



**UNION EUROPÉENNE DES MÉDECINS SPÉCIALISTES
EUROPEAN UNION OF MEDICAL SPECIALISTS**

Association internationale sans but lucratif

International non-profit organisation

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Training Requirements for the Specialty of Internal Medicine

European Standards of Postgraduate Medical Specialist Training

European Board of Internal Medicine

Brussels Feb 22, 2016

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Glossary of terms

CanMEDS	Guide to the framework of the essential competencies of physicians for optimal care.
Collaborator:	Internist who works effectively with other physicians and healthcare professionals.
Common trunk:	The first two years of a postgraduate training program that offers a broad experience in internal medicine for doctors training in any medical specialty.
Communicator:	Internist who establishes an excellent professional relationship with patient and their families.
Dual certification:	Attainment of certification at a national level of competence in Internal Medicine and another medical specialty.
EBIM:	European Board of Internal Medicine.
EFIM:	European Federation of Internal Medicine.
EPA:	Entrustable Professional Activity is a form of summative assessment that allows a trainee to be certified in a clinical activity that is part of the practice of internal medicine
Harmonisation:	The process of creating common standards in the training of Internal Medicine across the different European nations.
Healthcare Advocate:	Role of internist applied to serve and improve the healthcare situation of the patient and populations concerned.
Internal Medicine:	The medical specialty dedicated to the diagnosis and medical treatment of adults.
Internist:	A physician who specialises in internal medicine.
Leader:	Internist who contributes to the improvement of healthcare delivery in teams, organisations and systems.
Medical Expert:	Internist who practises medicine within the clinical scope of practice and expertise of internal medicine.
Milestone:	Progression of competencies from the onset of medical training to advanced practice.
Professional:	Internist who demonstrates a commitment to patients by applying best practices and adhering to high ethical standards.
Scholar:	Internist who engages in lifelong learning and professional development through on-going development.



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Preamble

The UEMS is a non-governmental organisation representing national associations of medical specialists in Europe. With a current membership of 34 national associations and operating through 39 Specialist Sections and European Boards, the UEMS is committed to promoting the free movement of medical specialists throughout Europe while ensuring the highest standard of training to improve the quality of care for the benefit of all European citizens. Specific areas of interest to the UEMS include:

- continuing medical education
- postgraduate medical training
- quality assurance.

The UEMS' believes that the standard of medical care and expertise is directly linked to the standard of training provided to medical professionals. Therefore the UEMS is committed to contributing to the improvement of medical training in Europe through the development of a set of core competencies in the different medical disciplines to provide consistency regardless of where doctors are trained.

The legal mechanism for ensuring the free movement of doctors within Europe through recognition of their qualifications was established back in the 1970s by the European Union. One of the sectorial directives (in the Treaty of Rome) specifically addressed the issue of Europe-wide medical training. However, in 2005, the European Commission suggested to the European Parliament and Council that there should be a single legal framework for the recognition of professional qualifications to facilitate and improve the movement of all workers throughout Europe. This directive (Directive 2005/36/EC) established the mechanism for automatic mutual recognition of qualifications for doctors according to the training requirements within the individual member states; this is based on the length of training in the specialty and the type of qualification.

In 1994, the UEMS adopted its Charter on postgraduate medical training aimed at providing the recommendations to be applied within Europe. The six chapters of this charter set out the basis for a European approach to postgraduate medical training. Chapters 1-5 would be common to all specialties. "Chapter 6" would be completed by each Specialist Section according to the specific needs of each discipline.

Since the introduction of this Charter, the UEMS Specialist Sections and the European Boards have been working to develop core European competencies in medical training to reflect modern medical practice and current scientific research. In doing so, the UEMS Specialist Sections and European Boards were not aiming to supersede the core competences as defined by the national competent authoritiesⁱ in their home states but rather to complement these and ensure that a high standard of training was provided across Europe.

Given the long-standing experience of the UEMS Specialist Sections and the European Boards on the one hand and the European legal framework enabling medical specialists and trainees to move from one country to another on the other, the UEMS is uniquely placed to provide specialty-based recommendations. The UEMS values professional competence as *“the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served”ⁱ*.

Professional activity is regulated by national law in EU member states, and the UEMS understands that it has to comply with international treaties and UN declarations on human rights as well as the WMA International Code of Medical Ethics.

In view of the developments outlined above, the European Board of Internal Medicine (EBIM) has generated a curriculum in internal medicine to guide postgraduate education in the specialty of internal medicine. The curriculum presents minimum requirements for training towards qualification as a specialist in internal medicine. When implemented in individual European countries, additional requirements can be added in accordance with national traditions and needs. At present, the curriculum has no legal obligations and is not compulsory for the member states of the European Union.

Background

The objectives of the UEMS Section of Internal Medicine include the progressive harmonisation of the content and quality of training in internal medicine within the member states of the European Union (EU) and the other European countries. To this end the UEMS Section of Internal Medicine and the European Federation of Internal Medicine (EFIM) have founded a EBIM that has defined training requirements to reflect the opinion of the individual national internal medicine societies and professional organisations. This will include the contents of training, the assessment of competence and an outline of the desirable context for training i.e. requirements for trainees, trainers and training institutions.

The EBIM acknowledges the EC Directive (Directive 2005/36/EC, amended 2013/55/EC)ⁱⁱ that regulates the free movement of professionals within the European community based on harmonised minimum training requirements and transparent recognition of professional qualifications. The EBIM, therefore, recognises the need for a core European competency-

ⁱ Defining and Assessing Professional Competence, Dr Ronald M. Epstein and Dr Edward M. Houndert, Journal of American Medical Association, January 9, 2002, Vol 287 No 2

ⁱⁱ DIRECTIVE 2013/55/EU OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 20 November 2013 amending Directive 2005/36/EC on the recognition of professional qualifications and Regulation (EU) No 1024/2012 on administrative cooperation through the Internal Market Information System ('the IMI Regulation')

based curriculum of internal medicine. National authorities may supplement the recommendations in the European curriculum with the additional training and assessments that they deem relevant to their own training programme structure.

There is at present no standardised accreditation of postgraduate training periods completed in another European country towards qualification as an internist. Individual recognition of retrospective training will be decided at the national level according to each national authority rules. This curriculum may help this process of accreditation of previous internal medicine training in another country as this curriculum aims to standardise training in internal medicine across Europe.

EBIM has tasked a subgroup (Appendix A.1) to devise a core European competency-based curriculum taking into account representative national curricula put forward by individual European countries. The subgroup has representation from trainees, young internists (YIs), trainers and national training programme directors.

The training requirements for the speciality of Internal Medicine are based on earlier UEMS documents, including the 1994 Charter on Specialist Training with its Chapter 6 on Internal Medicine, and previous UEMS and EFIM documents.^{1, 2, 3, 4, 5, 6, 7}

This current document has a basis in the previously mentioned Chapter 6 of the Charter on Postgraduate Medical Specialty Training and provides definitions of specialist competencies and procedures as well as how to document and assess them. For the sake of transparency and coherence, it has been renamed as “Training Requirements for the Specialty of Internal Medicine”. As the title suggests, this document aims to provide the basic training requirements for the specialty. It should be regularly updated by the UEMS Section of Internal Medicine, in conjunction with EFIM to reflect scientific and medical progress. The three-part structure of this document (training requirements for trainees, trainers and training institutions) reflects the UEMS and EFIM approach to provide a coherent pragmatic document not only for medical specialists but also for decision-makers - at both the national and the European levels - interested in knowing more about medical specialist training.

Several countries are not members of the European Community or European Economic Area, but are affiliated to either UEMS or EFIM (appendix A.2); they are invited to adopt this curriculum.

Devising a European curriculum for the speciality of internal medicine is more difficult than devising curricula for most other specialties. The main reason for this is the highly variable role of the internist throughout Europe. In some countries, internists are largely office-based and provide care directly to patients in an outpatient setting whereas elsewhere they are more in-patient-based and their principal role is to care for the acutely ill patient with medical problems. The diseases cared for by internists may vary between countries; the national training curricula are likely to reflect these differences.^{5, 6}

Many medical specialties have their core competencies based in internal medicine. To meet the future healthcare challenges in Europe⁸, the EBIM believes it is essential that all physicians practising these specialties not only obtain a broad training in internal medicine but also nurture and maintain expertise in this field. This should be irrespective of any subsequent specialisation or practice. These basic competencies in internal medicine, often referred to as the common trunk are defined further in Appendices B and C below.

The process of standardisation of internal medicine training in Europe runs in tandem with

other European developments. These include certification, recertification, continuing medical education (CME) and continuing professional development (CPD) of internists. In time a European Diploma of Internal Medicine will be developed together with supporting online educational material.

It is clear that the development of the curriculum is not the whole story. For example, the curriculum does not cover the quality assurance of national programmes nor the formal accreditation of training centres. In addition, the ability to travel and practice throughout Europe is dependent upon the national requirements of each country.

This curriculum provides a stepping stone in the process towards an ambition that internists will be trained to a common standard. The curriculum may provide guidance as to how that may be achieved.

Definition of internal medicine and mission statement

Internal medicine is the core medical discipline that is responsible for the care of adults with complex illness, both in the hospital and in the community. It is patient-centred, scientifically based and committed to ethical and holistic principles of care. Internal medicine is a clinical and scientific discipline that creates and promotes medical knowledge, methods and clinical abilities. It analyses the findings of other medical specialties and integrates them into strategies for diagnosis, treatment and care for individual patients.

Demographic studies show that European countries will face increased numbers of patients suffering from several chronic health problems and hence need an integrated response to patient care. This trend will necessitate both a holistic and a multi-disciplinary approach, which together form a core element of internal medicine.

Definition of the internist

Internists have a fundamental role in modern healthcare systems. This is largely due to the high prevalence of chronic and complex diseases that are associated with the lifestyle of ageing western societies. This demographic change will bring a shift towards a preventative strategy focusing on health promotion.

The UEMS defines an internist as follows. "An internist is a physician trained in the scientific basis of medicine, who specialises in the assessment, diagnosis and management of general medical problems, atypical presentations, multiple problems and consequential complex health issues, and system disorders (**Professional**). The physician is skilled in the management of acute unselected medical emergencies and the management of patients in a holistic and ethical way, considering all psychosocial as well as medical factors for enhancing quality of life. The physician values the continuing care of all patients irrespective of the nature of the patient's complaint, and is committed to lifelong continued professional development (**Scholar**). The physician practices clinical audit and evidence-based medicine. The physician functions in a number of roles, including clinical counselling, educating, leading and managing."

The onset of many chronic diseases is influenced by lifestyle-related risk factors. These conditions contribute significantly to the increased burden of disease and disability amongst older people. Associated health care costs will rise accordingly unless greater effort is made

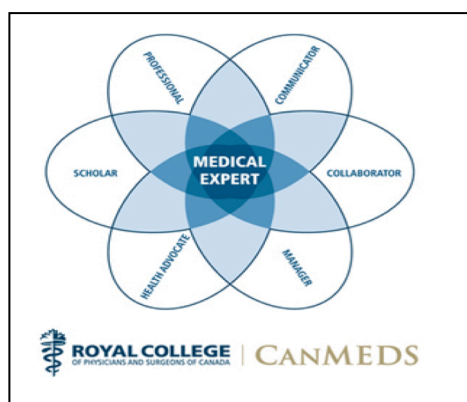
to either prevent or treat these conditions earlier. This role of **Healthcare Advocate** in this wider conversation is an important part of the internist's function.

The specific fields of expertise of internists include patients with general or non-specific symptoms, patients with complex multisystem clinical problems, and patients with comorbidities and polypharmacy. The internist provides acute, chronic and palliative care, as well as preventive care (**Medical Expert**). Although medical practice for internists varies between European countries, the provision of comprehensive medical care is a common theme.

The basic instrument of the internist is clinical reasoning.^{9,10} As part of a wider healthcare team, the internist has to effectively coordinate the care provided by other professionals for the benefit of the patient (**Collaborator**). Internists should also facilitate and support the participation of patients in their own care and aid them in making decisions about health issues (**Communicator**). The internist needs to be an advocate for health issues for both individual patients and within the community at large (**Healthcare Advocate**). Furthermore, the internist will, in certain situations, require managerial and business skills (**Leader**). Finally, internists should be proficient in both teaching and scientific enquiry (**Scholar**).

The training requirements for the specialty of Internal Medicine aim to produce a competent internist for all European healthcare systems, which allow for efficient coordination of care by all medical specialties and a mobile workforce. Medical care has to be optimised, with the use of advanced diagnostic and therapeutic tools at its disposal. It is important that these objectives are reflected in the training requirements of internists across Europe.

The competency framework adopted and adapted by the curriculum working group is the CanMEDS framework^{11,12} which defines the generic competencies of the internist (see I training requirements for trainees and Appendix B). These generic competencies are listed below and are referenced and elaborated upon throughout the document to emphasise their importance:



1. **Medical Expert**
2. **Communicator**
3. **Collaborator**
4. **Leader**
5. **Health Advocate**
6. **Scholar**
7. **Professional**

The training provided must enable the internist to manage complex decision-making and the challenge of developing better standards of care, quality improvement and patient safety tools, along with integrated healthcare delivery systems. An important mission of internal

medicine is to actively support the development of a dynamic and sustainable healthcare system for the future.

The Common trunk

As a consequence of an ageing population in Europe there are an increasing number of patients suffering from more than one chronic condition. They often require a number of different specialists involved in their care. It is important that all specialties stemming from internal medicine contribute to integrated care, having a basis of knowledge in internal medicine. Only a concerted action by all these specialties together with the specialty of internal medicine can bridge existing gaps in healthcare delivery and provide comprehensive patient care. The broad-based training requirements of the common trunk (see Section I below) should enable medical specialists other than internists to be proficient in the care of patients with common chronic diseases apart from their specific field of expertise. As a practitioner they should be willing to meet community needs and value the maintenance of their knowledge and skills in internal medicine.

Detailed training requirements for trainees are to be found in in Section I. Training requirements for trainers and training institutions are to be found in Sections II and III.

I. TRAINING REQUIREMENTS FOR TRAINEES

Content of training and learning outcomes

1.1 Generic competencies

As mentioned above, the curriculum working group has adopted the CanMEDS competency framework^{11, 12} to define the generic competencies of the internist. CanMEDS has been adopted by countries on five continents, making it the world's most recognised and most widely applied competency-based framework for physicians.

The following seven generic competences or roles have been identified that cover all areas of medical practice and thus provide a comprehensive foundation for medical education. Each role has been defined by key competencies (as listed below), which are translated in enabling competencies (Appendix B) and specific learning objectives for the internist. We have adapted and/or complemented the key competencies and/or enabling competencies as deemed appropriate for the European community based on the available position papers^{1, 4, 7} by EFIM as well as existing curricula from European countries.

Currently, individual European countries may have the competencies of the internist defined according to a framework that differs from the one used in this document. This should not be considered a problem as long as all key- and enabling competencies are covered in the learning objectives of their curriculum. Ultimately, the aim should be to harmonise the framework as well.

1.2 Key Competencies of the CanMEDS roles

Medical Expert

As medical experts, physicians/internists integrate all of the CanMEDS roles and apply medical knowledge, clinical skill, and a professional attitude when providing high-quality, safe patient-centred care. The medical expert is the central role of the physician/internist in the CanMEDS framework and defines the physician's/internist's clinical scope of practice.

As medical experts, physicians/internists are able to:

- 1. Practise medicine within the clinical scope of practice and expertise of internal medicine**
- 2. Perform a patient-centred clinical assessment and establish management plans**
- 3. Plan and perform interventions for the purpose of assessment and/or management**
- 4. Establish plans for timely follow-up and appropriate consultation**
- 5. Actively participate, as an individual and as a member of a team, in the continuous improvement in healthcare and patient safety**

Communicator

As communicators, physicians/internists form relationships with patients and their families that facilitate the gathering and sharing of information essential for exemplary healthcare. Physicians/internists are able to:

- 1. Establish professional therapeutic relationships with patients and their families**
- 2. Elicit and synthesise accurate and relevant information along with the perspectives of patients and their families**
- 3. Engage patients and others in developing plans that reflect the patient's health care needs and goals**
- 4. Document and share written and electronic information about the medical encounter to optimize clinical decision-making, patient safety, confidentiality, and privacy**

Collaborator

As collaborators, physicians/internists work effectively with other health care providers to provide the best standard of patient care.

As collaborators, physicians/internists are able to:

- 1. Work effectively with other physicians and other healthcare professionals**
- 2. Work in multidisciplinary healthcare teams to prevent misunderstandings, manage differences, and resolve conflict**
- 3. Effectively and safely hand over care to an appropriate health care professional**

Leader

As leaders, physicians/internists develop, in collaboration with other healthcare leaders, a vision of a high-quality healthcare system and take responsibility for effecting change to move the system toward the achievement of that vision.

As leaders, physicians/internists are able to:

- 1. Contribute to the improvement of healthcare delivery in healthcare teams, organisations, and systems**
- 2. Engage in the stewardship of healthcare resources**
- 3. Demonstrate leadership in professional practice**
- 4. Manage their practice and career**

Healthcare advocate

As health advocates, physicians/internists responsibly apply their expertise and influence to improve health by working with the patients, communities, or populations that they serve to determine and understand their needs, to develop partnerships, to speak on behalf of others when needed, and to support the mobilisation of resources to effect change.

As healthcare advocates, physicians/internists are able to:

- 1. Respond to individual patients' complex health needs by working with them in the clinical or outpatient environment**
- 2. Respond to the needs of a community or population that they serve by working with them to achieve system-level change**

Scholar

As scholars, physicians/internists demonstrate a lifelong commitment to excellence in practice through continuous learning, the teaching of others, the evaluation of evidence and other resources, and contributions to scholarship.

As scholars, physicians/internists are able to:

- 1. Engage in their continuous improvement and professional development through on going learning**
- 2. Facilitate the learning of students, trainees, other healthcare professionals, the public, and other stakeholders**
- 3. Integrate best available evidence, contextualised to specific situations, into real-time decision-making**
- 4. Critically evaluate the integrity, reliability, and applicability of health-related research and literature**
- 5. Contribute to the dissemination and/or creation of knowledge and practices applicable to health**

Professional

As professionals, physicians/internists are committed to the healthcare and well-being of individual patients and society through ethical practice, high personal standards of behaviour, commitment to the profession, profession-led regulation, and maintenance of personal health.

As professionals, physicians/internists are able to:

- 1. Demonstrate a commitment to patients by applying best practices and adhering to high ethical standards**
- 2. Demonstrate a commitment to society by recognising and responding to the social contract in health care**
- 3. Demonstrate a commitment to the profession by adhering to standards and participating in physician-led regulation**
- 4. Demonstrate a commitment to physician health and well-being to foster optimal patient care**

1.3 Specific areas of expertise

In addition to the above described roles there are specific areas of expertise where internists have to take the lead to address current and future healthcare needs.⁴

a. Multi-morbidity and ageing.

In an ageing European population, the number of patients with chronic disease and complex medical needs is steadily increasing.⁸ This is a challenge, now and will be in future years, in the European society where patients may have several diseases requiring treatment at the same time that may result in polypharmacy. This requires a generalist rather than a specialist approach and places the internist in a prominent and vital coordinating role. Older complex frail patients with significant co-morbidity may also benefit from close collaboration with and contribution from Geriatric Medicine services.

b. Acute care.

Internists need to be capable of managing common medical emergencies. They should be familiar with the triage of acutely ill patients. They should acquire and maintain skills in basic and advanced life support. They should be able to lead in the emergency setting with the prime responsibility of integrating the acute care provided by the acute care hospital healthcare team.¹³

c. Medical consultation.

Internal medicine is increasingly a medical speciality that supports other medical specialists who perform highly sophisticated and often invasive procedures in patients with multi-morbidities and complex needs. One consultant is generally needed to coordinate and integrate the care provided by these healthcare teams. The internist is particularly effective in this role.¹⁴

d. Shared decision-making.

It is an internist's responsibility to respect the autonomy of patients and help to empower them to make informed decisions about their treatment. Internists are especially qualified to support patients and, often, their families or representatives to reach informed decisions.^{15, 16, 17}

e. Collaborative care.

Internists assume responsibility for the comprehensive medical care of all patients who need such an approach. This is a patient-centred approach rather than a disease-specific one. Internists are particularly qualified to guarantee quality medical care for patients with a combination of health problems, multi-organ and systemic diseases and undetermined health problems. They are best prepared to coordinate the care of patients with multiple chronic conditions. Today, most medical care relies on teamwork. Internists possess the

necessary skills for leading and coordinating multidisciplinary teams and for collaborating with other medical specialists as needed to provide the best integrated care.¹⁸ The complex frail elderly patient is especially at risk so it is of paramount importance that sufficient care is given to this process.¹⁹

f. Transition of Care

The transition of younger patients from paediatrics to adult services is a dynamic active process that requires joined-up collaboration between the medical and allied healthcare professionals and patient associations. The internist should undertake the necessary training and develop the skills, attitudes, and values to deliver services amenable to young adults or any others requiring it. Transition of care should be monitored and evaluated to aid future development. The transition of care from a hospital to other appropriate safe environments for all patients should remain the internist's responsibility.

g. Vulnerable Adult

The vulnerable patient may be elderly, may have dementia, and/or psychiatric or complex physical disorders, and/or adverse financial and social circumstances. An acute illness resulting in hospital admission can heighten these frailties. The healthcare professional should aim to represent the best interests of the patient. The design and delivery of services will also consider the specific needs of the most vulnerable patients and those known to have poorer levels of access and outcomes. The delivery of dignified and patient-focused care in a safe clinical environment should always be one of the objectives of the internist.²⁰

h. Patient safety and quality of care.

Internists are aware of their responsibility towards society. If this responsibility leads to conflicts in decision making, they must endeavour to find evidence-based solutions. Internists are committed to lifelong learning and maintenance of the skills necessary for the provision of high standards of care. Internists are committed to the promotion and critical assessment of new medical knowledge and the implementation of scientific information and technology. Internists prioritise patient safety, improve standards of care and diminish barriers to health services.^{21, 22, 23}

i. Medical Leadership.

Internists are well-versed in the unique features of the integrated nature of their profession and require a multidisciplinary approach and teamwork. The internists' broad-based knowledge and skills make them best suited for leadership in the application of evidence-based and cost-effective strategies for the prevention, diagnosis and treatment of complex medical conditions.²⁴

1.4 Clinical Presentations and Diseases

Thus far, the curriculum has described the generic competencies required to practise internal medicine in a patient-centred manner. The definition of knowledge-based competencies is equally important. Appendix C lists common clinical presentations that internists should be able to manage. This does not avoid the need to have solid knowledge about specific medical conditions. This knowledge is founded in undergraduate education and related basic sciences.

The clinical presentations are divided into two categories:

- clinical presentations and diseases that each internist should be able to diagnose

- and treat independently and possess appropriate knowledge of the prognosis and likely response to therapy
- clinical presentations and diseases for which the internist should be able to initiate a diagnostic and therapeutic plan, but where (sub)specialty consultation or referral is warranted

It is duly noted that no list will ever be finite and all conditions and diseases that are listed have either a high enough prevalence or a high enough acuity that means they should be recognised. The environments in which these competencies are to be attained may range from the community and the out-patient clinic to the in-hospital and acute care setting. The list is a guideline to the topics that will form the basis for assessment.

1.5 Procedures

As exemplified by the recent EBIM survey on internal medicine practice,⁵ current clinical practice of procedures varies widely between countries and hospitals. The working group has placed the procedures into two categories:

- essential procedures which internists must be able to do
- desirable procedures which internists may require supervision when doing

Procedures that are commonly performed in more than 50% of countries have been classed as essential and the others as desirable (see Appendix C). The question is often raised as to why an internist should learn procedures during training when he or she may not continue to perform them in their future careers. Learning procedures gives context to the internist's training and improves his/her ability to understand them and apply them to clinical medicine.

1.6 Assessment

“The intended output of a competency-based programme is a health professional who can practise medicine at a defined level of proficiency, in accord with local conditions, to meet local needs.” World Health Organisation (1978):²⁵

At the conclusion of the training programme, the proficiency of a trainee to practise as an internist should be established. To be confident that a trainee has acquired the necessary competencies, developmental progression during training should be monitored and assessed. To this end, milestones and linked entrustable professional activities (EPAs) have been provided to guide decisions about which professional activities have become entrustable during and at the completion of training; such decisions are based on multiple (specific and observable) workplace based assessments (WBA's) carried out using a range of assessment tools over time; the acute admission to a medical unit is an example of a particularly important milestone in the progression of the trainee towards independence that can be entrusted with an EPA.

a. Milestones

Milestones will be used to mark the progression of competence from the onset of medical training through advanced practice. Milestones reflect the expected ability of a health professional at a given stage of expertise. They provide clearly defined targets to guide authentic learning and assessment. Milestones serve as a framework to inform and guide the development of the curriculum, the choice of assessment methods and instruments, and assessment by the supervising body.

The milestones of internal medicine are a learning road map, a “palette” of competency statements to be embedded in the local curriculum. Each milestone is framed as an observable behaviour to facilitate criteria-based assessment of competence. They must be set in a clinical context to make them meaningful and should, therefore, be mapped to the purpose and objectives of each rotation. This enables trainees/internists to focus their learning activities more effectively. It enables assessors (and programmes) to know when a trainee/internist has achieved a given milestone or set of milestones and is truly ready to move to the next stage of development.

It is not anticipated that each and every one of these milestones will be used explicitly for every trainee/internist over the course of his or her development. Milestones also do not define the complete spectrum of internal medicine as a specialty. Rather, they are key elements of a larger “whole” of clinical competence. Substantial professional judgment, on the part of the supervising body is still required to assess a trainee’s/internist’s overall fitness to practice.

Milestones for internal medicine years 2 and 5ⁱⁱⁱ are provided in Appendix D. After completion of 2 years of an internal medicine training programme, the trainee/internist should have achieved competency in the basic areas of internal medicine as defined by the milestones of year 2 and linked EPAs. This important stage of the training process also represents the completion of **the common trunk** for trainees in other medical specialties.

The end of year 5 completes the minimum duration of a training programme in internal medicine and the trainee should have achieved the competences of an internist as defined by the milestones of year 5 and should be entrusted according to the linked end of training EPAs.

b. Entrustable Professional Activities (EPAs)²⁶

EPAs place competencies in the physician’s every day work. They consist of daily professional activities, namely a set of tasks that internists perform in their clinical role, that lead to some outcome that can be observed e.g. running an outpatient diabetic clinic, taking care of a specific group of patients in a ward etc. The complexity of these activities requires an integration of knowledge, skills and attitudes across (several) competency domains. The assessment system is then tailored towards measuring entrustment of specific internal medicine practice activities.

The following criteria are suggested for EPAs which:

- are part of essential professional work
- require specific knowledge, skills and attitude
- are generally acquired through training
- lead to recognised output of professional labour
- are usually confined to qualified staff
- are independently executable within a time frame
- are observable and measurable in their process and their outcome
- lead to a conclusion (done well or not done well)
- reflect the competencies to be acquired

ⁱⁱⁱ Where a specific milestone for the acquisition of a competency is not specified for a given stage, it should be assumed that earlier milestones for that competency still apply.

There is typically overlap in many of the curricular milestones and, therefore, it is not necessary to choose every potential milestone when constructing an assessment for an EPA. The milestones and competencies chosen should be tailored to the specific training programme based upon the local resources, rotation structure, and existing culture. More importantly, both trainees and supervisors should develop a “shared mental model” of the desired performance through group conversations about expectations.

EPAs help to make formal entrustment decisions through direct observation of pre-determined tasks and not random aspects of performance. EPAs are summative assessments and it is necessary for trainees to be entrusted with particular EPAs as they progress through training. One should keep in mind, however, that EPAs are not set to assess every professional activity that trainees engage in; rather they assess a representative sample of the professional activities in which trainees /internists must attain competence.

How many EPAs should there be in the curriculum?

EPAs are broad responsibilities that may, however, include smaller ones. For a broad specialty such as internal medicine, this could mean hundreds of EPAs over the course of training. Therefore a list of 40 comprehensive EPAs is provided, each of which can be viewed as consisting of smaller, more elementary EPAs, and serves as an example²⁷ (appendix E). EPAs should be identified in each (local) training programme and should represent a set of tasks that the trainee/internist should perform during training. It is suggested that all EPAs should follow a common template (Appendix F). An example of how to build assessments for end-of-training EPAs, is provided by the Alliance for Academic Internal Medicine.²⁸ The total number or sets of EPAs to be used in a training programme should be decided at a national level. A limited number of carefully selected EPAs is recommended, for example 12-16.

2. Organisation of training

2.1 Schedule of training

According to the EU-directive 2005/36 /EC the minimum requirement of training to be recognised as an internist is 5 years.

a. Common trunk in internal medicine

As already mentioned, internal medicine is a core medical specialty that forms the foundation for many other medical specialities, and in accordance with the aforementioned Chapter 6 (amended in 2008), the following has been agreed. At least 2 years of continuous common trunk training in internal medicine - in the first two years of a postgraduate training programme - is essential to give the necessary breadth of experience for physicians proceeding to train in any medical specialty that stems from internal medicine. These principles have been agreed by the specialist sections of the UEMS, the UEMS council and by the scientific societies of the different specialties in Europe²⁹. This duration of training in internal medicine is considered necessary in view of the demographic changes of the population with increasing numbers of elderly patients affected by multiple conditions. Trainees who complete a common trunk in internal medicine followed by training in another specialty will only qualify for certification in that specialty.

The first two years of training in internal medicine and the common trunk for other specialties arising from internal medicine are essentially the same, and preferably, do not

involve training in the chosen (final) specialty, if applicable.

b. Dual certification in internal medicine and another specialty related to internal medicine

In order to attain certification in both internal medicine and another internal medicine related specialty (known as dual certification) a minimum duration of 5 years postgraduate training in internal medicine is required. Training in both specialties can partly occur concurrently, which may shorten the total duration to 7 or 8 years. This is based on exemptions from part of the training requirements in national legislations, according to Directive 2013/55/EU, amending Annex V of Directive 2005/36/EC on the recognition of professional qualifications. However, required competencies must be achieved before completion of training.

2.2 Programme

The training in internal medicine and other medical specialties comprises a 2-year common trunk followed by a minimum period of 3 years to become certified in internal medicine. The aim of the common trunk, as defined by the corresponding milestones, is to ensure that the necessary fund of knowledge and skills for diagnosis and treatment of common medical problems and the management of acute medical emergencies will be obtained. The minimum proposed for the duration of the rotations for the common trunk is 4 months.

Here is an outline of how a typical 24 month common-trunk programme in internal medicine may look (the order and the programme of the rotations is neither prescriptive, nor exhaustive):

- 6 months in an emergency ward or an acute medical unit
- 4 months in an intensive care unit or high-dependency care unit
- 6 months in ambulatory care (outpatients and/or day care)
- 8 months in an inpatient internal medicine service (which may include, if necessary, rotations in different specialties, preferably excluding the specialty of final choice, if applicable)

The following 3 years of training in internal medicine are organised in 4 to 6 month rotations. All medical specialties within the scope of practice of internal medicine are eligible for inclusion. The training should comprise different settings depending on the local organisation of health services and may include any combination of in-hospital care, emergency care, outpatient clinics and community health services. Also, research or medical education and participation in an exchange programme can be considered, but these are not mandatory.

The individualised training programme should be mutually agreed upon by the trainee and the training programme director.

2.3. The assessment system and the entrustment process³⁰

The purpose of the assessment system is to facilitate learning by providing formative feedback, to drive the training process by identifying what areas the trainees/internists should subsequently focus on to improve their performance. The assessment system

should provide robust evidence that trainees/internists meet the training requirements detailed in the curriculum.

Assessment and documentation of skills comprises knowledge-based assessments, workplace-based assessments and a logbook.

A portfolio is used to document the achievements and the progress of the trainee throughout the training period.³¹ Progress is guided by the milestones reached and the linked EPAs. Twice a year, progress of trainees is monitored by a synthesis of assessments (summative feedback) obtained during rotations to ensure that enabling competencies are acquired at a desired stage and are sustained and developed further through subsequent rotations.

To entrust a clinical activity as described in an EPA, the educational supervisor draws on all the available data regarding a trainee's/internist's competence in that particular task, including his or her performance in relevant workplace-based assessments (WBAs) and information from other staff or sources (multisource feedback).

To ensure a broad evidence base, a minimum of three WBAs must be used to assess each EPA. This does not mean that a trainee must complete three WBAs on the same activity as that of the EPA. Training environments are clinically diverse so WBAs on any aspect of a task relevant for a particular EPA but linked to another clinical activity may thus be extrapolated to be valid for that EPA as well.

Workplace-based assessments (WBAs) include:

-Case-based discussion

-Observed clinical activity:

- patient-encounter (mini-clinical evaluation exercise or Mini-CEX)
- medical record review
- hand-over
- morning report
- on-call service
- ward rounds
- patient presentation (grand round, multidisciplinary meeting i.e. oncology)
- direct observation of procedural skills (DOPS)

In addition other assessments, which may inform the entrustment process may include:

-Professional presentation:

- Critical appraisal
- Journal club
- Scientific meeting

-360 degree feedback (multisource feedback)

-Objective structured clinical examinations (OSCE)

The degree of supervision (see below) determines the decision to entrust the trainee. Entrustment is awarded when the assessor determines the trainee can perform the EPA without direct supervision i.e. level 4. Entrustment of professional activities is documented in a portfolio.

The levels of supervision are:

1. Observation but no execution, even with direct supervision
2. Execution with direct, proactive supervision
3. Execution with reactive supervision, i.e. on request and quickly available
4. Supervision at a distance and/or post hoc
5. Supervision provided by the trainee to more junior colleagues

Conversely, entrustment concerns are reflected by “increased oversight”. This is a general strategy supervisors frequently use to manage concerns if patient safety is at risk. Oversight may include double-checking or monitoring more closely the work of trainees/internists, or, in extreme cases, assuming direct control over patient care.³² Supervision levels other than the above mentioned are admissible, if they are comparable and their compatibility is defined.

Clinical Examinations

The assessments of clinical skills at 2 and 5 years should be covered by the EPAs, but each national authority decides if a formal clinical examination should be part of the qualification process.

Knowledge-based assessment (KBA)

During the whole training period the trainee has to undertake at least two KBA on all topics relevant to internal medicine (e.g. haematology, oncology, infectious diseases, gastroenterology, and acute medicine etcetera); there will be one exam at the end of year two and one in the final year of the training programme. The type of exam is up to each national authority.

European Diploma of Internal Medicine

Other specialty boards have successfully established European examinations that are accepted as requirements for certification or accepted as an equivalent. It is anticipated that the development of a European Diploma of Internal Medicine will be developed in due course following the introduction of this curriculum.

Recertification

At present, recertification follows the rules set by each national authority. In due course general rules applicable to all European countries should be agreed.

2.4 Governance

Each national competent authority should:

- Work with its respective internal medicine society and its doctors’ professional union to provide quality assurance of training in internal medicine.
- Approve opportunities for trainees/internists to undertake part of their training in recognised training institutions in other member states of the EU as well as outside the EU.
- Consider previous training in internal medicine (or other medical speciality) in another European country in the evaluation of the total duration of training in internal medicine. Ensure that a formal assessment by the current training institution is part of this process.
- Determine a process for the selection and appointment of trainees in internal medicine. Entry criteria should be the minimum of a nationally recognized qualification, either a medical degree or completion of a compulsory foundation

training.

- Implement regulation of access to training in internal medicine in accordance with national manpower planning projections in the EC member state.
- Ensure close involvement of trainers, training institutions and any other responsible bodies to select and appoint trainees who are suitable for internal medicine in accordance with the established selection procedure.
- Ensure this selection procedure to be transparent and open to all persons who have at least completed medical undergraduate education.
- Decide when an applicant meets the entry criteria for specialty training in internal medicine.
- Ensure that assessment and certification during training is transparent, that both trainee and trainer have agreed responsibility and accountability, and that there is a possibility of appeal by a defined procedure.

II. TRAINING REQUIREMENTS FOR TRAINERS

The director of the training programme must be certified in internal medicine, have practised internal medicine for at least 5 years after specialist certification and possess the proper educational, organisational and leadership qualities. Ample dedicated time must be devoted to daily management of the training programme and adequate administrative support should be provided. The programme director is responsible for creating a safe and prosperous learning environment.

All trainees should have an educational supervisor responsible for overseeing their education. The educational supervisor must be certified in internal medicine. He or she should meet regularly with the trainee and assess progress and professional development, ensure that there is an appropriate balance between service and training, ascertain that necessary assessments are carried out and provide support and advice regarding professional development. Educational supervisors should be familiar with the use of modern assessment tools, how to support trainees in difficulty and how to give effective feedback, including objective setting and career advice.

All physicians practicing in a teaching hospital should recognise their responsibility to participate in the postgraduate training of future physicians. A clinical supervisor (trainer) should be familiar with all aspects of the internal medicine curriculum as it relates to practice within his or her country, experienced in teaching, skilled in identifying and meeting the needs of trainees, able to recognise trainees whose professional behaviours are unsatisfactory and initiate supportive measures. Teaching activities must be included in the work schedule of trainers. There should be a minimum number of internists on the staff to ensure adequate supervision of trainees. Furthermore, staff policy should include support for trainers and offer courses or workshops on the principles and practice of medical education. The policy on appointment of trainers, supervisors and teachers must specify the expertise required and their responsibilities and duties.

III. TRAINING REQUIREMENTS FOR TRAINING INSTITUTIONS

The European Board of Internal Medicine has developed guidance³ for the accreditation process for training centres, which is based on standards produced by the World Federation for Medical Education.³³

Training institutions offering postgraduate education in internal medicine should be recognised and accredited by the national competent authority. An organised training programme under the leadership of a programme director must be in place and the mission and outcome objectives must be clearly defined.

Postgraduate training in internal medicine should generally be carried out in university hospitals or affiliated teaching hospitals, while part of the training rotation may take place in general hospitals and/or the community. The teaching institution must possess the infrastructure to provide training in internal medicine. This must include a diverse and sufficiently large inpatient and outpatient service, adequate teaching staff,

conference rooms and office space for trainees to ensure a proper learning environment. The training programme director and postgraduate education and training committee are responsible for the organisation and management of the training programme. Each training institution should have an internal system of medical audit or quality assurance, including a mortality review process for reporting adverse events.

The selection and appointment of trainees should be in line with a policy established by the national competent authority, and the selection process must be transparent. The number of training positions must be in accordance with the resources of the training centre. The work delivered by trainees must comply with the European Working Time Directive. Part-time training should be allowed; duration of training should be extended accordingly.

The curriculum should be delivered through a variety of learning experiences. The foundation of postgraduate education in internal medicine is practice-based training in conjunction with formal teaching sessions with the aim of integrating theory and clinical activities. The trainees should be given opportunities for self-directed learning and professional development. The main goals and outcomes must be clearly outlined. To this purpose the learning objectives and milestones should be applied according to local circumstances. There must be an appropriate balance between teaching and service provided by trainees. The structure of rotas and on-call schedules should consider the needs of patients, continuity of care and the educational needs of the trainee.

There should be appropriate levels of clinical supervision throughout the training period with increasing clinical independence and responsibility. A system for support, counselling and career guidance of trainees must be in place.

Comprehensive assessment of trainees and documentation of their progress must be an integral part of the training programme. The use of diverse assessment methods and tools is recommended (see above).

At the national level a standardised process of assessments should be in place. There should be a formal ruling in regard to completion of training and fulfilment of all training requirements.

Furthermore, training centres should undergo monitoring by the national competent authority at least every five years based on well-defined criteria with emphasis on organisation and quality of the training process, facilities, appropriate assessment methods and measured outcomes such as trainee performance and qualification. Feedback from trainers and trainees must be incorporated in the review of the programme.

In Europe, a training centre can be recognised by the European Board of Internal Medicine, if the centre complies with the following:

- is recognised by the national competent authority as a formal training centre in internal medicine in that country
- has a training programme that is in accordance with the European curriculum of internal medicine described in this document

- submits a 5-yearly self-evaluation of the training programme according to certification guidelines (to be developed)
- submits the training programme and its assessment system for approval by EBIM

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Appendix A

Curriculum Working Group

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Head and Chairman of Medicine, University Hospital Groningen, University Medical Center Groningen, The Netherlands; Chairman of Program Directors of Internal Medicine in the Netherlands; President of the UEMS Section of Internal Medicine; Vice-president European Board of Internal Medicine.

Dr W. Bauer

President of European Board of Internal Medicine,; Member of the UEMS section of Internal Medicine; Past President of EFIM, President Swiss Institute of Education (SIWF); Lecturer in Internal Medicine, University of Zurich Medical School.

Prof Dr I Bruckner

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Dr M Cranston

Consultant in Acute Medicine at NHS; Member EFIM Young Internists Assembly.

Dr JWF Elte

Associate Secretary of EFIM; Past Secretary General of EFIM; Past Treasurer Netherlands Association of Internal Medicine (NIV); Past Member of the UEMS Section of Endocrinology/European Board of Endocrinology.

Dr CA Higgins

Secretary of the UEMS Section of Internal Medicine; Clinical Director and Consultant, Northwest London Hospitals NHS Trust; Director of Medical Education, North West London NHS Trust.

Prof Dr R Palsson

President-Elect EFIM; Vice-President UEMS Section of Internal Medicine; Chief, Division of Nephrology, Landspítali - The National University Hospital of Iceland; Professor of Medicine, University of Iceland.

Dr MS Slee-Valentijn

Past Board member of the Young Internists Assembly; Past President of the Netherlands Young Internists Association.

Appendix A2

List of full EFIM/UEMS country members:

Algeria	Iceland	Romania
Austria	Ireland	Serbia
Belgium	Italy	Slovakia
Cyprus	Latvia	Slovenia
Czech Republic	Lithuania	Spain
Estonia	Malta	Sweden
Finland	Netherlands	Switzerland
France	Norway	United Kingdom
Germany	Poland	
Greece	Portugal	

Nations not full member of both EFIM and UEMS:

	EFIM	UEMS	EFIM assoc. member	UEMS assoc member	UEMS observer
Bulgaria		+			
Armenia				+	
Croatia				+	
Luxembourg		+			
Denmark		+			
Ukraine				+	
Serbia	+				+
Russia	+				+
Albania	-	-	-	-	-
Israel	+			+	
Turkey	+			+	
Algeria			+		
Morocco			+		+
Tunisia			+		+

Appendix B CanMeds Competency Framework adapted to Internal Medicine

Medical Expert

As medical experts, physicians/internists integrate all of the Can MEDS roles and apply medical knowledge, clinical skill, and a professional attitude when providing high-quality, safe patient-centred care. The medical expert is the central role of the physician/internist in the Can MEDS framework and defines the physician's/internist's clinical scope of practice.

As medical experts, physicians/internists are able to:

1. Practise medicine within the clinical scope of practice and expertise of internal medicine

- 1.1 Demonstrate a commitment to high-quality care of their patients
- 1.2 Integrate the Can MEDS intrinsic roles into the practice of medicine
- 1.3 Apply knowledge of the clinical and biomedical sciences relevant to internal medicine
- 1.4 Perform an appropriately timed consultation, presenting well-documented assessments and recommendations in written and/or oral form
- 1.5 Carry out professional duties in the face of multiple, competing demands
- 1.6 Recognise and respond to the complexity, uncertainty, and ambiguity inherent in medical practice

2. Perform a patient-centred clinical assessment and establish management plans

- 2.1 Identify and prioritise issues to be addressed in a patient encounter
- 2.2 Elicit a history, perform a physical examination, select investigations, and interpret the results for the purpose of diagnosis and management, disease prevention, and health promotion
- 2.3 Establish outcomes of care with the patient and his or her family, which may include slowing disease progression, achieving recovery, improving functions, treating symptoms, and palliative care
- 2.4 Establish a patient-centred management plan

3. Plan and perform interventions for the purpose of assessment and/or management

- 3.1 Determine indicated interventions for the purpose of assessment and/or management
- 3.2 Obtain and document informed consent, explaining the risks and benefits of, and the rationale behind, the options discussed
- 3.3 Triage interventions, taking into account clinical urgency, the potential for deterioration, and available resources
- 3.4 Develop and implement a plan incorporating the degree of clinical uncertainty and the expertise of team members individually and as a whole
- 3.5 Perform the intervention in a skilful and safe manner, adapting to findings or changing clinical circumstances
- 3.6 Establish and implement a plan for both pre- and post-procedure care

4. Establish plans for timely follow-up and appropriate consultation

- 4.1 Establish the roles of the patient and all team members when following up investigations, the effects of treatment, and consultations, and ensuring that the agreed follow-up plan occurs
- 4.2 Recognise when care should be transferred to another physician or healthcare provider

5. Actively participate, as an individual and as a member of a team, in the continuous improvement in healthcare and patient safety

- 5.1 Recognise and respond to adverse events and near misses
- 5.2 Seek opportunities to provide the best standard of care
- 5.3 Contribute to a culture that promotes continuous improvement in standards of healthcare and patient safety
- 5.4 Describe how human and system factors influence decision-making and the provision of patient care
- 5.5 Engage patients and their families in the continuous improvement in standards of healthcare and patient safety

Communicator

As communicators, physicians/internists form relationships with patients and their families that facilitate the gathering and sharing of information essential for exemplary healthcare.

As communicators, physicians/internists are able to:

1. Establish professional therapeutic relationships with patients and their families

- 1.1 Communicate using a patient-centred approach that encourages patient trust and autonomy and is characterised by empathy and respect
- 1.2 Optimise the physical environment for comfort, dignity, privacy, engagement, and safety of the patient
- 1.3 Recognise when the values, bias, or perspectives of patients, physicians, or other healthcare providers may affect quality of care and modify the approach to the patient appropriately
- 1.4 Respond appropriately to patients' non-verbal communication and display appropriate non-verbal behaviour to enhance communication with patients
- 1.5 Manage emotionally charged conversations and conflicts
- 1.6 Adapt to the unique needs and preferences of each patient and to his or her clinical condition and circumstances

2. Elicit and synthesise accurate and relevant information along with the perspectives of patients and their families

- 2.1 Use effective patient-centred interviewing skills to identify and gather relevant biomedical information
- 2.2 Manage the flow of a physician–patient encounter
- 2.3 Enquire about and explore the patient's beliefs, values, preferences, context, expectations, and outcomes in regard to his or her state of health
- 2.4 Seek out and synthesise, with the patient's consent, relevant information from other sources, including the patient's family

3. Engage patients and others in developing plans that reflect the patient's healthcare needs and expected outcomes

- 3.1 Provide explanations that are clear, accurate, and adapted to the patient's needs and ability to understand
- 3.2 Share information that is timely, accurate, and transparent/open in regard to the patient's health status, care, and outcome
- 3.3 Engage patients in a way that is respectful, non-judgmental, and ensures cultural safety
- 3.4 Assist patients and others to identify and make use of information and communication technologies to support their care and manage their health
- 3.5 Use counselling skills and decision aids to help patients make informed choices regarding their care
- 3.6 Disclose adverse events to patients and/or their families accurately and appropriately

4. Document and share written and electronic information about the medical encounter to optimise clinical decision-making, patient safety, confidentiality, and privacy

- 4.1 Document clinical encounters in an accurate, complete, timely, and accessible manner to comply with legal and regulatory requirements
- 4.2 Communicate effectively using electronic medical records or other digital technology
- 4.3 Share information with patients and appropriate others in a manner that respects patient privacy and confidentiality

Collaborator

As collaborators, physicians/internists work effectively with other healthcare providers to provide the best standard of patient care.

As collaborators, physicians/internists are able to:

1. Work effectively with other physicians and other healthcare professionals

- 1.1 Establish and maintain healthy working relationships in multidisciplinary healthcare teams for collaborative care
- 1.2 Negotiate overlapping and shared responsibilities in multidisciplinary healthcare teams for episodic or on-going care of patients
- 1.3 Engage in effective and respectful shared decision-making with other care providers

2. Work in multidisciplinary healthcare teams to prevent misunderstandings, manage differences, and resolve conflict

- 2.1 Demonstrate a respectful attitude towards other colleagues and members of a multidisciplinary healthcare team
- 2.2 Work with others to prevent conflict
- 2.3 Use collaborative skills to resolve conflict
- 2.4 Respect differences, misunderstandings, and limitations in others
- 2.5 Recognise one's own differences, misunderstandings, and limitations that may contribute tension among colleagues in multidisciplinary healthcare teams
- 2.6 Reflect on objectives of the multidisciplinary healthcare team

3. Effectively and safely hand over care to an appropriate healthcare professional

- 3.1 Demonstrate effective and safe handover during transfer of a patient to a different setting or level of care
- 3.2 Demonstrate effective and safe handover during transfer of responsibility for care

Leader

As leaders, physicians/internists develop, in collaboration with other healthcare leaders, a vision of a high-quality healthcare system and take responsibility for effecting change to move the system toward the achievement of that vision.

As leaders, physicians/internists are able to:

1. Contribute to the improvement of healthcare delivery in healthcare teams, organisations, and systems

- 1.1 Demonstrate personal responsibility for improving patient care
- 1.2 Contribute to quality improvement and patient safety using the best available knowledge and practices
- 1.3 Engage others to work collaboratively to improve systems of patient care
- 1.4 Use and adapt systems to learn from adverse events and near misses
- 1.5 Use health informatics to improve the standard of patient care and optimise patient safety

2. Engage in the stewardship of healthcare resources

- 2.1 Allocate healthcare resources for optimal patient care
- 2.2 Apply evidence and management processes to achieve cost-appropriate care
- 2.3 Contribute to strategies that improve the value of healthcare delivery

3. Demonstrate leadership in professional practice

- 3.1 Develop leadership skills
- 3.2 Facilitate change in healthcare to enhance services or outcomes
- 3.3 Design and organise elements of healthcare delivery

4. Manage their practice and career

- 4.1 Set priorities and manage time to balance practice and personal life
- 4.2 Manage career planning, finances, and human resources in a medical practice
- 4.3 Implement processes to ensure personal improvement in practice

Healthcare Advocate

As healthcare advocates, physicians/internists responsibly apply their expertise and influence to improve health by working with the patients, communities, or populations that they serve to determine and understand needs, to develop partnerships, to speak on behalf of others when needed, and to support the mobilisation of resources to effect change.

As healthcare advocates, physicians/internists are able to:

1. Respond to individual patients' complex health needs by working with them in the clinical or outpatient environment

- 1.1 Work with patients to address factors that affect their health
- 1.2 Work with patients and their families to increase their opportunities to adopt healthy behaviour
- 1.3 Consider disease prevention, monitoring and promotion of activities beneficial to health when working with individual patients

2. Respond to the needs of a community or population that they serve by working with them to achieve system-level change

- 2.1 Use a process of continuous quality improvement that incorporates disease prevention and monitoring and promotion of activities beneficial to health
- 2.2 Work with a community or population to identify the factors that affect their health
- 2.3 Participate in a process to improve health in the community or population that they serve

Scholar

As scholars, physicians/internists demonstrate a lifelong commitment to excellence in practice through continuous learning, the teaching of others, the evaluation of evidence and other resources, and contributions to scholarship.

As scholars, physicians/internists are able to:

1. Engage in their continuous improvement and professional development through on-going learning

- 1.1 Develop, monitor, and revise a personal learning plan to enhance professional practice
- 1.2 Regularly analyse their performance, using various data and other sources to identify opportunities for learning and improvement
- 1.3 Engage in collaborative learning to continuously improve personal practice and contribute to collective improvement in practice

2. Facilitate the learning of students, residents, other healthcare professionals, the public, and other stakeholders

- 2.1 Recognise the power of role-modelling and the impact of the hidden curriculum on learners
- 2.2. Promote a safe learning environment
- 2.3. Ensure that patient safety is maintained when learners are involved
- 2.4. Collaboratively identify the learning needs of others and prioritise learning outcomes
- 2.5. Demonstrate effective teaching to facilitate learning
- 2.6. Seek and provide meaningful feedback
- 2.7. Use assessment tools and practices that are appropriate to a given learning context

3. Integrate best available evidence, contextualised to specific situations, and integrate it into real-time decision-making

- 3.1 Recognise uncertainty and knowledge gaps in clinical and other professional encounters and generate focused questions that can address them
- 3.2 Demonstrate proficiency in identifying, selecting, and navigating pre-appraised resources
- 3.3 Integrate evidence into decision-making

4. Critically evaluate the integrity, reliability, and applicability of health-related research and literature

- 4.1 For a given professional scenario, formulate scholarly questions using a structure that encompasses the patient or population, intervention, comparison, and outcome (PICO)
- 4.2 Identify one or more studies or scholarly sources that shed light on a given professional question
- 4.3 Interpret study findings, including a discussion and critique of their relevance to professional practice
- 4.4 Determine the validity and risk of bias in a wide range of scholarly sources
- 4.5 Describe study results in both quantitative and qualitative terms
- 4.6 Evaluate the applicability (external validity or ability to generalise) of evidence from a wide range of biomedical research products
- 4.7 Translate and apply the findings of studies into professional practice, and discuss the barriers and facilitators to achieving this
- 4.8 Identify and use automatic information-delivery services that highlight new evidence appropriate to their scope of professional practice

5. Contribute to the dissemination and/or creation of knowledge and practices applicable to health

- 5.1 Describe the principles of research and scholarly inquiry and their role in contemporary healthcare
- 5.2 Discuss and interpret the ethical principles applicable to health-related research
- 5.3 Discuss the roles and responsibilities of researchers, both principal investigators and research collaborators, and how they differ from clinical and other practice roles and responsibilities
- 5.4 Pose medically and scientifically relevant, appropriately constructed questions that warrant scholarly investigation
- 5.5 Discuss and critique the possible methods of addressing a given scholarly question
- 5.6 Summarise and communicate to professional and lay audiences, including patients and their families, the findings of relevant studies and reports

Professional

As professionals, physicians/internists are committed to the healthcare and well-being of individual patients and society through ethical practice, high personal standards of behaviour, commitment to the profession, profession-led regulation, and maintenance of personal health.

As professionals, physicians/internists are able to:

1. Demonstrate a commitment to patients by applying best practices and adhering to high ethical standards

- 1.1 Demonstrate appropriate professional behaviour and relationships in all aspects of practice, reflecting honesty, integrity, commitment, compassion, respect, altruism, respect for diversity, and maintenance of confidentiality
- 1.2 Demonstrate a commitment to excellence in all aspects of practice and to active participation in collaborative care
- 1.3 Recognise and respond to ethical issues encountered in practice
- 1.4 Recognise and manage conflicts of interest
- 1.5 Demonstrate professional behaviour in the use of technology-based communication

2. Demonstrate a commitment to society by recognising and responding to the social contract in healthcare

- 2.1 Demonstrate a commitment to the promotion of the public good in healthcare, including stewardship of resources
- 2.2 Demonstrate a commitment to maintaining and enhancing competence
- 2.3 Demonstrate a commitment to quality improvement and patient safety
- 2.4 Demonstrate accountability to patients, society, and the profession by recognising and responding to the societal expectations of the profession

3. Demonstrate a commitment to the profession by adhering to standards and participating in physician-led regulation

- 3.1 Fulfil the professional and ethical codes, standards of practice, and laws governing practice
- 3.2 Recognise and respond to unprofessional and unethical behaviours in others
- 3.3 Commit to participation in peer assessment and standard-setting
- 3.4 Promote a culture of collegiality and respect, and maintain professional relationships

4. Demonstrate a commitment to physician health and well-being to foster optimal patient care

- 4.1 Demonstrate self-awareness and effectively manage influences on personal well-being and professional performance
- 4.2 Manage personal and professional demands for a sustainable practice through the physician life cycle
- 4.3 Promote a culture that recognises, supports, and responds effectively to colleagues in need

C.1 Presentations and Diagnosisⁱⁱ

Evaluation of patients with emergency presentations

All internists should be able to recognize and initiate management for serious and/or potentially life-threatening medical emergencies. Below is a compilation of commonly encountered emergencies but the list is neither exhaustive nor complete. The purpose is to guide trainees but the approach to each condition will depend upon the severity of the condition, the context of the patient and the access to specialist advice and services.

	INDEPENDENT DIAGNOSIS AND THERAPY	INITIAL DIAGNOSIS AND THERAPY TIMELY CONSULTATION AND/OR REFERRAL
Acute allergic reactions	Acute allergic reactions including anaphylaxis	
Acute coronary syndromes		Acute coronary syndrome/myocardial infarction
Arrhythmias	Supraventricular tachycardia	Ventricular tachycardia
Abdominal aortic aneurysm/aortic dissection		Imminent rupture of Abdominal Aortic Aneurysm/ suspect Aortic dissection
Arthritis	Gout and pseudo gout	Septic arthritis
Cardiopulmonary arrest	Advanced cardiac life support	
Hypertensive crisis		Hypertensive crisis
Meningitis		Meningitis
Sepsis	Sepsis	Recognise the need for consultation of Intensive care, intervention (surgery, drainage)
Other infections requiring emergency treatment	Pyelonephritis (male: consider referral to specialist) Pneumonia Gastroenteritis Spontaneous bacterial peritonitis	Septic arthritis Endocarditis Cholangitis
Gastrointestinal bleeding	Haematemesis, melaena, haematochezia	Endoscopic diagnosis and intervention depending on trainee
Hypotension and shock	Hypovolaemic shock Distributive shock (<i>sepsis, anaphylaxis</i>) Addisonian crisis	Cardiogenic shock Obstructive shock (cardiac tamponade, pulmonary embolism)
Stroke		Transient ischaemic attack/stroke
Seizures		Seizures
Syncope	Neurocardiogenic syncope Orthostatic syncope Micturition or defecation syncope Medication-induced syncope Hypoglycaemia Pulmonary embolism Hyperventilation, panic disorder Psychogenic syncope	Rhythm and conduction disturbances Myocardial infarction Cardiac tamponade Aortic stenosis Carotid sinus dysfunction Vertebro-basilar insufficiency Pulmonary hypertension
Serious acid-base and electrolyte disorders	Serious acid-base and electrolyte disorders Acute kidney injury (stage 1 and 2)	Acute kidney injury (stage 3) Chronic kidney disease (stage 4 and 5) Intoxication that need specific interventions
Sickle cell crisis	Sickle cell crisis	
Diabetic ketoacidosis and hyperosmolar hyperglycaemic state	Hyperglycaemia	Diabetic ketoacidosis and hyperosmolar hyperglycaemic state

Evaluation of patients with emergency presentations (cont.)	INDEPENDENT DIAGNOSIS AND THERAPY	INITIAL DIAGNOSIS AND THERAPY
		TIMELY CONSULTATION AND/OR REFERRAL
Pulmonary embolism	Pulmonary embolism	Obstructive shock due to pulmonary embolism
Hypoxaemia or acute respiratory distress	Heart failure Asthma Exacerbation of chronic obstructive pulmonary disease Pneumothorax (tension)	Hypoxaemia or acute respiratory distress Pneumothorax
Stupor or coma	Intoxication due to alcohol or substance use Hypoglycaemia Sepsis Post-ictal state	Intoxication requiring specific intervention (mechanical ventilation, haemodialysis) Acid-base and electrolyte disorders Diabetic ketoacidosis; hyperosmolar hyperglycaemic state Hypothyroidism Hepatic encephalopathy Meningitis Encephalitis Status epilepticus Stroke Subarachnoid haemorrhage Subdural hematoma Cerebral venous sinus thrombosis Hypercapnia Trauma Psychiatric disorder
Acute abdominal pain	Pancreatitis Diverticulitis	Complicated pancreatitis Complicated diverticulitis Peritonitis Ileus
Acute liver failure		Acute liver failure
Acute renal failure	Acute kidney injury (stage 1 and 2)	Acute kidney injury (stage 3)
Spinal cord compression		Spinal cord compression
Drug overdose or complications of misuse of drugs	Common intoxications Intoxication, unknown	Breathlessness Coma Shock Renal failure Hepatic failure Rhythm and conduction disturbances Caustic injury
Hypothermia	Cold exposure Drugs, alcohol, toxins Medication Endocrine causes	Severe burns, trauma Hypothalamic hypothermia Panhypopituitarism Sepsis
Hyperthermia		Thyroid storm

Evaluation of patients with common clinical presentations

All internists should be competent in performing initial evaluation of the adult patient with common presenting features of undiagnosed conditions, followed by differential diagnosis and generation of a tentative diagnosis.

All internists should be competent in the diagnosis and management of common and important disorders of internal medicine and related specialties. These include common chronic illnesses, particularly those that affect the aging population and common co-morbid conditions affecting patients who receive their care from either internists or other specialists.

	INDEPENDENT DIAGNOSIS AND THERAPY	INITIAL DIAGNOSIS AND THERAPY TIMELY CONSULTATION AND/OR REFERRAL
Presentations with general, non-specific symptoms		
Oedema	Heart failure Generalized oedema (hypoalbuminemia) Venous insufficiency Postthrombotic syndrome Oedema caused by medication Idiopathic or cyclic swelling Angioedema	Upper extremity thrombosis Pulmonary hypertension Cirrhosis or hepatic failure Inferior or superior vena cava syndrome Nephrotic syndrome Constrictive pericarditis Protein-losing enteropathy Lymphatic oedema
Fever	Upper and lower airway infection Urinary tract infection (female) Gastroenteritis Skin infection Abscess Soft tissue infection Nosocomial infection Diverticulitis Fever in travellers Viral infection Pyrexia of unknown origin	Septic shock Urinary tract infection in male Central nervous system infection Pyogenic spinal infection Epiglottitis, tonsillar-pharyngeal infection, complicated sinusitis Osteomyelitis Arthritis Fever in travellers including malaria, Dengue, Ebola Cholangitis Infected pancreatic necrosis Empyema Endocarditis Endovascular and device-related infection Infected prosthesis Tuberculosis Fever in systemic diseases Fever in immunocompromised host Periodic fever syndromes Paraneoplastic syndrome
Weight loss	Decreased calorific intake Medication-related Increased energy expenditure Hyperthyroidism/thyrotoxicosis	Malignancy Inflammatory bowel disease Malabsorption: pancreatic disease, coeliac disease Cardiac cachexia Pulmonary cachexia Chronic kidney disease Other endocrine disease Neurologic conditions Psychiatric and eating disorders Infections (viral, bacterial, fungal and parasitic) Systemic disease

Weight gain	Obesity Hypothyroidism Medication-related	Cushing's disease and syndrome Polycystic ovary syndrome Other endocrine diseases Neurologic and psychiatric disorders
Fatigue	Chronic fatigue syndrome Medication-related Post-infectious disease syndrome	Psychiatric disorders Sleep disorders, obstructive sleep apnoea syndrome Systemic disease
Polyuria	Osmotic diuresis Medication-related (e.g. mannitol, lithium) Polyuric phase after AKI	Central diabetes insipidus Nephrogenic diabetes insipidus
Pruritus	Urticaria Medication-related Infectious disease	Liver diseases Renal disease Pregnancy Haematologic diseases Paraneoplastic syndrome Autoimmune disease Metabolic disorders Psychiatric disorders

Physical Symptoms in Absence of Organic Disease

Somatoform disorders
Functional somatic disorders

Presentations with pain

Chest pain	Pneumonia Pulmonary embolism Pleurisy Intercostal neuralgia Tietze syndrome/Bornholm disease/costochondritis Gastro-oesophageal reflux disease Rib fracture	Angina, acute coronary syndrome Pericarditis/myocarditis Dissecting aortic aneurysm Pneumothorax Postherpetic neuropathy Malignancy
Abdominal pain ⁱⁱⁱ	Dyspepsia Irritable bowel syndrome Cystitis Chronic Pyelonephritis in a female Diseases of the abdominal wall Gastroenteritis Enterocolitis Peptic ulcer disease Pancreatitis Diverticulitis Porphyria Familial Mediterranean fever	Cholecystitis (Peri) hepatitis Chronic pancreatitis Appendicitis Complicated diverticulitis Pelvic inflammatory disease Peritonitis CAPD peritonitis Intestinal obstruction Acute and chronic mesenteric ischaemia Abdominal mass Inflammatory bowel disease Postoperative complication Acute surgical abdomen Peritoneal carcinomatosis C1 esterase inhibitor deficiency
Headache	Headache	

Presentations with pain (cont.)	INDEPENDENT DIAGNOSIS AND THERAPY	INITIAL DIAGNOSIS AND THERAPY TIMELY CONSULTATION AND/OR REFERRAL
Acute back pain	Lumbago Spondyloarthrosis Sciatica	Bone metastasis Spondylodiscitis Myeloma Radicular pain and radiculopathy
Limb pain and swelling	Venous thrombosis	Phlegmasia coerulea alba and dolens
	Superficial thrombophlebitis	
Chronic pain syndrome	Fibromyalgia	Complex regional pain syndrome
Presentations with selected organ system symptoms or problems		
Respiratory	Pneumonia Pulmonary embolism Hyperventilation Allergic rhinitis Asthma Chronic obstructive pulmonary disease	Unexplained breathlessness Stridor/upper airway obstruction Pneumothorax Pulmonary hypertension Interstitial lung diseases Lung cancer Pleural effusion Heart failure Myocardial infarction Pericarditis Thoracic cage abnormalities Carbon monoxide intoxication
Gastrointestinal	Functional dyspepsia Gastro-oesophageal reflux disease Peptic ulcer disease Medication-related Hiccups (Gastro)enteritis Steatorrhea Osmotic or secretory diarrhoea Paradoxical diarrhoea Constipation	Oesophageal obstruction due to tumour Achalasia Motility disorders Raised intracranial pressure Benign Paroxysmal Positional Vertigo and Meniere's disease Eating disorders Intestinal obstruction Colon carcinoma or colon polyp Inflammatory bowel disease Intestinal Ischaemia Malabsorption Short bowel syndrome Endocrine disorders
Liver	Toxic or drug-induced injury Haemochromatosis Alcoholic and non-alcoholic steatohepatitis Chronic liver disease (cirrhosis) Liver metastasis	Obstructive jaundice Hereditary bilirubin disorders Viral hepatitis Auto-immune hepatitis Complications of chronic liver disease Haemolytic jaundice Acute liver failure Lysosomal and other storage disorders of the liver Infiltrative disease of the liver

Presentations with selected organ system symptoms or problems (cont.)	INDEPENDENT DIAGNOSIS AND THERAPY	INITIAL DIAGNOSIS AND THERAPY
		TIMELY CONSULTATION AND/OR REFERRAL
Cardiovascular	<p>Atrial fibrillation</p> <p>Common cardiac arrhythmias</p> <p>Primary or essential hypertension</p> <p>Secondary hypertension due to medication or chemicals (oral contraceptives, alcohol, enoxolone)</p> <p>Hypertension and chronic kidney disease stage 1-3</p> <p>Primary and secondary prevention</p> <p>Stable angina pectoris</p> <p>Heart failure</p>	<p>Hypertensive crisis</p> <p>Coarctatio aortae</p> <p>Endocrine hypertension</p> <p>Renal artery disease</p> <p>Obstructive sleep apnoea syndrome</p> <p>Hypertension and chronic kidney disease stage 4 and 5</p> <p>Pregnancy</p> <p>Neurological disorders</p>
Blood	<p>Anaemia of chronic diseases</p> <p>Anaemia due to nutritional deficiency</p> <p>Pancytopenia due to medication or infection</p> <p>Bleeding due to medication (antiplatelet agents or oral anticoagulants)</p> <p>Anticoagulation bridging</p>	<p>Bone marrow diseases</p> <p>Chronic gastrointestinal blood loss</p> <p>Excessive uterine bleeding</p> <p>Anaemia of chronic kidney disease</p> <p>Haemoglobinopathies</p> <p>(Autoimmune) haemolysis</p> <p>Mesenteric thrombosis</p> <p>Renal vein thrombosis</p> <p>Portal vein thrombosis</p> <p>Thrombocytopenia or thrombocytopathy</p> <p>Thrombocytosis</p> <p>Hereditary and acquired coagulopathies</p> <p>Malignancy, autoimmune disease-related haemostatic disorders</p> <p>Disseminated intravascular coagulation</p>
Lymphatic system	<p>Epstein-Barr virus infection</p> <p>Cytomegalovirus infection</p> <p>Bartonella Henselae infection</p> <p>Toxoplasmosis</p> <p>Sarcoidosis</p>	<p>Human Immunodeficiency virus infection</p> <p>Tuberculosis</p> <p>Purulent lymphadenitis</p> <p>Sexually transmitted disease</p> <p>Goucher's disease</p> <p>Metastasis</p> <p>Lymphoproliferative disease</p> <p>Kikuchi disease</p>
Malignancies	Common cancers	<p>Haemato-oncological diseases</p> <p>Complications of neoplastic diseases</p>
Electrolyte and acid-base disorders	<p>Hyperkalaemia and hypokalaemia</p> <p>Hypernatremia and hyponatraemia</p> <p>Metabolic acidosis and alkalosis</p> <p>Respiratory acidosis and alkalosis</p> <p>Combined respiratory and metabolic acid disorders</p> <p>Hypercalcaemia and hypocalcaemia</p> <p>Hyperphosphatemia and hypophosphatemia</p> <p>Hypermagnesemia and hypomagnesemia</p>	<p>Abnormalities that need extracorporeal therapy (e.g. haemodialysis)</p> <p>Acute and chronic kidney failure</p>

Presentations with selected organ system symptoms or problems (cont.)	INDEPENDENT DIAGNOSIS AND THERAPY	INITIAL DIAGNOSIS AND THERAPY
		TIMELY CONSULTATION AND/OR REFERRAL
Renal	<p>Microalbuminuria</p> <p>Proteinuria</p> <p>Hematuria</p> <p>Pre-renal and acute kidney injury (stage 1 and 2)</p> <p>Chronic kidney disease stages 1-3</p> <p>Infection (cystitis, pyelonephritis)</p> <p>Lower urinary tract symptoms (LUTS)</p>	<p>Nephrotic syndrome</p> <p>Glomerulonephritis</p> <p>Paraproteinaemia, amyloidosis</p> <p>Hereditary renal diseases</p> <p>Medication, interstitial diseases</p> <p>Acute kidney injury (stage 3)</p> <p>Chronic kidney disease stage 4 and 5</p> <p>Post-transplant kidney</p> <p>Autosomal dominant polycystic kidney disease (ADPKD)</p> <p>Renal infarction</p> <p>Thrombotic thrombocytopenic purpura/haemolytic-uremic syndrome</p> <p>Malignancy</p> <p>Kidney stones</p> <p>Obstructive nephropathies</p> <p>Papillary necrosis</p>
Musculoskeletal disorders	<p>Gout and pseudo gout</p> <p>Fibromyalgia</p> <p>Sicca syndrome</p> <p>Polymyalgia rheumatica and RS3PE</p> <p>Giant cell arteritis</p> <p>Lyme disease</p> <p>Post-infectious arthritis (sexually transmitted disease, post-streptococcal)</p> <p>B19 parvovirus</p> <p>Osteoarthritis</p> <p>Regional and peri-articular pain syndromes (bursitis, tendinitis)</p>	<p>Septic arthritis</p> <p>Rheumatoid arthritis</p> <p>Systemic lupus erythematosus</p> <p>Scleroderma</p> <p>Small vessel vasculitides (granulomatosis with polyangiitis, microscopic polyangiitis, Churg-Strauss syndrome)</p> <p>Polyarteritis nodosa</p> <p>Psoriatic arthritis</p> <p>Ankylosing spondylitis</p> <p>Amyloidosis</p> <p>Paraneoplastic syndrome</p> <p>Charcot joint</p> <p>Haemarthrosis</p>
Nervous system disorders	<p>Delirium</p> <p>Alcohol or, medication withdrawal</p> <p>Hepatic encephalopathy</p> <p>Hypoglycaemia</p> <p>Hypoxia</p> <p>Hypercapnia</p> <p>Medication-related</p>	<p>Central nervous system infection</p> <p>Cerebral vasculitis</p> <p>Stroke, sub-arachnoid haemorrhage, venous sinus thrombosis</p> <p>Hypertensive encephalopathy and posterior reversible encephalopathy syndrome (PRES)</p> <p>Cerebral mass</p> <p>Epilepsy</p> <p>Endocrine diseases</p> <p>Psychiatric disorders</p>
Skin		<p>Malignant dermatosis</p> <p>Bullous dermatoses</p> <p>Hirsutism and alopecia</p> <p>Erythema exsudativum multiforme, Stevens-Johnson syndrome, toxic epidermal necrolysis</p> <p>Urticaria</p> <p>Desensitisation in drug allergy</p> <p>Vasculitides and auto-immune diseases</p>

Presentations with selected organ system symptoms or problems (cont.)	INDEPENDENT DIAGNOSIS AND THERAPY	INITIAL DIAGNOSIS AND THERAPY
		TIMELY CONSULTATION AND/OR REFERRAL
Skin (cont.)		Sarcoidosis Arterial and venous skin diseases
Diabetes and Endocrinology	Type 1 and 2 diabetes Cardiovascular risk management Diabetic neuropathy Diabetic nephropathy stage 1-3 Peri-operative diabetes care Lipid disorders Hypothyroidism and hyperthyroidism Benign thyroid nodule Goitre Thyroiditis Obesity Primary and secondary osteoporosis Hirsutism (idiopathic, medication-related) Gynaecomastia (puberty, pseudo-, medication-related) Galactorrhea (pregnancy, medication-related, mechanical)	Polycystic ovary syndrome Insulin pump therapy Diabetic nephropathy stage 4 and 5 Nephrotic syndrome in diabetes Pregnancy in diabetes Diabetic foot Thyroid mass Pituitary disease Pheochromocytoma and paraganglioma Cushing's disease Addison's disease Hirsutism (hormone overproduction) Gynaecomastia (hormone overproduction) Galactorrhea (prolactinoma)
Medical Problems in Pregnancy	Physiological changes in pregnancy Chronic hypertension Gestational diabetes Glucose intolerance Venous thrombo-embolic disease Pre-existing hypothyroidism Post-partum-thyroiditis Medication use in pregnancy	Gestational hypertension, preeclampsia and eclampsia Haemolysis, elevated liver enzymes, low platelets (HELLP) syndrome Renal disease in pregnancy Hyperthyroidism in pregnancy Sheehan syndrome, diabetes insipidus, pituitary adenoma Ovarian hyperstimulation syndrome Post-partum-cardiomyopathy
Miscellaneous medical problems	Presentations with multisystem clinical features Presentations related to specific patient populations e.g. migrants Common genetic conditions Postoperative medical problems	
Women's health issues		Breast mass Pelvic pain Abnormal vaginal bleeding Amenorrhoea Galactorrhea Vaginal discharge
Men's health issues		Lower urinary tract symptoms Erectile dysfunction

Miscellaneous medical problems (cont.)	INDEPENDENT DIAGNOSIS AND THERAPY	INITIAL DIAGNOSIS AND THERAPY TIMELY CONSULTATION AND/OR REFERRAL
Geriatric issues		Immobility Memory loss (progressive) Mental status change Delirium Urinary incontinence Failure to thrive, sarcopenia Abuse or neglect
Patients with substance addiction	Alcohol, nicotine- and/or drug addiction Alcohol and/or drug withdrawal	Substance addiction
Palliative Care and end-of-life Care	Symptom palliation (pain, delirium, dyspnoea, nausea, diarrhoea, cough) Nutrition Cachexia Agitation	
Incidental Findings on Imaging	Solid mass or cyst in organ Hepatomegaly, splenomegaly Vertebral fracture, bone abnormalities Unexpected venous thrombo-embolism	Pituitary incidentaloma, empty sella syndrome Adrenal tumour Unexpected metastases
Laboratory abnormalities	Elevated erythrocyte sedimentation rate (ESR), C-reactive protein (CRP) Liver enzyme abnormalities Electrolyte- or acid-base disorders Paraproteinaemia Elevated ferritin and/or iron saturation Anaemia Polycythaemia Leucocytosis, leukopenia, leukocyte differential abnormalities Thrombocytosis, thrombocytopenia Dyslipidaemia Elevated serum creatinine, urinary abnormalities Abnormal coagulation Abnormal thyroid function tests	

C.2 Specific knowledge domains

Knowledge and skills in several important subjects constitutes a fundamental feature of internal medicine practice. The internal medicine trainee must achieve competence in the topics listed below.

Clinical Pharmacology

Many patients are affected by more than one medical problem and take several medications. In fact, multimorbidity and polypharmacy are relatively common, particularly among the elderly. Hence, all internists should possess a sound knowledge of all common types of medications used for the management of frequently encountered medical conditions and the important interactions among these medications and these diseases.

	<p>Basic principles of pharmacology</p> <p>Drug interactions (including interactions with commonly used alternative medicine agents e.g. herbal medicines)</p> <p>Common drug-disease interactions</p> <p>Effect of age on use of medications and patient safety, including problems associated with polypharmacy</p> <p>Drug allergies</p>	
Transfusion Medicine	<p>Indications for transfusion of packed red cells</p> <p>Platelet transfusion</p> <p>Transfusion reactions: febrile-, transfusion-related acute lung injury (TRALI), allergic-, haemolytic-</p> <p>Transfusion related infections</p>	<p>Massive transfusion</p> <p>Leukapheresis</p>

Basic Preventive Care

All internists should be competent in the principles of screening and preventive care that applies to large segments of the population and across the adult age spectrum.

	<p>Promote healthy life style</p> <p>Cancer screening recommendations</p> <p>Non-cancer screening recommendations (e.g., bone density)</p> <p>Vaccination</p> <p>Pharmacological measures (e.g., aspirin, calcium)</p> <p>Screening for common problems among older patients (e.g., cognitive impairment, depression, functional impairment, falls and gait instability, incontinence)</p> <p>Thromboprophylaxis</p> <p>Infection prevention</p> <p>Antibiotic prophylaxis and stewardship</p>	
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Interpretation of Clinical Tests and Images

All internists should be competent in the interpretation of common clinical laboratory tests and imaging studies obtained as part of the diagnostic evaluation and management of patients with undifferentiated presentations and common medical conditions.

Clinical statistics	<p>Basic principles of probability, test performance characteristics, accuracy, and reliability</p>
Standard laboratory tests	<p>Full blood count</p> <p>Coagulation screen</p> <p>Haemolysis screen</p> <p>D-dimer test</p> <p>Blood film report</p> <p>Basic blood biochemistry tests: electrolytes, creatinine, liver function tests, glucose, calcium</p> <p>Cardiac biomarkers and cardiac-specific troponin</p> <p>Creatine kinase</p>

Standard Laboratory tests (cont.)	<p>Amylase</p> <p>Inflammatory markers: C-reactive protein and erythrocyte sedimentation rate</p> <p>Paraproteinaemia, light chains</p> <p>Urinalysis and urine microscopy</p> <p>Stool testing for faecal elastase, calprotectin</p>	
Body fluid analysis	urine, pleural fluid, ascitic fluid, joint fluid, cerebrospinal fluid	
Basic imaging interpretation	<p>Chest X-ray</p> <p>Ultrasound</p> <p>Computerized tomography scan</p> <p>Magnetic resonance imaging</p> <p>Positron emission tomography scan</p> <p>Joint radiographs</p> <p>Radioisotope bone scan</p> <p>Bone densitometry</p> <p>Scintigraphy in endocrinology</p> <p>Ventilation/perfusion scan</p>	
Microbiologic data	<p>Blood, sputum, urine or stool for microscopy, polymerase-chain reaction (PCR), culture and sensitivity</p> <p>Helicobacter pylori testing</p> <p>Viral hepatitis serology and screening</p> <p>Human immunodeficiency virus testing</p>	
Endocrine tests	<p>Cortisol and short synacthen test</p> <p>Glucose tolerance test</p> <p>Thyroid function tests</p> <p>HbA1C</p> <p>Lipid profile</p> <p>Plasma and urinary metanefrines, catecholamines</p> <p>Sex hormones: follicle-stimulating hormone (FSH), luteinising hormone (LH), testosterone, oestrogen, progesterone; prolactin</p>	<p>Specialist endocrine suppression or stimulation tests: dexamethasone suppression test; insulin tolerance test; water deprivation test, and growth hormone stimulation test</p>
Immunology	<p>Coeliac serology and screening</p> <p>Autoantibodies: Extractable nuclear antigens (ENA), anti-neutrophil cytoplasmic antibody (ANCA), antinuclear antibodies (ANA), rheumatoid factor (RF), cyclic citrullinated peptide antibody (CCP)</p>	
Pathology	<p>Liver biopsy</p> <p>Renal biopsy</p> <p>Bone marrow and lymph node biopsy</p> <p>Cytology: pleural fluid, ascitic fluid, cerebrospinal fluid, sputum, urine, lymph node, mass of unknown origin</p> <p>Fine needle aspiration thyroid nodule</p>	
Endoscopic Examinations	<p>Bronchoscopy</p> <p>Upper and lower gastrointestinal endoscopy</p> <p>Endoscopic retrograde cholangiopancreatography (ERCP)</p>	

C.3 Procedures

There is a number of procedures, which all internal medicine trainees should have become proficient in at the completion of their training programme.

There are other procedures performed by internists depending upon the scope of their practice or the setting in which they work. The needs of the internal medicine trainee to learn these procedures will depend upon his or her interests, potential area of specialisation, practice setting, geographic location, and the availability of other physicians who carry out the procedures.

Many procedures can be done either by internists or by physicians in other specialties stemming from internal medicine, with the deciding factor being the experience and proficiency of the physician carrying out the procedure rather than the type of specialty qualification.

It is appropriate for physicians to learn new skills as their interests or scopes of practice change, or when new procedures become available. Opportunities must exist for physicians in the course of their practice to learn new procedures, retrain in procedures they have not practiced recently, and to improve their skills in performing procedures that are part of their current practice.

For all types of procedures, performance must be accompanied by knowledge and understanding of the indications and contraindications, patient preparation methods, aseptic/sterile technique (when relevant), pain management, awareness and treatment of complications, and proper technique for handling specimens (when relevant).

There is also a broad spectrum of procedures that internists may not necessarily perform themselves but for which they must understand the indications, contraindications, complications, and post-procedure management.

For all procedures carried out by an internal medicine trainee, it is essential that appropriate supervision (different levels are listed on page 19 of the curriculum) be provided by a physician (usually a higher-level medical specialist) already experienced and competent in performing the procedure.

Certain procedures that are performed by internists in more than 50% of European countries are designated as mandatory for all internal medicine trainees. Other procedures are considered optional.

	Mandatory (>50% of European countries)	Optional (could do, but may need to refer to other specialist)
Percutaneous needle-related skills and performance of a range of percutaneous procedures* *if available preferably under ultrasound guidance	Venepuncture Arterial puncture Peripheral intravenous line insertion Abdominal paracentesis Thoracentesis Lumbar puncture Simple surgical stitching/suturing Soft tissue Injection: intradermal, subcutaneous, and intramuscular	Central venous catheter insertion Arterial catheter insertion Pulmonary artery catheter insertion Joint aspiration Incision and drainage of an abscess Joint and other related soft tissue injection (e.g., tendon or bursa) Bone marrow aspiration and biopsy Skin biopsy
Skills and procedures related to entry of a body orifice	Nasogastric tube insertion Urethral catheterization (male and female)	Endoscopy Endotracheal intubation,
Non-invasive diagnostic testing	Comprehensive geriatric assessment Electrocardiographic recording and interpretation 24 hour electrocardiographic monitoring Treadmill exercise testing Spirometry Ambulatory blood pressure monitoring Ankle-brachial index Bed side 'binary' ultrasound ¹	Tilt table testing Polysomnography Specialized ultrasound: e.g. echocardiography
Resuscitative skills	Advanced cardiac life support	Emergency endotracheal tube placement Invasive mechanical ventilation Non-invasive ventilation

¹ yes or no questions e.g. is there ascites, pleural effusion?

C.4 Presentations to other specialties that may need input from the internist

initial diagnosis and therapy, timely consultation and referral

<u>Ear, nose and throat disorders</u>	<u>Eye disorders</u>	<u>Neurological system disorders</u>
Epistaxis	Uveitis	Mononeuropathy, polyneuropathy, radiculopathy
Hoarseness	Scleritis	Carpal tunnel syndrome
Parotitis	Episcleritis	Paraplegia
Sinusitis	Conjunctivitis	Headache
Glossitis	Painful eye	Guillain-Barré syndrome
Tonsillitis	Sicca syndrome	Fits / seizure
Pharyngitis	Exophthalmos	Parkinson's disease
Parapharyngeal and retropharyngeal abscess	Visual disturbances	Multiple sclerosis
Vertigo	Cataract	Myopathy or myositis
Otitis media	Red eye	Bell's Palsy
Otitis externa		Vertigo
Mastoiditis		Sleep disorders
Congenital disease		Weakness and paralysis
Salivary gland tumour		Abnormal sensation (paraesthesia and numbness)
Lymphadenopathy		Head injury
		Visual disturbance (diplopia, visual field deficit, reduced acuity)
		Speech disorder

ⁱ This chapter and paragraphs are adjusted from the Specialty Training Curriculum for General Internal Medicine August 2009 and amended 2012 by the Joint Royal Colleges of Physicians Training Board GIM curriculum (http://www.gmc-uk.org/2009__AUC__GIM_curriculum__amendments_2012__AUC.pdf_56436570.pdf) and the Training Requirements for Internal Medicine 'Intellect', 2015, by the Dutch Society of Internal Medicine (NIV).

ⁱⁱ Presentations and Diagnoses mostly rated as common in $\geq 75\%$ of countries as per highlighted items in this chapter

ⁱⁱⁱ Surgical Presentations and symptoms are traditionally managed by surgical teams. The reason that these symptoms appear in this curriculum is to recognise that often a physician is called upon to perform the initial assessment of these patients. These presentations frequently occur in the context of long-term medical illness and as a complication of medical illness. Also, the hospital-at-night team structure leads to physicians at all levels of training taking responsibility for surgical in-patients. The role of the physician in these situations is not to take responsibility for the full management of these patients. However, a physician is expected to stabilise the patient as necessary, perform initial investigations and management if urgently required, and make a referral to the appropriate surgical team for a specialist opinion in a timely manner.

Medical Expert

As medical experts, physicians/internists apply medical knowledge, clinical skill, and a professional attitude when providing high-quality, safe patient-centred care. The medical expert is the central role of the physician/internist and defines the physician's/internist's clinical scope of practice.

As medical experts, physicians/internists are able to:

Milestones Yr 2	Milestones Yr 5
Obtain a relevant history from the patient in an efficient, compassionate, and factual manner	Obtain relevant historical subtleties that inform and prioritise both differential diagnoses and diagnostic plans, including sensitive, complicated, and detailed information that may not often be volunteered by the patient
Perform a physical examination that is appropriately targeted to the patient's symptoms. Identify pertinent abnormalities using recognised techniques	Routinely identify subtle or unusual physical findings that may influence clinical decision making, using advanced techniques where applicable
	Demonstrate and teach how to obtain important physical findings for junior members of the healthcare team
Analyse all available data, including interview, physical examination, and preliminary laboratory data, to define a patient's presenting complaint	
Seek out and analyse appropriate, verified, and prioritised data from secondary sources (e.g. family, records, pharmacy); obtain patient's consent	
Prioritise differential diagnoses and develop evidence-based diagnostic and therapeutic care plans for common inpatient and ambulatory conditions	
Accurately monitor important changes in the patient's physical condition through examination over time in outpatient and inpatient settings	
Modify differential diagnosis and care plans based on clinical course and data as appropriate	
Recognise when to seek additional guidance	
Reach agreement with patients and their families as to priorities for each encounter at the outset	
	Consider urgency, feasibility, availability of resources, and co-morbidities in determining clinical priorities for the patient encounter
Address the patient's and/or carer's ideas about the nature and cause of the condition, demonstrating awareness of their fears, concerns, expectations	Establish outcomes of care, which may include slowing disease progression, recovery, improved function, treatment of symptoms, and palliative care
With supervision (3) ¹ , customise care in the context of the patient's preferences and overall health	Tailor care in line with the patient's preferences and overall health
	Ensure that patients and their families are informed about the risks and consequences of each choice of treatment in the context of best evidence and guidelines
Assess patients' decision-making capacity	Tailor approaches to decision-making to patient capacity, values, and preferences
On the basis of patient-centred priorities, address and prioritise, under supervision (3), multiple competing tasks that need to be addressed	Maintain a duty of care and patient safety while juggling multiple responsibilities

Medical Expert (cont.)

Milestones Yr 2	Milestones Yr 5
Understand indications for, risks of, and basic interpretation of common diagnostic tests, including but not limited to routine blood tests, haematology studies, coagulation screening, arterial blood gases, ECG, chest X-rays, lung function tests, analysis of urine and other body fluids	Recognise indications and demonstrate basic skills when interpreting more advanced diagnostic tests
Make appropriate clinical decisions based on the results of common diagnostic testing, including, but not limited to, routine blood tests, haematology studies, coagulation screening, arterial blood gases, ECG, chest X-rays, lung function tests, analysis of urine and other body fluids	Make appropriate clinical decisions based upon the results of more advanced diagnostic tests
With patients' consent, prepare and perform simple procedures with minimal assistance: venapuncture, abdominal tap, pleural tap, arterial lines, urinary catheterisation, gastric tube insertion, haemodynamic monitoring	Obtain appropriate consent, when preparing and performing invasive procedures and provide post-procedure management
With minimal supervision (4), manage patients with common clinical presentations seen in the practice of inpatient and ambulatory internal medicine, including anaemia, oedema, dyspnoea, chest pain, liver function abnormalities, impaired renal function, electrolyte- and acid-base imbalances, abdominal pain, constipation, diarrhoea	
Demonstrate sufficient knowledge to diagnose and treat common conditions that require hospitalization	
	Demonstrate sufficient knowledge to diagnose and treat undifferentiated and arising conditions
Demonstrate sufficient knowledge to assess common ambulatory conditions	
Demonstrate awareness of opportunities to provide preventative care	Demonstrate sufficient knowledge to provide preventative care
With minimal supervision (4), manage patients with common clinical disorders seen in the practice of inpatient and ambulatory internal medicine, including diabetes mellitus, thyroid diseases, osteoporosis, heart failure, atrial fibrillation, chronic obstructive pulmonary disease, chronic kidney disease, deep vein thrombosis, pulmonary embolism, pneumonia, pleurisy, uncomplicated pancreatitis, uncomplicated diverticulitis, cellulitis, urinary tract infection, infectious diarrhoea	Incorporate a broad base and depth of knowledge in clinical and biomedical sciences to independently manage patients with a broad spectrum of clinical disorders seen in the practice of general internal medicine
Consider urgency, and potential for deterioration, in promoting the timely execution of procedures for patients	Triage procedures, taking into account clinical urgency, potential for deterioration, and available resources
Recognise situations with a need for urgent medical care, including life-threatening conditions	Demonstrate sufficient knowledge to identify and treat medical conditions that require intensive care
Initiate management and stabilise patients with acute medical conditions, including chest pain, dyspnoea, confusion, anaphylaxis, sepsis, rhythm disturbances, coma, syncope, shock, gastrointestinal bleeding, adverse effects from use of anticoagulants and antiplatelet drugs	Manage patients with conditions that require intensive care
Identify clinical situations in which complexity, uncertainty, and ambiguity may play a role in decision-making	

Medical Expert (cont.)

Milestones Yr 2	Milestones Yr 5
With supervision (3), manage patients with complex clinical disorders seen in inpatient and ambulatory care settings	Demonstrate sufficient knowledge to evaluate complex or rare medical conditions and multiple co-existing conditions
	Adapt care as the complexity, uncertainty, and ambiguity of the patient's clinical condition as it evolves
	Recognise disease presentations that deviate from common patterns and that require complex decision making
	Manage complex or rare medical conditions
Determine the necessity and appropriate timing of consultation	Request consultative services in an effective manner
With supervision (3), customise care according to consultations provided by other services	Coordinate investigation, treatment, and follow-up plans when several consultants are involved
With supervision (3), perform consultations, presenting well-documented assessments and proposing appropriate recommendations	Provide specific, responsive consultation to other services with clear and useful recommendations
	Provide internal medicine consultation for patients with more complex clinical problems; perform detailed risk assessment

Communicator

As communicators, physicians/internists form relationships with patients and their families that facilitate the gathering and sharing of information essential for exemplary healthcare.

As communicators, physicians/internists are able to:

Milestones Yr 2	Milestones Yr 5
Communicate in a respectful way with the patient	
Optimise the physical environment for comfort, privacy, engagement, and safety of the patient	
Recognise and respond to non-verbal cues on the part of patients and their families	Use verbal and non-verbal skills effectively to create rapport with patients/families
Manage emotionally charged conversations when strong emotions (e.g., anger, fear, anxiety, and sadness) are interfering with an interaction	Access personal emotions in interactions with patients as valuable clues to an individual patient's emotional state
Engage with patients, family or advocates in shared decision making for uncomplicated diagnostic or therapeutic scenarios	Engage with patient, family or advocates in shared decision-making for difficult, ambiguous or controversial scenarios
	Actively seek to understand patient differences and views and reflect this in respectful communication to achieve shared decision-making with the patient and the healthcare team
Use strategies to ensure a patient understands the diagnosis, anticipated outcomes and management plan	Counsel patients about the risks and benefits of tests and procedures highlighting cost awareness and resource allocation
	Communicate risks and benefits of alternative therapeutic options to patients
	Share information and explanations that are clear, accurate, timely, and skilfully adapted to the patient's level of understanding
	Recognise when patient and physician values, biases, or perspectives threaten the quality of care, and modify the approach to patient care as appropriate
	Utilise patient-centred educational strategies
	Use role models to communicate effectively in challenging situations
Assess a patient's health literacy	Effectively engage the patient in the clinical context, particularly through the use of patient education (tools)
	Use tailored teaching aids, provide handouts, and suggest online resources for the information of the patient in accordance with his/her health literacy
Provide timely communication to patients/healthcare advocates	Share information related to the patient's health status, care, and needs in a timely, honest, and transparent fashion
Demonstrate sensitivity to differences in patients including but not limited to race, culture, gender, sexual orientation, socio-economic status, literacy, and religious beliefs	Engage patients in a way that is respectful and non-judgmental and provides cultural safety
Deliver bad news in a compassionate way	Anticipate and respond to the patient's emotional reactions with compassion and support
Engage patient, family or healthcare advocates in shared decision-making regarding end of life care	
Deliver appropriate, succinct, evidence-based oral presentations during case discussions	

Communicator (cont.)

Milestones Yr 2	Milestones Yr 5
Effectively communicate care plan to all members of the healthcare team and seek their advice	
Document clinical encounters in an accurate, complete, timely and accessible manner, and in compliance with legal and confidentiality requirements	
Provide clear, effective written and verbal communication (medical records) to healthcare professionals in line with recognised medical practice	Document clinical encounters to adequately convey clinical reasoning and the rationale for decisions
Provide succinct, relevant and patient-specific written communications	
Provide timely and comprehensive verbal and written communications to patients, family or healthcare advocates/professionals during transfer of care	Communicate effectively with patients/advocates and healthcare professionals during transfer of care
Communicate effectively the role of consultant to the patient	
	Use electronic tools appropriately to communicate with patients while protecting their confidentiality

Healthcare Advocate

As healthcare advocates, physicians/internists responsibly apply their expertise and influence to improve health through working with patients, communities, or populations that they serve. This helps determine and understand the needs, to develop partnerships, to speak on behalf of others when necessary, and support the mobilisation of resources to effect change.

As healthcare advocates, physicians/internists are able to:

Milestones Yr 2	Milestones Yr 5
Respect and maintain patient confidentiality	
Recognise when it is necessary to support an individual patient needs	Act as advocate for the individual, especially vulnerable, patient's needs
Identify with patients and their families any challenges they may face with respect to access to healthcare provision and related resources	Analyse a patient's health needs and facilitate timely patient access to services and resources
Treat patients with dignity, civility and respect, regardless of race, culture, gender, ethnicity, age, or socio-economic status	
Reflect awareness of common socio-economic barriers that impact patient care	Demonstrate sufficient knowledge of socio-behavioural sciences including, but not limited to, healthcare economics, medical ethics and medical education
Recognise that disparities which exist in healthcare among populations may impact patient care	Embrace the physician's role in assisting the public and policy makers in understanding and addressing causes of disparity in disease and suffering
Record critical incidents in accordance with local policies	
Report patient safety hazards and adverse events	
Identify, reflect on, and learn from critical incidents such as near misses and preventable medical errors	Understand the mechanisms for analysis and correction of systems errors
	Participate in analysis to generate change after an adverse event or near miss
	Lead or actively engage in a process for change to prevent future adverse events or near misses
Accept personal errors, honestly acknowledge them and value the lessons learned	
Recognise pressures in the healthcare system that increase the risk of error including barriers to providing optimal care	
Work effectively as a member of the multidisciplinary team to ensure safe patient care	Consult with care team members to identify risks and avert of medical error
	Identify areas in personal practice and local system that can be changed to improve the processes and outcomes of care
	Perform an audit review of a panel of patients using standardised, disease-specific, and evidence-based criteria
	Reflect on audits compared with local or national benchmarks and explore possible explanations for deficiencies, taking into account doctor-related, system-related, and patient-related factors
	Use informatics for quality improvement by improving information flow into, within, and out of his/her practice
Budget appropriately when choosing care options	

Healthcare Advocate (cont.)

Milestones Yr 2	Milestones Yr 5
Demonstrate cost-awareness when making routine clinical judgments and decisions	Demonstrate cost-awareness related to complex clinical scenarios
Minimise unnecessary care including tests, procedures, therapies and ambulatory or hospital encounters	Advocate/promote appropriate allocation of limited health care resources
Understand unique roles and services provided by local healthcare delivery systems	
Identify stakeholder roles including providers, suppliers, financiers, purchasers and consumers and determine the impact of the various roles upon the cost of, and access to healthcare	
Understand how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines)	
Apply evidence and guidelines as relevant to common clinical scenarios	Apply available evidence or recommendations to cost-appropriate care and develop plans to change areas of wasteful practice
Follow formal policies and guidelines	Engage in a quality improvement activity Demonstrate the ability to understand and engage in a system level quality improvement initiative Partner with other healthcare team professionals to identify and propose improvement opportunities within the system
Understand fully the responsibility to assess and improve care collectively for a specific group of patients	
Identify patients or populations that are not receiving optimal clinical care	
Provide appropriate preventative care and educate patients regarding activities beneficial to health	Incorporate disease prevention, health promotion, and health surveillance activities into interactions with individual patients
	Recognise and take responsibility for situations where public health supersedes that of the individual (e.g. reportable infectious diseases)

Collaborator

As collaborators, physicians/internists work effectively with other healthcare providers to provide the best standard of patient care.

As collaborators, physicians/internists are able to:

Milestones Yr 2	Milestones Yr 5
Understand fully the roles of a variety of healthcare providers including, but not limited to, consultants, therapists, nurses, home care workers, pharmacists, and social workers	
Carry out timely interactions with colleagues, patients, and their designated carers	Engage in collaborative communication with all members of the healthcare team
	Demonstrate how to manage a multidisciplinary team by utilising the skills and coordinating the activities of the individual team members
	Be alert to patient safety concerns relating to team function, anticipate issues that could impact situational awareness, and take appropriate action to mitigate potential harm to patients
Welcome, and treat productively, feedback from all members of the healthcare team including faculty, peers, students, nurses, allied health workers, patients and their advocates	Actively seek feedback from all members of the healthcare team
	Communicate constructive feedback to other members of the healthcare team
Communicate clearly and directly to resolve conflict	Implement strategies to resolve conflict in a manner that supports a collaborative culture
Listen in order to understand differences of opinion between healthcare providers and to find common ground	Gain consensus among colleagues in resolving conflict
Establish care plan in a respectful way with other multidisciplinary team members	Ensure patient-centred care among multiple care providers
Consider management suggestions and alternative solutions provided by other team mates and modify care plan as appropriate	Partner with internal and external professionals in addition to the patient and his or her family to integrate the patient's perspective and personal circumstances into the care plan
Liaise with physician colleagues during handover to ensure safe, effective and accountable transfer of patient care	In complex situations, coordinate the safe transfer of care to the most appropriate healthcare provider
Communicate effectively with the receiving team to facilitate transfer of care	Summarise on-going clinical concerns at handover including plans to deal with on-going issues during and after transfer
	Remain available to the receiving team following transfer of care to help clarify issues as needed
Communicate effectively with other care givers in order to maintain appropriate continuity during transfer of care	Manage and coordinate care and transfers of care across multiple delivery systems, including ambulatory, sub-acute, acute, rehabilitation and advanced nursing
	Involve fully medical and other allied healthcare professionals when transferring younger patients from paediatric to adult services
Consult with other healthcare providers, including physicians or surgeons, as appropriate	Communicate consultative recommendations to the receiving team in an effective manner

Collaborator (cont.)

Milestones Yr 2	Milestones Yr 5
	Establish overlapping roles and shared responsibilities with internal and external - healthcare providers for episodic or continuing care of patients
Recognise referral and consultation as opportunities to improve quality of care and patient safety through shared expertise	
	Consistently discuss with patients and their families any plan for involving other healthcare professionals, including other physicians, in their care and discuss their expectations of such involvement

Professional

As professionals, physicians/internists are committed to the healthcare and well-being of individual patients and society through ethical practice, high personal standards of behaviour, commitment to the profession, profession-led regulation, and maintenance of personal health.

As professionals, physicians/internists are able to:

Milestones Yr 2	Milestones Yr 5
Dress and behave professionally	Act as a professional role model for more junior colleagues (e.g. medical students, interns)
	Act as a role-model of respectful behaviour for physician and non-physician colleagues in clinical, educational, and administrative settings
	Respond on an individual level to colleagues' lapses of professional conduct in all areas of practice
	Intervene when behaviour toward colleagues and learners compromises a respectful environment
Maintain professional relationships with patients, families and staff	Maintain ethical relationships with industry
Uphold ethical principles and comply with relevant policies and codes of practice	Uphold ethical expectations of research and scholarly activity
Demonstrate empathy and compassion to all patients	Provide support (physical, psychological, social and spiritual) for dying patients and their families
Demonstrate a commitment to relieve pain and suffering	
Identify learning needs as they emerge in patient care activities and take appropriate action	Demonstrate a commitment to identifying and addressing gaps in the knowledge and skills necessary for optimal practice of internal medicine
Actively participate in teaching conferences	
Recognise the scope of his/her abilities and ask for supervision and assistance when appropriate	
Recognise medical ethical issues encountered in the clinical setting and during academic activities	Manage medical ethical issues encountered in the clinical setting and during academic activities
Welcome feedback and treat it productively	Reflect on, and adapt to, multisource feedback
With supervision (4), reflect on actions	Reflect (in action) when surprised, apply new insights to future clinical scenarios, and reflect (on action) when looking back
	Be aware of what is happening and respond to meet situational needs
Recognise and address personal, psychological, and physical limitations that may affect performance	Recognise, respond to and report under-performing colleagues or substandard care using the peer review process
Recognise and manage obvious conflicts of interest, such as caring for family members and professional associates	Recognise and manage subtle conflicts of interest
	Recognise and manage conflict when patients' values differ from your own
Fulfil clinical responsibilities without a need to be reminded	Recognise the need to assist colleagues in the provision of duties
Separate personal responsibilities from that of other healthcare team members	
Recognise the tension between the physician's role as advocate for individual patients and the need to manage limited resources	Demonstrate an ability to balance duty of care for patients with the public good

Professional (cont.)

Milestones Yr 2	Milestones Yr 5
Respond to patients' and society's expectations in clinical interactions	Recognise and manage tensions or differences between the expectations of society and the profession
Manage effectively the impact of physical and environmental factors on performance	Demonstrate resilience in challenging situations and help others to use their own skills in adaptation and recovery
	Manage competing personal and professional priorities effectively
Seek mentorship to address various professional development needs	Support others when undergoing professional change
	Address, in a sensitive and supportive way, behaviour that compromises collegiality in the workplace
	Manage and support others as they deal with the impact of critical incidents or adverse events
	Exhibit proficiency in providing support for physician colleagues and in educating learners
Speak up in situations in the clinical training environment where patient safety may be compromised	Respond to barriers in the health care system that compromise patient safety and care

Scholar

As scholars, physicians/internists demonstrate a lifelong commitment to excellence in practice through continuous learning, the teaching of others, the evaluation of evidence and other resources, and contributions to scholarship.

As scholars, physicians/internists are able to:

Milestones Yr 2	Milestones Yr 5
Regularly engage in personal learning by drawing upon various sources (daily work, publications, scanning of literature, formal or informal education sessions) to identify and prioritise learning needs	Engage in reflective practice
	Identify the learning needs of a healthcare team in order to improve the quality of care and patient safety
	Engage at all times in collaborative learning to improve personal practice and contribute to collective improvement in practice
Formulate an appropriate research question (PICO), define a search strategy and select the appropriate literature for critical appraisal	Classify and precisely articulate clinical questions
	Formulate detailed scholarly questions in the categories of diagnosis, prognosis, prevention, therapy, harm reduction, and clinical prediction, incorporating outcomes important to the patient
	Develop a system to monitor, examine, and reflect on clinical questions
Access appropriate sources of medical information to answer clinical questions and support decision making	Effectively and efficiently source evidence-based summary medical information
	Demonstrate proficiency in identifying, selecting, and navigating sources of clinical information that provide, or are based on, pre-appraised evidence
	Assess sources of medical information and select for use the most appropriate based on the clinical question posed
With assistance, engage in critical appraisal of clinical research papers	Independently, engage in critical appraisal of clinical research papers
	Independently analyse recommendations in clinical guidelines to determine bias and cost-benefit considerations
For a given clinical case, demonstrate the application of evidence during clinical decision-making	Demonstrate the use of an integrated model of decision making that combines best evidence, resources, and clinical expertise in the context of patient values and preferences
Determine and explain if clinical evidence can be generalised to an individual patient	Customise clinical evidence for an individual patient
Understand the relevant pathophysiology and basic science for common medical conditions	Understand the relevant pathophysiology and basic science for uncommon or complex medical conditions
Recognise uncertainty and knowledge gaps in clinical and other professional encounters relevant to internal medicine	Recognise uncertainty and knowledge gaps in clinical and other professional encounters and generate focused questions that can address them
Guide and educate medical students	Guide and educate junior trainees

Scholar (cont.)

Milestones Yr 2	Milestones Yr 5
Seek and respond to feedback from supervisors, peers, and others	Provide written or verbal feedback to other learners, faculty and other members of the team
	Balance the tension between direct clinical supervision and graduated responsibility
	Identify ethical principles for research and incorporate them into obtaining informed consent; consider also risks and benefits and vulnerable populations
Identify potentially relevant questions that lend themselves to scholarly enquiry in internal medicine	Pose relevant, appropriately constructed questions that lend themselves to scholarly investigation

Leader

As leaders, physicians/internists develop, in collaboration with other healthcare leaders, a vision of a high-quality healthcare system and take responsibility for effecting change to move the system toward the achievement of that vision.

As leaders, physicians/internists are able to:

Milestones Yr 2	Milestones Yr 5
Maintain a portfolio of performance	
Perform ward rounds in an efficient and timely manner	
When a question or problem arises, decide if it can wait until later or if it has to be addressed immediately e.g. during 'on call'	
Follow formal policies and procedures	
Ensure prompt completion of clinical, administrative and curricular tasks	Develop time management skills in specific contexts, such as delegation, meeting administration, and teamwork
	Determine objectives and timelines
	Adjust priorities to enable participation in: clinical, professional, institutional, provincial, national, and/or international activities
Develop systematic habits for practice management (e.g. checklists, prompts, to-do lists, and standard operating procedures)	Apply educational experience in order to gain competencies necessary for future, independent practice
Seek performance assessments and reflect on how they will modify future performance	Seek feedback and undertake audits in order to drive practice improvement
	Participate in activities and educational programmes such as developing self-awareness, self-reflection, and self-management in order to become a leader and a follower in health care organisations
	Provide leadership for a team that respects patient dignity and autonomy
	Take a leadership role in the education of all members of the healthcare team
	Use key performance indicators during team discussions to support team decision-making
	Use management or performance indicators to monitor service delivery against accepted outcomes
	Engage with a multidisciplinary team to implement a changes to delivery of clinical care using a relevant change framework
	Provide advice and guidance from a clinical perspective to managers and policy-makers
Balance personal life with participation in educational opportunities and provision of patient care	Balance personal life with responsibilities in education, research, administration, and patient care
	Integrate teaching, feedback and evaluation with supervision of trainees' and students' patient care
Organise work using strategies that address strengths and areas to improve in personal effectiveness and efficiency	Align goals with opportunities for participation in unanticipated work and other activities
	Align early practice with career goals and current opportunities

ⁱ number between brackets signifies level of supervision

Appendix E

Set out below is a listⁱ of comprehensive Entrustable Professional Activities (EPAs) that can be viewed as consisting of smaller, more elementary EPAs and serves as an example; **end of training EPAs are highlighted.**

1. Evaluate and manage a new medical condition in an ambulatory patient and co-ordinate care between healthcare providers across multiple care settings
2. Manage the care of patients with acute medical conditions across multiple care settings
3. Manage the care of patients with complex medical conditions, and/or co-morbidities, across multiple care settings
4. Manage transition of care for adult patients transferring to another care setting
5. Manage transition of care for young patients transferring from paediatric to adult services
6. Provide medical consultation to non-medical specialties
7. Admit to, and manage, an acutely ill patient in the medical admissions unit
8. Manage an inpatient with an acute exacerbation of a chronic medical condition on the ward
9. Lead a family meeting to discuss serious news (bad news, end-of-life care) with a patient and/or family and other health providers
10. Obtain initial history, perform physical examination, and formulate a management plan for a new ambulatory patient in continuing care
11. Provide continuity of care and conduct interim visits for primary care patients with multiple chronic conditions
12. Manage the care of patients with chronic conditions across multiple care settings
13. Formulate and implement a safe discharge plan for a patient in the acute care setting
14. Triage patients to an appropriate level of care
15. Provide peri-operative assessment and care
16. Access medical information to provide evidence-based care
17. Identify and manage emergency presentations
18. Provide emergency multidisciplinary care to medical inpatients
19. Lead a team in managing multiple inpatients and work with multidisciplinary teams
20. Facilitate the understanding of patients, their families, and members of the multidisciplinary team
21. Recognise and diagnose common non-medical conditions (i.e. surgical, neurological, dermatologic, etc.) and refer appropriately to other specialty care
22. Diagnose and co-manage patients with complex conditions needing other specialty care (inpatient or outpatient)
23. Organise and maintain information and knowledge through medical practice to improve personal development when delivering care and educating others (journal club, etc.)
24. Recognise when palliative care is needed and liaise with palliative care specialists
25. Counsel patients appropriately
26. Advocate for individual patients by representing them, supporting them and working for them
27. Improve patient safety
28. Resuscitate, stabilise, and care for unstable or critically ill patients and admit them to ICU
29. Provide age-appropriate screening and preventative care
30. Identify and address any need for quality improvement in a clinical setting
31. Improve the quality and safety of healthcare at both individual and systems levels
32. Provide telephone management for an ambulatory patient in an emergency
33. Provide care to non-native speakers in an inpatient or outpatient setting through the use of appropriate translation services
34. Develop and implement a management plan based on review of outcome data for ambulatory patient population
35. Provide inpatient and outpatient care for patients with difficulty in accessing appropriate healthcare; advocate for individual patients where needed
36. Participate in, and lead, an in-hospital cardiopulmonary resuscitation
37. Perform common procedures in internal medicine (lumbar puncture, thoracentesis, central line insertion, joint aspiration)
38. Undertake a research project (e.g. a degree or diploma, quality improvement, educational opportunity, other)
39. Develop the practice of life-long learning
40. Demonstrate professional behaviour at all times

ⁱ Modified from Karen E. Hauer, Jeffrey Kohlwes, Patricia Cornett, Harry Hollander, Olle ten Cate, Sumant R. Ranji, Krishan Soni, William Iobst, and Patricia O'Sullivan (2013) Identifying Entrustable Professional Activities in Internal Medicine Training. Journal of Graduate Medical Education: March 2013, Vol. 5, No. 1, pp. 54-59 and the Alliance for Academic Internal Medicine. Internal Medicine End of training EPAs, 2012.

Appendix F

EPA template

EPA

Area of practice	Rotation title			
Stage of training	Stage			Version
The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described to the required standard with the required level of supervision or none at all. Your supervisor will expect you to know when to ask for additional help; s/he will also trust you to seek assistance as appropriate and in a timely manner.				
Title				
Description				
Competencies	ME	sub competencies #	HA	Sub competencies #
	COM	sub competencies # sub competencies #	SCH	Sub competencies #
	COL	sub competencies #	PROF	Sub competencies #
	LEAD	sub competencies #		
Knowledge, skills and attitude required	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge skills and attitude described below			
	Ability to apply an adequate knowledge base			
	Skills			
	Attitude			
Assessment method	Continuous assessment during individual and clinical supervision			
Suggested assessment method details	Case based discussions; multisource feedback			

COL, Collaborator; COM, Communicator; HA, Health Advocate; LEAD, Leader; ME, Medical Expert; PROF, Professional; SCH, Scholar

EPA – SAMPLE REPORT

Area of practice	Rotation title		
Stage of training	Stage	Year 1	Version
The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described to the required standard with the required level of supervision or none at all. .Your supervisor will expect you to know when to ask for additional help; s/he will also trust you to seek assistance as appropriate in a timely manner.			
Title	Producing discharge summaries and organising appropriate transfer of care		
Description	The trainee can produce succinct and informative discharge summaries and organise appropriate transfer of care. S/he understands the importance of clinical records in transfer of care and discharge and can make the appropriate arrangements for medication and/or ongoing other treatment and liaise with appropriate clinicians, teams, community, organisations and primary care providers. The trainee formulates relapse prevention and recovery plans in collaboration with the patient and provides appropriate and timely handover of written information. The discharge summaries are succinct yet informative and can function as a clinical handover as well as a historical record of the patient’s hospitalisation, treatment and progress including key points of decision making.		
Competencies	ME	sub competencies #	HA
	COM	sub competencies # sub competencies #	SCH
	COL	sub competencies #	PROF
	LEAD	sub competencies #	
Knowledge, skills and attitude required	Competence is demonstrated if the trainee has shown sufficient aspects of the knowledge skills and attitude described below		
	<p>Ability to apply an adequate knowledge base</p> <ul style="list-style-type: none"> • Understands the importance of handover of information especially during transition of clinical care • Understands the principles of relapse prevention and recovery • Demonstrates knowledge of risks associated with transfer of care e.g. loss of information, lack of follow-up • Demonstrates knowledge of range of follow-up and community services <p>Skills</p> <ul style="list-style-type: none"> • Uses effective and timely verbal and written communication (including electronic communication where appropriate) • Grasps and formulates the essentials of the case and the treatment plan including relapse-prevention and risk-management plans • Communicates key points of decision making • Communicates and collaborates effectively with patients and families/carers in organising transfer of care • Uses discretion where required, avoids pejorative language • Appropriately considers confidentiality issues and consent <p>Attitude</p> <ul style="list-style-type: none"> • Uses appropriate means of communication (e.g. telephone) when required • Exhibits a patient-centred approach to care • Demonstrates willingness to include all appropriate stakeholders in the transfer of care • Demonstrates respect for the patient, other members of the multidisciplinary team, patient supports and their views 		
Assessment method	Continuous assessment during individual and clinical supervision		
Suggested assessment method details	Case based discussions; multisource feedback		

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