Short Guide to IM3

Internal Medicine Training year 3 (IM3) is the third and final year of the first stage of speciality training in a physicianly speciality. On successful completion of IM3 trainees can enter ST4 in group 1 specialities, or ST3 group 2 specialities. It prepares trainees for senior roles on the acute medical take, and managing acute and chronic medical problems in outpatients and inpatients. The focus is on developing as a Medical Registrar rather than development in a particular specialty. Further information on Internal Medicine Training can be found at www.jrcptb.org.uk/imt.

Group 1 specialties: Acute Internal Medicine, Cardiology, Clinical Pharmacology & Therapeutics, Endocrinology & Diabetes Mellitus, Gastroenterology, Genitourinary Medicine, Geriatric Medicine, Infectious Diseases (except when dual with Medical Microbiology or Virology), Neurology, Palliative Medicine, Renal Medicine, Respiratory Medicine, Rheumatology and Tropical Medicine (except when dual with Medical Microbiology or Virology).

Supervision

An IM3 should have an educational supervisor (ES) for the year, and a clinical supervisor (CS) for each of their two six-month attachments (who can also be their ES).

The CS should meet the trainee at least at the start, around the mid-point, and at the end of the attachment; specific forms in the appraisal tab relate to the start and end of attachment meeting, an educational meeting can be recorded for the midpoint. At the start of a placement a Personal Development Plan (PDP) should be agreed and recorded. The end of placement form should include Local Faculty Group (LFG) feedback, and documentation of completion of the PDP.

The ES should meet the trainee monthly to discuss their progress, and plan their ongoing training needs; these meetings should be recorded as an Educational meeting in the appraisal tab.

At the start of the year the ES should document the progress expected in the Competencies in Practise (CiPs) with suggested relevant evidence. The ES should agree a personalised Educational Work Schedule, and a training plan for the year with particular attention given to developing in the medical registrar role. Around May it is expected an ES report is completed, agreed with the trainee, then finalised on the e-portfolio. The levels expected for the completion of IM3 are documented below.

Levels to be achieved by the end of each training year and at critical progression points for IM clinical CiPs

Level descriptors
Level 1: Entrusted to observe only – no provision of clinical care
Level 2: Entrusted to act with direct supervision
Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

Clinical CiP	IMY1	IMY2	CRITICAL PROGRESSION POINT	IMY3	CRITICAL PROGRESSION POINT
1. Managing an acute unselected take	2	3		3	
2. Managing an acute specialty-related take	2*	2*		2*	
3. Providing continuity of care to medical in-patients	2	3		3	
4. Managing outpatients with long term conditions	2	2		3	
5. Managing medical problems in patients in other specialties and special cases	2	2		3	
6. Managing an MDT including discharge planning	2	2		3	
7. Delivering effective resuscitation and managing the deteriorating patient	2	3		4	
8. Managing end of life and applying palliative care skills	2	2		3	

*** This entrustment decision may be made on the basis of performance in other related CiPs if the trainee is not in a post that provides acute specialty-related take experience**

Teaching

The curriculum states IM3 trainees must attend 50 hours of documented teaching a year, including 20 hours of regional teaching (recognised for CPD points or organised/ approved by HEE local office/deanery) though there may be local adaptions. They must also attend simulation training including human factors and scenario training in IM3. At the end of the year this can be recorded in a Summary of Teaching form.

Timetable

An IM3 post is equivalent to a first-year registrar post and as such a registrar like timetable is expected, example below. This should include at least one consultant ward round and one independent ward round a week, at least 2 clinics a week, an allocated admin session, an allocated study afternoon, and time for referrals. IM3 Doctors are not junior Doctors and as such covering the ward should only occur in exceptional circumstances, and can be educationally exception reported.

	Morning	**Lunchtime**	**Afternoon**
Monday	Consultant ward round	Grand Round	Referrals / MAU and ED in reach
Tuesday	Clinic	IM3 teaching	Admin
Wednesday	IM3 ward round		Referrals / MAU and ED in reach
Thursday	Consultant ward round	Radiology meeting / MDT	Study afternoon
Friday	Clinic		Ward supervision / admin

Oncall

A key aspect of IM3 is to develop as a medical registrar; once ready oncall should be on the registrar rota reviewing patients admitted by junior colleagues, and providing advice to other specialities; primary clerking is expected to be a maximum of 20% of time spent oncall.

Opportunities

It is important to fully embrace training in each speciality, whilst developing a strong curriculum vitae for ST4 applications. It is hoped the study afternoon will allow broadening of the training experience eg a project overlapping the speciality of a placement with the future career, learning skills such as ultrasound, achieving publications, taking part in research, audit, leading MDTs, front door facing speciality interventions, interview skills acquisition and other speciality specific skills.

Mandatory training requirements

Evidence to enable feedback, development and inform the ES report:

- 4 Multi-consultant reports (MCRs) - of which at least 3 MCRs written by consultants who have personally supervised the trainee in an acute take/post-take setting. There must be at least one from a geriatrician over the three years.
- 1 Multi-source feedback (MSF) with 12 replies and a self-assessment to include at least three consultants and a mix of other professionals, all correlated within three months. If significant concerns are raised a repeat MSF may be required by the ES.
- 4 Acute care assessment tools (ACATs) are required of a minimum of 5 cases, assessed by a consultant (these can be split over more than one oncall or correlated by two consultants or performed when reviewing acute new cases on a ward).
- 4 Supervised learning events (SLEs) as either Mini-clinical evaluation exercises (Mini-CEX) or Case-based discussions (CbDs) including structured feedback.
- Demonstrating leadership in QI activity (eg supervising another healthcare professional); the plan, report and assessment can be uploaded to the eportfolio.

Examinations:

- Completion of full MRCP UK diploma.
- Valid ALS throughout.

Experience:

- 20 outpatient clinics in IM3, with 80 over the three years of training; ES to confirm level 3 for clinical CiP4.
- Be actively involved (sufficient input for involvement to be recorded in the patient's clinical notes) in the care of at least 100 patients presenting with acute medical problems per year of IM training, and at least 500 patients by the end of IM3. ES to confirm level 3 for clinical CiP1.
- Indicative rather than absolute numbers in the curriculum are designed to provide the recommended experience from which the training outcomes will be attained, and evidence accrued to inform the ES end of year report.
- Trainees should have been involved in the day-today management of acutely unwell medical inpatients for at least 24 months, had 10 weeks of ITU/HDU placement, and 4 months geriatrics by the end of the three year IM programme.
- Participation at medical registrar level with acute medical oncall.

E-portfolio:

- Sign all declarations and agreements.
- Upload a form R on request.
- Organise and populate the personal library and curriculum.

Procedures	**IM1**	**IM2**	**IM3**
Advanced cardiopulmonary resuscitation (CPR)	Skills lab or satisfactory supervised practice	**Participation in CPR team (fDOPS or sDOPS)**	**Leadership of CPR team (sDOPS)**
Direct current (DC) cardioversion	Skills lab or satisfactory supervised practice	**Competent to perform unsupervised (sDOPS)**	Maintain
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
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
Access to circulation for resuscitation (femoral vein or intraosseous)[a]	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Pleural aspiration for fluid (diagnostic) [b]	Skills lab or satisfactory supervised practice	**Competent to perform unsupervised (sDOPS)**	Maintain
+/- Pleural aspiration (pneumothorax)[c]	Skills lab or satisfactory supervised practice	**Competent to perform unsupervised (sDOPS)**	Maintain
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 [b]	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Nasogastric (NG) tube	Skills lab or satisfactory supervised practice	**Competent to perform unsupervised (sDOPS)**	Maintain
Ascitic tap	Skills lab or satisfactory supervised practice	**Competent to perform unsupervised (sDOPS)**	Maintain
Abdominal paracentesis	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Lumbar puncture	Skills lab or satisfactory supervised practice	**Competent to perform unsupervised (sDOPS)**	Maintain

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

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

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