Respiratory Medicine Portfolio Pathway evidence map

A two-page working sheet for senior respiratory doctors mapping evidence against the GMC Specialty Specific Guidance, respiratory curriculum and the General Internal Medicine requirement.

Page 1 - the evidence buckets assessors expect to see

Evidence bucket	What strong evidence usually shows	Common files to gather
Respiratory scope	Current practice across lung cancer pathways, integrated respiratory care, complex infection, respiratory failure, tertiary interfaces and respiratory therapeutics.	Clinic lists, ward logs, MDT attendance, consultant reports, Mini-CEX, CbD, ACAT, patient feedback.
General Internal Medicine	Ability to manage acute unselected take, acute specialty admissions, inpatients, long-term conditions, MDT discharge and deteriorating patients.	Acute take log, GIM clinics, ACATs, MCRs, ALS, inpatient case summaries, reflective notes.
Procedural competence	Evidence that you are competent to perform required respiratory and GIM procedures, normally through suitable DOPS or a senior structured report.	Pleural procedures, ultrasound, safe sedation, bronchoscopy, NIV, lung function, sleep studies, TB and relevant reports.
Professional evidence	How you work as a senior specialist: communication, patient partnership, leadership, safety, probity, teaching, CPD, audit and quality improvement.	MSF, patient survey, audit/QI, teaching feedback, appraisal, job plan, CPD diary, structured reports.

Respiratory procedures to review early

Pleural	Pleural aspiration, chest drain insertion, medical pleurodesis and focused pleural ultrasound.
Airway and ventilation	Bronchoscopy, non-invasive ventilation and CPAP, safe sedation and escalation of respiratory failure.
Diagnostics and services	Lung function, sleep studies, allergy skin testing and TB pathways. Confirm what your SSG asks for before upload.

Page 2 - a 90-day respiratory portfolio reset

Use this as a practical triage plan before deciding whether your current post gives you enough respiratory and GIM evidence to submit strongly.

Weeks 1-2	Download the live Respiratory Medicine with GIM SSG. Build a spreadsheet with every specialty CiP, internal medicine CiP, procedure, referee and evidence file you already have.
Weeks 3-4	Test your evidence against current independent practice. Highlight anything that only proves participation, old training, narrow subspecialty work or unverified experience.
Weeks 5-8	Fix the easiest gaps: request consultant reports, schedule DOPS, collect acute and clinic logs, close one audit/QI loop and start patient or colleague feedback if missing.
Weeks 9-12	Check whether the remaining gaps are job-design problems. Respiratory PP is hard without the right service mix: acute medicine, outpatient breadth, procedures, MDTs and supportive supervisors.

Referee prompt

Your referee set should include people who have directly observed your current respiratory and GIM work. Ask whether each referee can comment on breadth, independence, procedures, acute work, communication, safety, governance and professional conduct. A famous distant name is weaker than a consultant who has watched you run the service.

Important note

This worksheet is general guidance. Always check the current GMC Respiratory Medicine SSG, the relevant curriculum and your Royal College guidance before relying on any checklist.