



“Shaping the future: updates on the EU Curriculum in Internal Medicine”

11th EFIM day

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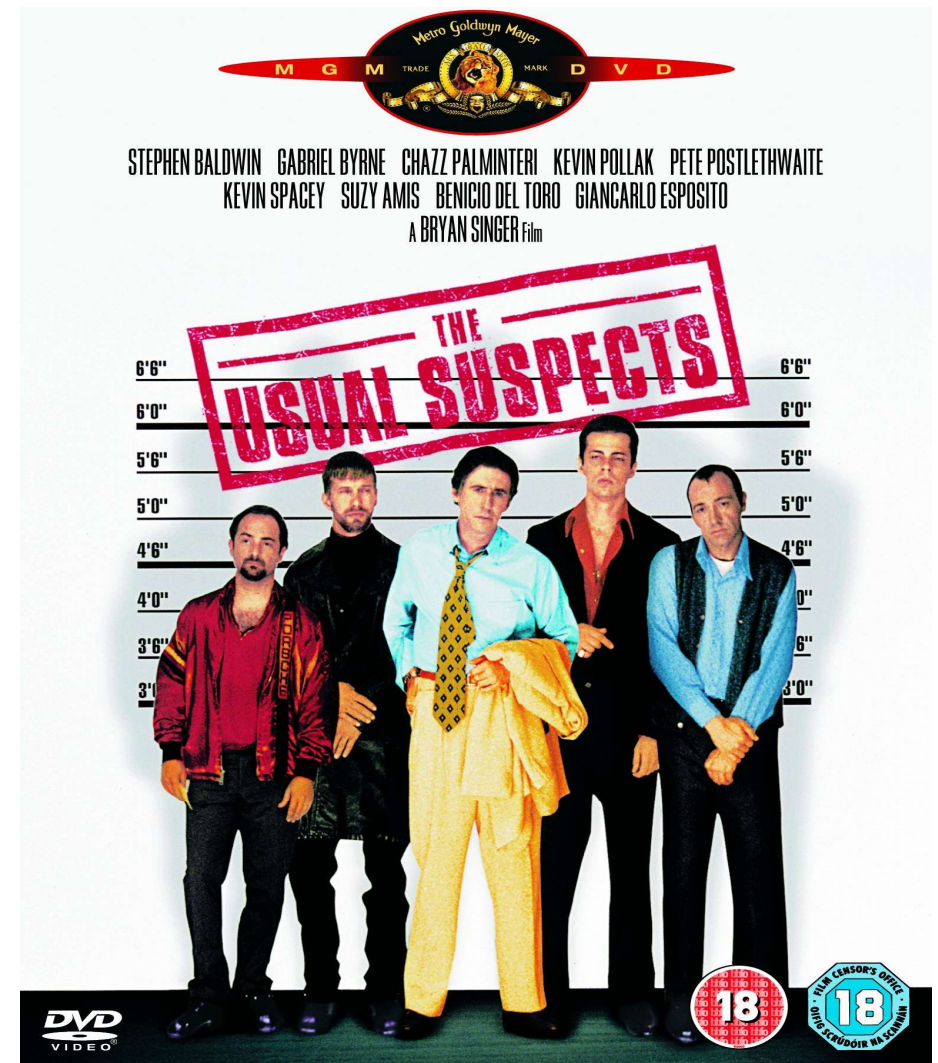
NOVA Medical School, Lisboa



MEDICAL
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MÉDICAS



EBIMS – Board members for 2025-2028



- Update on the EU Curriculum
- Insuring the autonomy of Internal Medicine
- Entrustable Professional Activities (EPAs) in Internal Medicine
- Internal Medicine around the world: the example and the role of Europe
- Final comments

Update on the EU Curriculum

Update on the EU Curriculum

- What has changed in Europe in the last 10 years (for Int. Med.)?
- Implementation of the EU curriculum has not changed after the initial years (ex. Sweden, Greece).
- The “qualitative aspects”: practice-related settings have not changed. But the conceptual and organisational ones did!
- The “quantitative reality” has changed a lot, at least in some countries.

The 2015-era European CV and “non-clinical” contexts

- The EBIM/EFIM 2016 CV positioned Internal Medicine as an institutionally embedded work, delivered through teams, governance systems and multiple workplaces:
 - Making CanMEDS roles (Communicator/Collaborator/Leader/Health advocate/Scholar/Professional) explicit expectations, not “soft extras”.
 - Requiring structured supervision, workplace-based assessment, and EPA-style entrustment consistent with competency-based training.
 - Defining responsibilities of training institutions: quality systems, audit/M&M, patient safety, protected education time, and monitored training environments.
 - Emphasising cross-setting practice (acute care, wards, ambulatory care, ICU/HDU exposure, interfaces with community services).

The key question since 2015 is less:

Do these non-clinical domains matter?

and more,

**How have institutions and workplaces reorganised,
so that these domains could now dominate
day-to-day practice?**

What has changed since 2015 across european countries (practice + institutional context)

- System-wide shift to “closer-to-home” care is now formal policy in multiple countries. A clear Europe-wide pattern is care moving out of traditional inpatient beds toward community, home-based, and digitally supported models:

What has changed since 2015 across european countries
(practice + institutional context)

Non-clinical implication: the internist's “workplace” is now routinely multi-organisational (hospital + community + digital platforms),

so the curriculum emphasis on collaboration, handover, discharge planning and leadership is becoming more the “core job”, and less the “complement”.

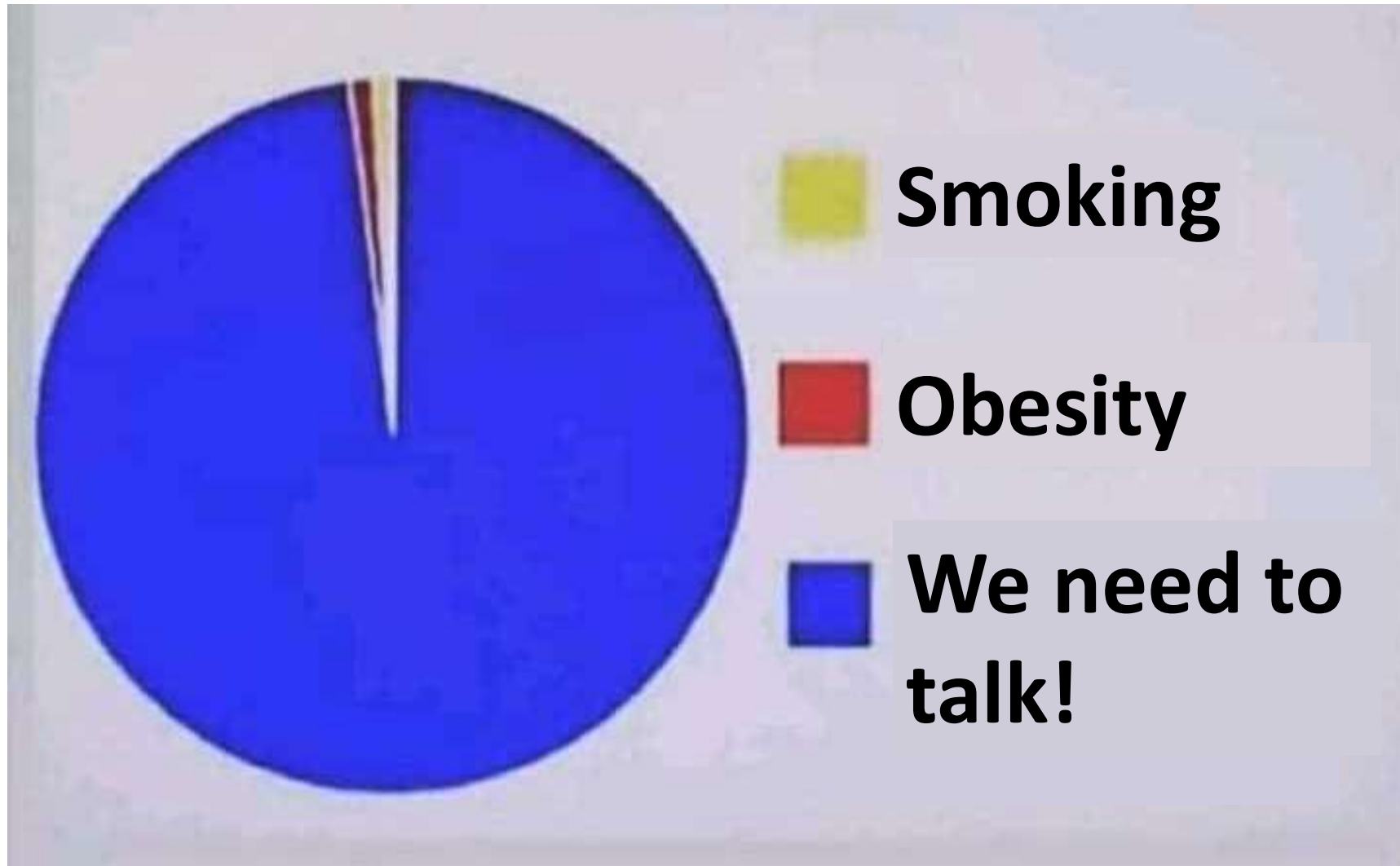
The implications of non-clinical duties and their increasing relevance

- Internal Medicine practice is increasingly constrained/defined by institutional mandates (service portfolios, flow targets, regional plans, quality reporting), so “Leader/Collaborator” capabilities become operational necessities.
- Institutions increasingly need reliable systems for supervision, entrustment decisions, multisource feedback, and documented competence (the 2016 curriculum described as training-site obligations).
- Across UEMS and neighbouring systems there is a continued momentum towards competency-based postgraduate training (CBME), which amplifies non-clinical assessment, feedback, and governance.
- Competency-based training and harmonisation pressures have continued across Europe.

The “organisational trap!”

- Internists: leaders and coordinators vs clinical doctors
- In the European heterogeneity, who are we following? How is the homogenisation of a cv done when countries are drifting apart (in terms of clinical practices and expectations)
- The example of the US hospitalists
- Will there be room for the Internist as a differentiated clinician ?

Main causes of angina in men



Insuring the autonomy of Internal Medicine

The autonomy of Internal Medicine

2016

Presentations with general, non-specific symptoms

Oedema	Heart failure	Upper extremity thrombosis
	Generalised oedema (hypoalbuminemia)	Pulmonary hypertension
	Venous insufficiency	Cirrhosis or hepatic failure
	Postthrombotic syndrome	Inferior or superior vena cava syndrome
	Oedema caused by medications	Nephrotic syndrome
		Renal failure
	Idiopathic or cyclic swelling	Constrictive pericarditis
	Angioedema	Protein-losing enteropathy
		Lymphatic oedema
Fever	Upper and lower airway infection	Septic shock
	Urinary tract infection in a female	Urinary tract infection in a male
	Gastroenteritis	Central nervous system infection
	Skin infection	Pyogenic skin infection
	Abscess	Epiglottitis, tonsillar-pharyngeal infection, complicated sinusitis
	Soft tissue infection	Osteomyelitis
	Nosocomial infection	Arthritis
	Diverticulitis	Systemic infections, including fever associated with malaria, dengue and Ebola
	Fever in travellers	Cholangitis
	Viral infection	Infected pancreatic necrosis
		Empyema
	Pyrexia of unknown origin	Endocarditis
		Endovascular and device-related infection
		Infected prosthesis
		Tuberculosis
		Fever in systemic diseases
		Fever in immunocompromised host
		Periodic fever syndrome
		Paraneoplastic syndrome

2026

INDEPENDENT DIAGNOSIS AND THERAPY	INITIAL DIAGNOSIS AND THERAPY; TIMELY CONSULTATION AND/OR REFERRAL**
Acute allergic reactions, including anaphylaxis	Acute c
Supraventricular tachycardia	Ventric
Gout and pseudogout	Imme
Advanced cardiac life support	or susp
	Septic a
	Hyperte
	Mening
	Infected prosthesis
	Tuberculosis
	Fever in systemic diseases
	Fever in immunocompromised host
	Periodic fever syndrome
	Paraneoplastic syndrome
	Malignancy
	Inflammatory bowel disease
	Malabsorption, including pancreatic disorders
Pyelonephritis (in males, consider referral to specialist)	Septic arthritis
Pneumonia	Endocarditis
Gastroenteritis	
Spontaneous bacterial peritonitis	
Haematemesis, melaena, haematochezia	
Hypovolaemic shock	
Distributive shock (sepsis, anaphylaxis)	

p068092
consider consultation depending on context

Move this to the left column (INDEPENDENT DIAGNOSIS AND THERAPY)

Add: Recognize the need for intervention (endoscopic, surgery, drainage)

The autonomy of Internal Medicine

2016

2026

Evaluation of patients with emergency presentations

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

D1 Clinical presentations and diseasesⁱⁱ

Evaluation of patients with emergency presentations

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Evaluation of patients with common clinical presentations

All physicians/internists should be competent in performing the initial evaluation of the adult patient with common presenting features of undiagnosed conditions, followed by differential diagnosis and the generation of a tentative diagnosis. All internists should be competent in the diagnosis and management of common and important disorders that belong to internal medicine and related specialties. These include common chronic illnesses, particularly those that affect the ageing population, and common co-morbid conditions affecting patients who receive their care from either internists or other specialists.

Patients with emergency presentations

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that should be considered a minimum

INDEPENDENT DIAGNOSIS AND THERAPY

INITIAL

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p068092
merely

INDEPENDENT

DIAGNOSIS AND THERAPY;

complete. While the purpose of this list is to guide trainees, the approach to each condition will depend upon the severity, the context of the patient and the available access to specialist advice and services.

	INDEPENDENT DIAGNOSIS AND THERAPY	INITIAL TIME
Acute allergic reactions	Acute allergic reactions, including anaphylaxis	
Acute coronary syndromes		Acute

p068092
, on either local or national level*

Entrustable Professional Activities (EPAs) in Internal Medicine



**European agreement concerns the expected standard of work.
National programs determine how trainees learn and
demonstrate it.**

The purpose of an EPA

An Entrustable Professional Activity describes a meaningful unit of professional work. Supervisors judge whether a trainee can undertake that activity safely, how much supervision they need and when they must seek help.

An EPA connects competence with real work

An entrustment decision links evidence about the trainee to a specified activity, setting a level of supervision.

Activity and competency

An EPA names the work, such as assessing and managing an unscheduled medical patient. Competencies describe the abilities needed to do it, including clinical reasoning, communication, collaboration and professional judgement.

An EPA connects competence with real work

An entrustment decision links evidence about the trainee to a specified activity, setting a level of supervision.

A usable unit of responsibility

The activity has a recognisable beginning and endpoint.

Supervisors can observe its process, assess its outcome and specify the conditions under which a trainee may undertake it with less oversight.

An EPA connects competence with real work

An entrustment decision links evidence about the trainee to a specified activity, setting a level of supervision.

The practical entrustment question

Can a trainee undertake a defined activity safely and consistently, recognise their limits and obtain appropriate support?

Supervision levels and entrustment decisions

Level	Responsibility	Supervision arrangement
1	Observes the activity	Trainee observes rather than undertakes the activity
2	Performs with direct guidance	Supervisor is present and actively oversees the work
3	Performs with indirect supervision	Supervisor is readily available, with agreed case review
4	Performs within an entrusted scope	No routine direct oversight, with advice and escalation
5	Supervises another learner	Authority applies to the specified activity and setting

The evidence behind the decision

Supervisors consider recent, varied observations, consistency of performance and relevant safety or professionalism concerns. Reflection and appropriate escalation help demonstrate trustworthiness.

The limits of independence

Levels differ between EPAs for the same trainee. Level 4 still requires senior help for complexity or risk beyond the agreed scope. Local rules determine required discussion, review and response times.

The proposed seven common-trunk EPAs

EPA	Professional activity	Main responsibility
1	Inpatient ward care	Organise and complete care for admitted medical patients
2	Acute and unscheduled care	Assess urgency, initiate management and arrange safe handover
3	Consultation to other specialties	Answer the clinical question and agree responsibility
4	Palliative and end-of-life care	Align care with patient goals and support patients/families
5	Outpatient care and continuity	Manage consultations, follow-up and digital care safely
6	A defined clinical supervision session	Delegate, review, intervene and give feedback
7	A defined local improvement project	Measure, test, evaluate and agree the next action

A common foundation

All internists need these activities. Subspecialty pathways add setting-dependent or disease-specific EPAs, such as dialysis care or longitudinal management of a specialist population.

Capabilities across every activity

The draft embeds multimorbidity, frailty, shared decisions, teamwork, equity, patient safety and responsible digital practice across the seven EPAs.

EPA 1: Managing inpatient ward care

The work the trainee owns

Conduct the ward round, interpret findings and maintain a prioritised problem list. Plan investigations and treatment, review medicines, communicate with patients and families, coordinate multidisciplinary input and complete discharge or handover.

Illustrative application

An older patient has pneumonia, delirium, heart failure and reduced mobility. The trainee integrates the competing problems, reviews response to treatment, agrees goals with the patient/family and organises rehabilitation and safe discharge.

Evidence supervisors can review

Observed ward rounds, case discussions, records and discharge letters show reasoning, prioritisation and continuity. Team feedback addresses reliability and collaboration.

EPA 1: Managing inpatient ward care

Supervision in the draft

Level 3 includes daily patient discussion and a joint ward round at least weekly. Level 4 includes independent rounds and selective senior review, with complex-case review at least twice weekly. Level 5 adds supervision of junior colleagues.

Indicative exposure benchmarks

150 patients managed, 30 independently led ward rounds, 15 family/goals-of-care meetings, 100 discharge letters and 10 observed rounds. These guide exposure planning rather than determine a pass.

Indicative progression

Level 3 by month 6, Level 4 during months 12–18 and Level 5 from month 48. Evidence and local scope govern the decision.

Assessment evidence and proposed workload

Assessment category	Total in source (hours)	Annual mean over 6 years
Mini-CEX	27	4.5
Case-based discussion	26	4.3
Multi-source feedback	11	1.8
Other direct observation	17	2.8
Document/portfolio review	37	6.2
Entrustment decisions	19	3.2
Total	137	22.8 (approximately 23)

Evidence with a purpose

Observation shows performance. Case discussion tests reasoning. Feedback describes reliability and teamwork. Records show continuity. Supervisor narratives integrate evidence over time.

Proportionate implementation

One encounter may inform several EPAs. Combine feedback cycles and avoid repetitive forms. These figures describe the draft's workload model, which needs reconciliation with its schedules before adoption.

Indicative progression across the seven EPAs

EPA	Level 3	Level 4	Level 5 in source
1 Inpatient ward care	Month 6	Months 12–18	Month 48+
2 Acute/unscheduled care	Months 3–6	Months 36–48	Month 54+
3 Consultation service	Months 12–24	Months 24–36	Month 54+
4 Palliative/end-of-life care	Months 12–18	Months 36–48	Month 54+
5 Outpatient clinic	Months 12–24	Months 24–36	Month 48+
6 Defined supervision session	Months 18–24	Months 36–48	Month 54+, optional
7 Local improvement project	Months 12–18	End of training	After training, optional

Timing guides opportunity planning

Recent, varied evidence determines progression. A missed time point prompts review of capability and access to training, rather than automatic failure. Programmes should recognise credible prior learning.

A discrepancy requiring resolution

EPA 1's assessment table places a Level 3-to-4 decision at month 6, while its narrative/matrix place Level 4 at months 12–18. EPAs 6–7 explicitly make Level 5 optional.

Have a break. **KitKat**[®]



Nestlé[®]

European implementation and evaluation

- **How can we implement the European cv ?**
 - Persuasion?
 - Reward?
 - Punishment /limitation ?
- **How can we assess it?**
 - Centralised exam?
 - “Trans-country” evaluations?
 - Minimal compliance and CV-driven?
- **How will we consider non-European specialists?**
 - “Europe only” assess?
 - Individual country regulations?
 - Both?

Internal Medicine around the world: the example (and the potential role) of Europe

- How does Internal Medicine stand in Europe?
- Do we need more Internal Medicine doctors?
- To do what?
- The “average and the standard deviation” in Europe and the impact on internal and external mobility.

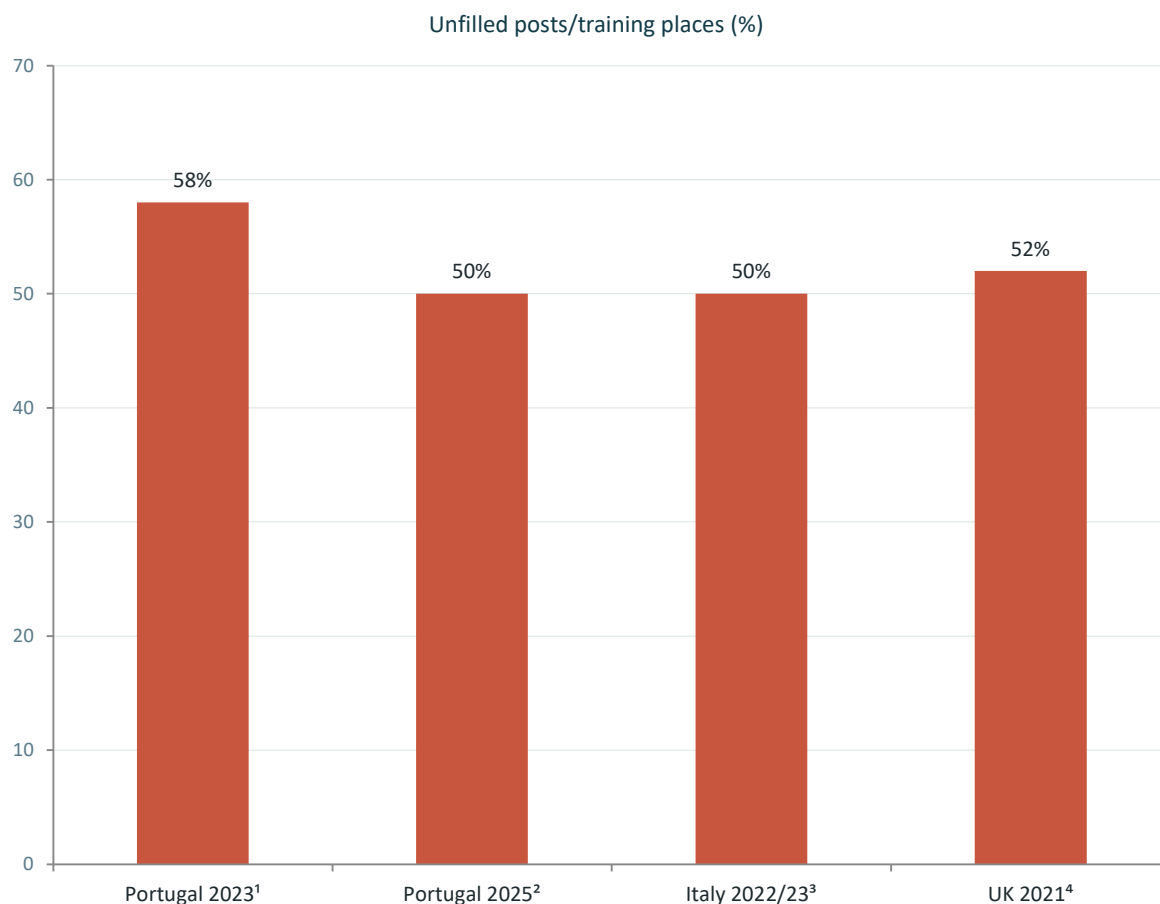
- Do we need more Internal Medicine doctors?
-

- We certainly do!
- But... what kind of internist and where do we need them?

Advantages of being married



The shortage varies widely between countries



≈1000

internists missing in the Portuguese NHS

OM/SPMI 2024 ♦

≥1500

internists missing in Italy

FADOI ♦

³⁴
-44%

of the Swiss general IM workforce lost by 2033

Swiss Med Wkly 2024 ●

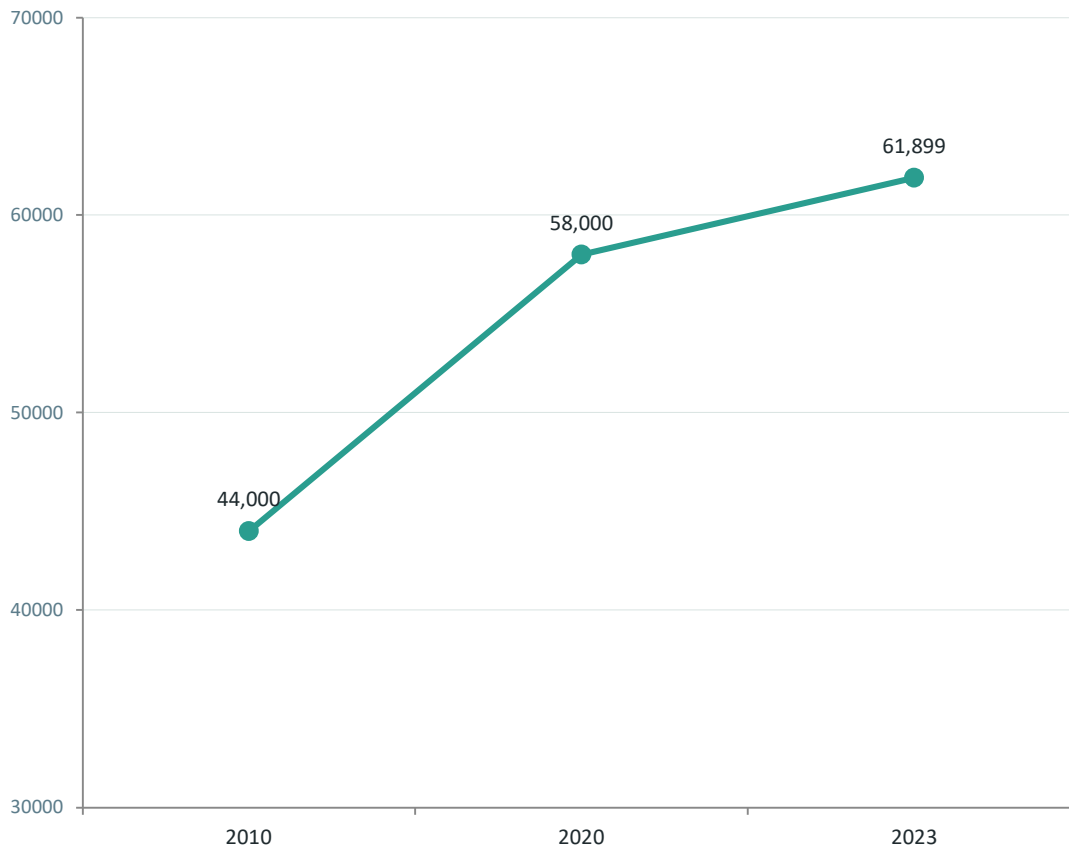
No crisis

projected in Austria to 2035

Hum Resour Health 2025 ★

More internists does not mean less shortage

Practising internists — Germany



Germany

+40% internists in last 15 years, yet regional gaps — more part-time work, fewer hours per doctor (DMW 2025 ●).

Switzerland

2,321 new FTEs needed by 2033 just to keep the 2023 workforce level (Swiss Med Wkly 2024 ●).

Austria

IM split into several training fields; no severe overall shortage projected to 2035 (Hum Resour Health 2025 ★).

Does a central role for IM mean more pressure?

Signals in favour

- Portugal: IM covers everything from the ED to the wards; 58% of training posts unfilled and 7 hospitals with no trainee at all (OM/SPMI ◆)
- Italy: staff shortages in ~86% of IM wards surveyed (FADOI ◆)
- UK and Switzerland: general IM work seen as less satisfying/attractive than subspecialty work (RCP ◆; Swiss Med Wkly 2018 ●)

Limits of the evidence

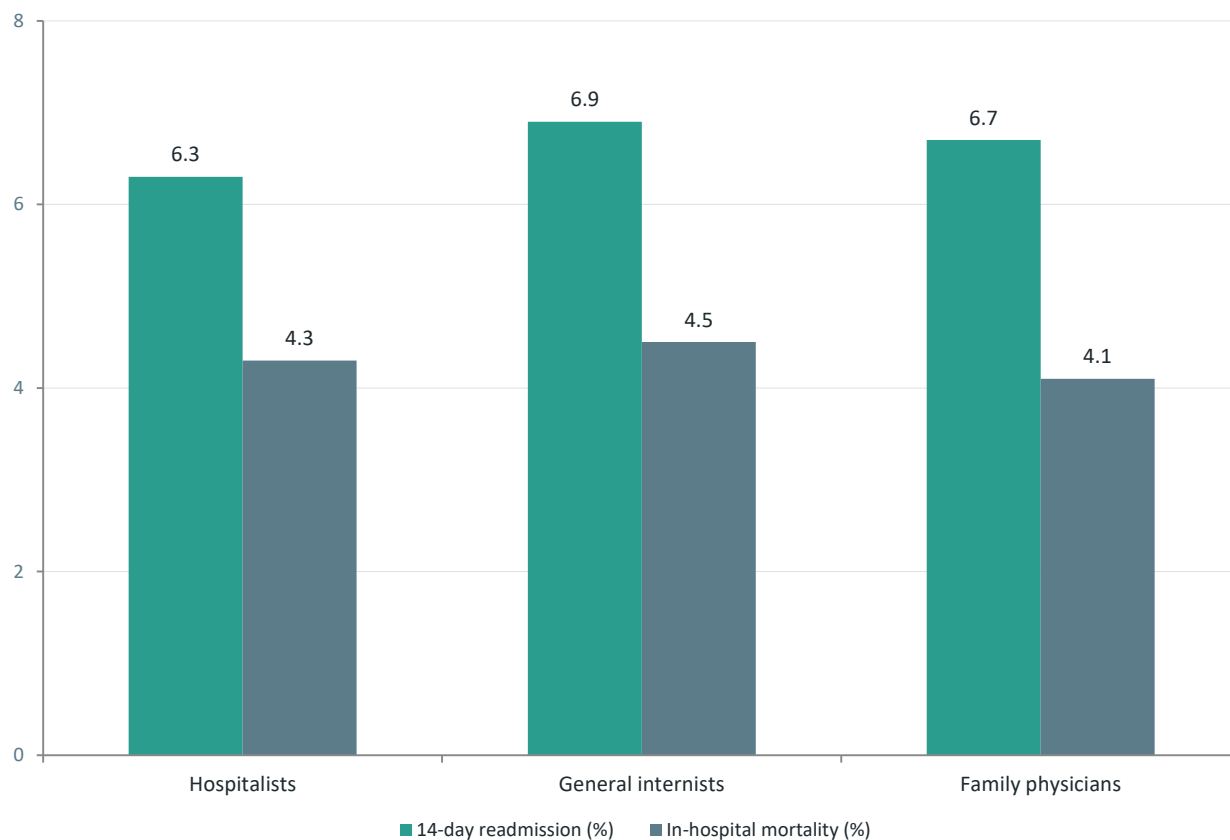
- There is no cross-country study in an IF > 3 journal linking the weight of IM to the severity of the shortage
- Germany and Austria, both with strong IM, show stable or growing supply (★ / ●)
- Confounders: pay, career structure, emergency workload, working conditions

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A plausible perception: the problem appears to be the workload and appeal of generalist IM, not the specialty itself

Impact of the generalist model on inpatient care

76,926 patients, 45 hospitals (NEJM 2007 ★)



-0.4 days

length of stay with hospitalists vs general internists and family physicians; similar mortality and readmissions (Lindenauer, NEJM 2007 ★)

2.75

chronic diagnoses per IM inpatient across 18 European countries (EJIM 2010 ★)

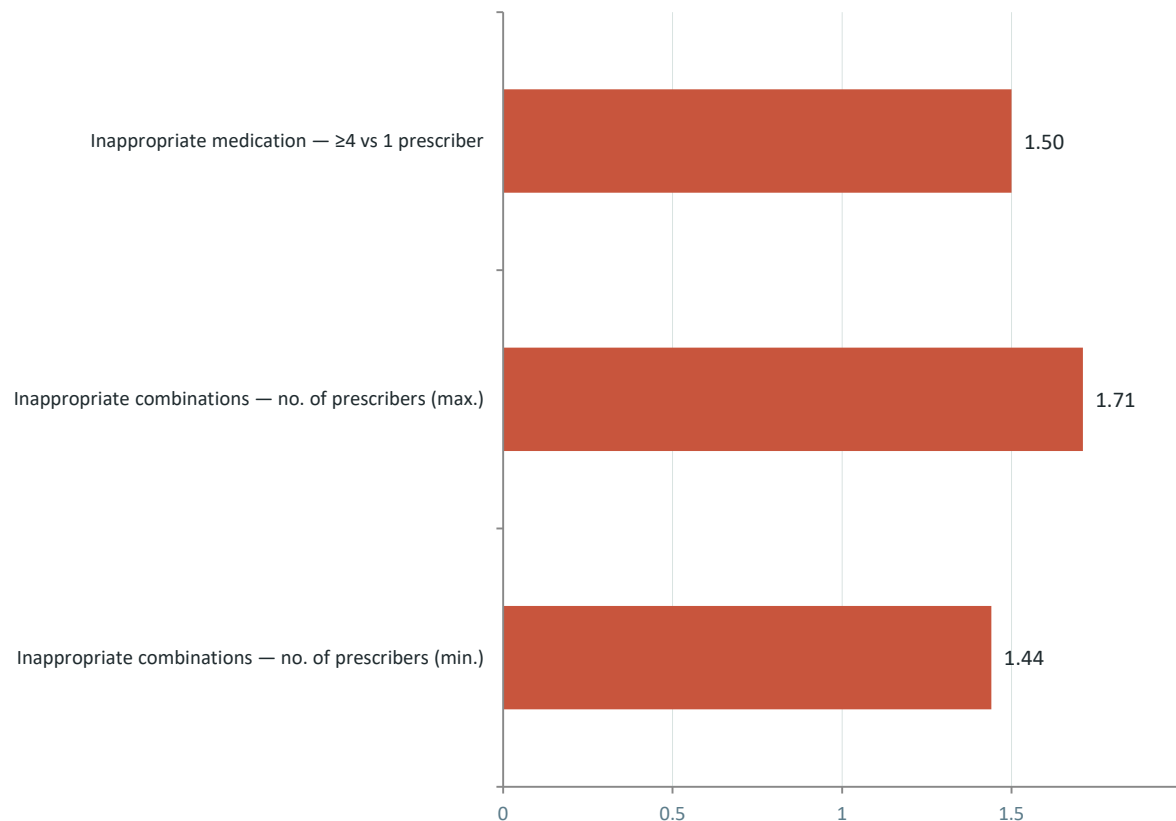
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Coordination

EFIM positions IM as the hub of care for ageing, multimorbid patients (Gómez-Huelgas, EJIM 2024 ★)

Impact on prescribing: fragmentation creates risk

Risk associated with multiple prescribers (OR)



Tamblyn, CMAJ 1996 ★

51,587 older adults: the number of prescribing doctors was the main risk factor; 18–26% of inappropriate combinations came from concurrent prescribing by different doctors.

OPERAM, BMJ 2021 ★

2,008 multimorbid patients aged ≥ 70 : medicines optimisation led by general IM reduced inappropriate prescribing, but not drug-related admissions (21.9% vs 22.4%; HR 0.95).

Countries with and without strong generalist IM

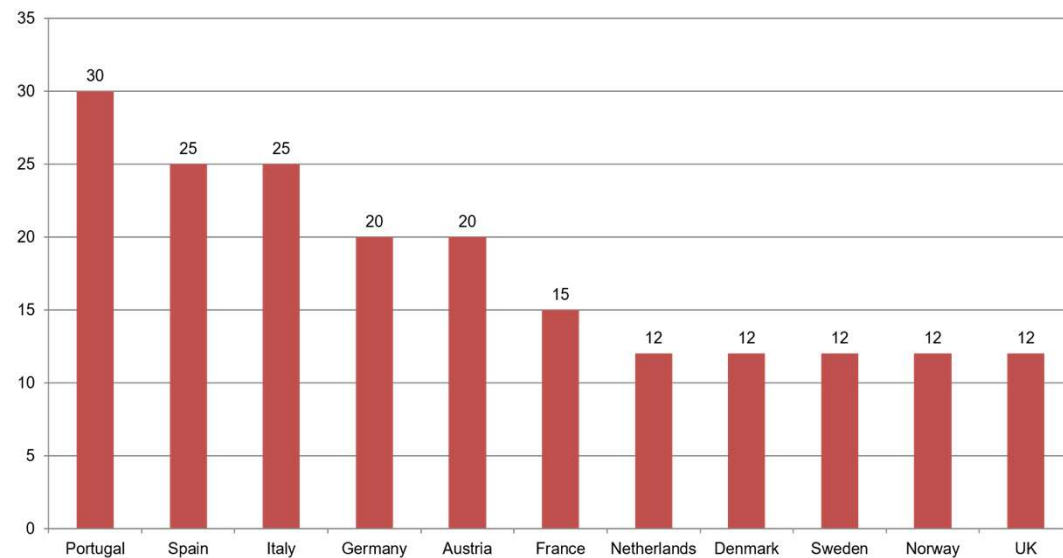
Model	Examples	What is observed
Generalist IM as the hospital backbone	Portugal, Spain, Italy	IM in the ED, on the wards and in surgical co-management; heavier workload and unfilled training posts
Common trunk + subspecialty	Germany, Austria, Switzerland, UK	Greater overall supply, but general IM loses appeal to the subspecialties
IM dissolved into organ specialties	Denmark	IM no longer a standalone specialty (split into 9); risk of fragmented care for multimorbid patients — no comparative outcome studies

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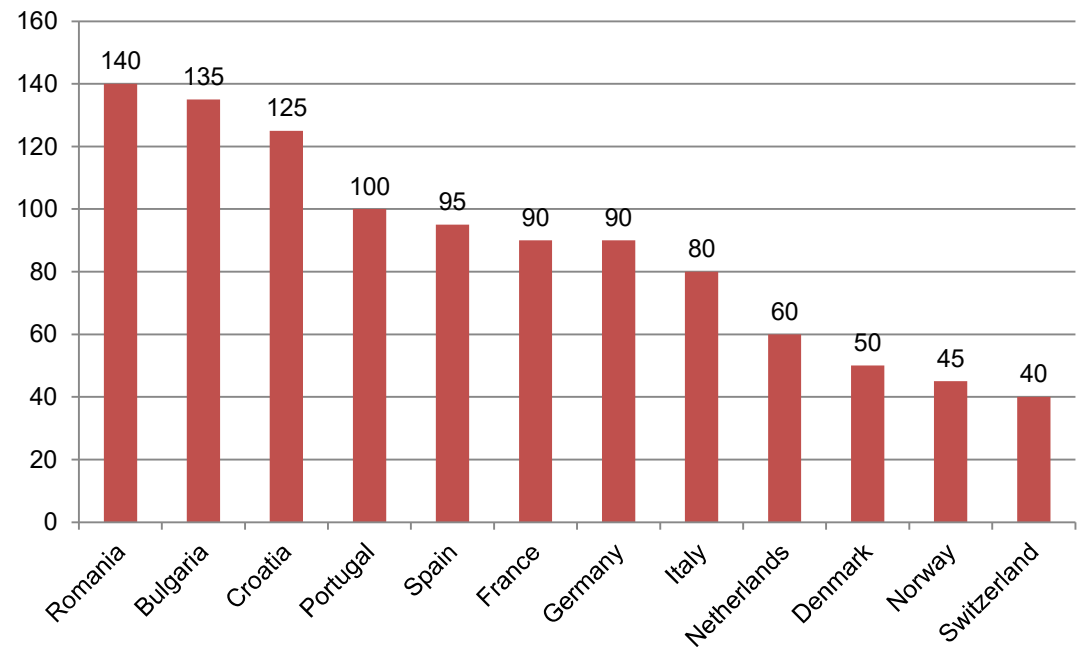
Variation between countries (Cranston, EJIM 2013 ★): in 8 countries most internists practise IM alone; in 7, at least half combine IM with a subspecialty. The evidence of benefit lies mainly in coordination and in reducing fragmented prescribing.

The impact of quantity... the portuguese reality in context

Internists per 100,000 (Pop)



Shortage Severity by Country

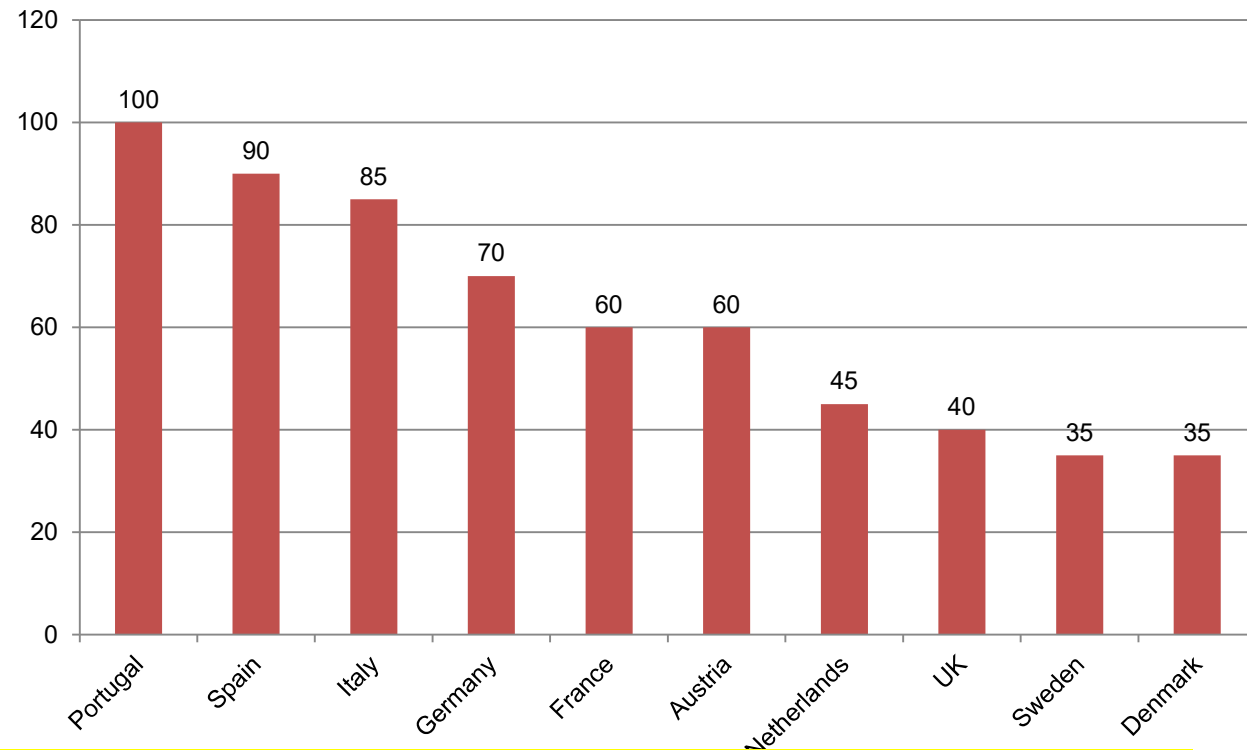


Portugal has the highest estimated internist densities in Europe

Internal Medicine Influence Index

Strengths:
large workforce,
multimorbidity management

Challenges:
ageing workforce,
recruitment pressure



Portugal is among the European countries where Internal Medicine specialists have the greatest clinical and prescribing impact per capita.

- The reality in South America...
- Asia: one continent, two (at least) approaches (Japan, Pakistan)
- Canada and Australia

- The CV is being updated, thank you very much!
- Hopefully will be finished no later than the end of 1st year of the board's mandate, leaving time to present (European tour!!!!) and implement it.
- There will be no time to assess results, but we can analyse the implementation ratio, which could give us important information on both the method and substance.
- Current update raises (indirectly through EPAs) the issue of the future role of internal medicine: teach, coordinate or do!

- The definition of what Internal Medicine will become, will reflect on whether we need more specialists or not.
- If we do, where are we going to get them?
- Under what set of criteria?
- Following central (European) or local coordination? How do we guarantee high standards?



*"THAT'S ONE SMALL
STEP FOR MAN,
ONE GIANT LEAP
FOR MANKIND"*

Neil Armstrong, July 20th, 1969

"GOOD LUCK, MR. GORSKY"

Neil Armstrong, July 20th, 1969



"SEX! YOU WANT SEX?!"

*YOU'LL GET SEX WHEN THE KID NEXT
DOOR WALKS ON THE MOON!"*

Mrs Gorsky, 1938

Thank you!!

- To George Dalekos for the trust!
- To Runólfur Pálsson for the support!
- To all the EBIM members for the (immense) work!
- To UEMS and EFIM for trying!

