.

Two clinical interviewers each will be there to assess different areas of candidate's skills, knowledge, and experience. So overall, a candidate will be assessed and scored by six different interviewers.

The maximum score available is 60 marks.

1) Portfolio station – 20 marks

a) Additional PG qualification / MRCP (Part- I) / NEET Qualification - 5 Marks

b) National Prizes, Distinction, Scholarship etc - 5 Marks

c) Presentations or Poster at International /National/ regional meetings etc. – 5 Marks

d) Publications - PubMed, Pear reviewed, first author, co-author or others etc - 5 Marks

2) Clinical Scenario Station – 20 Marks

a) Clinical discussion – diagnosis and differential diagnosis – 5 + 5 Marks (Two interviewers)

b) Management – Investigation and treatment - 5 + 5 Marks

3) Ethical and Communication skill station - 20 marks

a) Discussion of ethical issues - 5 + 5 Marks

b) Communication skills – 5 + 5 Marks

Counselling station

All the candidates should attend the counselling session where the candidate's suitability and commitment to the IMT will be assessed.

Publication of final list of selected candidates and waiting list will be announced in the website.

Training Faculty

The Training Faculty consists of the Training Programme Director, Deputy Programme Director, Educational Supervisors and Clinical Supervisors. All the Educational Supervisors are at the rank of Senior Consultants. The Clinical supervisors are from both Internal Medicine department and other major medical specialities.

Training Structure

1. Trainees will receive a contract of employment from HR Department.
2. Trainees will be called trainees.
3. The rules of the Contract will be the same as that of the other PG trainees in Rajagiri Hospital.
4. The trainees will be paid a stipend monthly as decided by Rajagiri Hospital.
5. Trainees will have rotational posting in all the major medical departments such as Acute Medicine, Cardiology, Gastroenterology, Pulmonary and Chest Medicine, Nephrology, Neurology, Critical Care, Geriatric Medicine, Pain and Palliative Care and Rheumatology, Infectious Diseases and Oncology.
6. It is mandatory for the all the trainees to obtain ACLS and BLS training either before joining the IMT Programme or within three months of joining.

Postings

STRUCTURE OF TRAINING	
FIRST 12 MONTHS	
GENERAL MEDICINE	4 MONTHS
GERIATRIC MEDICINE	4 MONTHS
CRITICAL CARE	4 MONTHS
SECOND 12 MONTHS	
CARDIOLOGY	2 MONTHS
PULMONOLOGY	2 MONTHS
NEUROLOGY	1 MONTH
GASTROENTEROLOGY	2 MONTHS
NEPHROLOGY	1 MONTH
PALLIATIVE MEDICINE	1 MONTH
RHEUMATOLOGY	1 MONTH
INFECTIOUS DISEASES	1 MONTH
ONCOLOGY	1 MONTH
THIRD 12 MONTHS	
GENERAL MEDICINE	5 MONTHS
GERIATRIC MEDICINE	5 MONTHS
CRITICAL CARE	2 MONTHS

Examinations

The trainees are expected to complete all three parts of MRCP by the end of their training, ideally by the end of Second year. Please refer to RCP website of MRCP Examinations.

Tuition Fees

Trainees should pay their Tuition Fees as a single instalment every year at the beginning of each academic period and the tuition fee is non-refundable.

Additional fee is applicable for MRCP examinations payable to MRCP (UK).

Misconduct of Trainees

During the training period, any misconduct from the trainees has to be reported to the Programme Director and necessary actions will be taken in consultation with the Rajagiri IMT Steering Committee.

ARCP

The ARCP Panel:

Composition: Programme Director, Deputy Programme Director, Educational Supervisors, two external advisors (one from another IMT site and a representative from the JRCPTB from the UK). The panel also includes a lay member. The Lay Member will review the process of the ARCP panel as measured against accepted general good practice for ARCP panels and the standards that are set in the Gold Guide.

Objective

ARCP is a formal process of the assessment of the progress in the training programme based on the evidence collected by the trainees. This is conducted on an annual basis.

Working Pattern of ARCP Panel

Trainees must keep a Portfolio of information and evidence collected during their training period. Periodic assessments are conducted by the ARCP Panel examining the portfolio information and come out with the appropriate outcomes according to the portfolio information. These outcomes will be discussed with each trainee and suggestions will be made for their further training appropriate to their ARCP outcomes.

Outcomes from the ARCP

After the appropriate quality management checks have been completed, the outcomes recommended by the panel for all trainees will be made available by the Training Programme Director to the trainee, Educational Supervisors and JRCPTB.

Outcome 1

Satisfactory Progress.

This is defined as achieving all the competencies in the IMT Curriculum at the rate required.

For outcomes 2 – 5 the trainees have to meet with the panel after the panel has reached its decision.

Outcome 2

Development of specific competencies required without additional training time requirement. This can normally be achieved without affecting the overall progress and requirement of extension of training period.

Outcome 3

Inadequate progress with additional training time required.

A formal additional training period is required resulting in extension of the duration of the training programme. This is allowed for a maximum of 1 year which can be taken in blocks instead of a continuous full year. However, in exceptional circumstances this can be extended to 2 years at the discretion of the Training Programme Director.

Outcome 4

Released from training programme with or without specific competencies. In spite of having had additional training to address concerns over progress, if the trainee shows insufficient and sustained lack in achieving the required progress, the panel will recommend that the trainee is released from the IMT programme.

Outcome 5

Incomplete evidence presented.

Additional time may be required. Trainees who fail to produce satisfactory evidences regarding their training progress maybe given additional time to do so with a designated deadline date. Alternatively, an outcome can be given to the trainee on producing satisfactory evidence of progress on a subsequent date and failing which the panel has to be reconvened.

Outcome 6

Satisfactory completion of all required competencies and recommended for completion of the Training Programme.

Appeals against ARCP Outcomes

Only outcomes 3 & 4 can be appealed. The trainee must appeal in writing within two weeks of the panel giving clear grounds for the appeal.

The local TPD will meet the trainee to try and agree an informal resolution within two weeks. If that fails, the trainee can send a written appeal to the Federation International Medical Director for the training together with the comments of the local TPD on the appeal grounds. The Federation IMD will appoint a senior UK Education Specialist to review all the submitted documentations and the trainee's e-portfolio record. They will make a recommendation to the Federation International Medical Director. The decision of the IMD will then be final.

Being an IMT Trainee and an Employee

Responsibility and Accountability to Rajagiri Hospital, Training Programme Director and Trainers.

Trainees joining the Rajagiri IMT Programme are playing a dual role while they are in the programme. They are undergoing speciality training under the management of the Training Programme Director and at the same time they are employees of Rajagiri Hospital. This particular situation provides them with certain rights and responsibilities. This leaves them with an employment relationship with Rajagiri Hospital and a training relationship with the Training Programme Director.

The Training Programme Director is responsible for the trainee's training while they are undergoing the training programme. Although TPD does not employ postgraduate trainees in Rajagiri Hospital, the training is done through an educational contract with the hospital. Through this contract the TPD has a duty and responsibility to look after all the aspects relating to the training and education of the postgraduate trainers in the employing environment.

Rajagiri Hospital ensures that monitoring mechanisms are in place to support the training of the trainees and any problem arising would be identified and addressed at an early stage. Rajagiri Hospital also makes sure the safety of the patients by assigning duties to our trainees according to their level of competencies.

Disciplinary Procedures

Apart from the training and educational relationship, the trainees have an employee relationship with Rajagiri Hospital. This means that, the trainees have to observe certain rules and regulations stipulated by the hospital regarding their performance and general behaviour. In case the hospital has to take some disciplinary action against the trainee, it maybe that the trainee's employment contract ends before the completion of the proceedings. However, it would be appropriate if the employment contract to be extended while investigations is in progress and it would be in the interest of trainee to resolve the issue at the earliest. The TPD will usually help and guide to facilitate this.

In case of a trainee having a significant health issue, which may impact the training and educational progress, this will be reviewed by the occupational health department and with the trainee's consent, the review report will be shared with the TPD. Information regarding any disciplinary action or occupational health review report will be shared with the concerned Educational Supervisor. The trainee has the right to know what information is being transferred to the relevant Educational Supervisor and has also the right to challenge its accuracy but not to prevent the information being transferred.

When personal misconduct is outside the training programme, Rajagiri Hospital may need to take action in accordance with the guidance from the hospital's HR Policy. The TPD will be able to help and guide trainee through this process. The end of an employment contract does not automatically end the disciplinary process. The TPD will make sure through the Educational Contract with Rajagiri Hospital the trainee will be managed in accordance with the best employment practice.

The TPD must not be a member of any disciplinary or appeal panel in any disciplinary procedures taken by Rajagiri Hospital against a trainee but may provide evidence to the panel and advice on training and education matter if required.

Professional Incompetence and Poor Performance

The TPD and the members of the Rajagiri IMT steering committee will be keen to support the trainees experiencing difficulty in performing their duties and help them in any deficiencies. Informal but clearly identified and documented action should be taken wherever possible prior to embark on formal disciplinary measures. Any action from the side of the trainee which

amounts to medical negligence may lead to a formal investigation. The TPD must be informed of any such incidents and all support is offered to the trainee throughout the process.

Kerala State Medical Council and fitness to practice

Sustained poor performance, serious misconduct or health concerns may warrant referral to Kerala State Medical Council's fitness to practice process.

The trainee must inform the TPD regarding their absence from the training explaining the reasons for the same. Any trainee taking more than 14 days leave of absence in 12 months period, a review of training should be undertaken and adjust the expected date of end of training.

Conclusion

The essence of this Gold Guide has been extracted from the approved UK Curriculum and the "Rough Guide to Internal Medicine Training" by the Royal College of Physicians of the United Kingdom. This is prepared for the guidance of the trainees, supervisors, programme directors and explains the training programme delivered through IMT at Rajagiri Hospital.