Training in general internal medicine: what do trainees want and what can we deliver?

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ABSTRACT

General internal medicine (GIM) training, usually as part of a dual accreditation programme, is increasingly challenging to deliver as a result of increased numbers of acute admissions, changes to consultant input into medical 'on call' and the reduction in the numbers of units taking unselected medical patients. GIM has become synonymous with acute medical take, reducing the scope of programmes to deliver a true general medical experience. The role of the 'medical registrar' is reported to be increasingly unpopular with trainees. Differing models of the delivery of training are in place. We have carried out a two-stage questionnaire in order to determine the views of both trainees and trainers on different models of training and their deliverability. The first stage defined the key areas of concern for trainees and the second focused on these areas and the ability of local education providers to deliver an expanded GIM programme. Our data suggest that trainees would value a face-to-face annual review of competence progression (ARCP) for GIM, separate from their specialty ARCP, and would support more structured blocks of GIM training in order to allow later specialty-focused training. However, significant concerns were raised about the ability of many units to deliver such training beyond the acute medical 'take'.

KEYWORDS: General medicine, GIM, junior doctors, postgraduate, training

Introduction

The delivery of general internal medicine (GIM) training in the UK has transformed with sequential changes to the structure of medical specialty training. The introduction of 'Calman' specialty training in medical specialties between 1994 and 1996 removed the ability for trainees to achieve a general medical registrar experience across several specialties prior to becoming a 'senior registrar' by introducing the concept of a 'specialist registrar'. Medical specialties closely related to GIM provide their trainees the opportunity to dual accredit within curricula and train in both their chosen specialty and GIM. While the GIM curriculum[1] provides an outline of GIM training, the current model equates GIM to periods of medical on call, with no specific outpatient-based or ambulatory training. Furthermore, there is little focus on training beyond the first 48 hours of the admission period, partly because of the service models in existence in the UK. As a result, GIM training in the UK focuses on acute provision of care, with a tacit expectation that longitudinal care experience can be gained within specialty.

The 47% increase in emergency presentations in the 15 years leading up to 2013[2] has made the role of the medical registrar significantly more challenging. Anecdotal evidence also suggests it has diminished value as a learning process, resulting in significant dissatisfaction with the acute medicine component of medical registrars' training.[3] There has been a widely documented reduction in those prepared to enter dual accrediting specialties,[4] partly because of the pressures of the medical registrar role; trainees frequently highlight the role as a key cause of stress in their professional lives. Some of this relates to the tension between GIM and specialty training requirements. Specific acute internal medicine training programmes remain small, so it remains the domain of the 'dual-accredited' consultant physician to provide a significant amount of the acute on-call service commitment.[5]

The 'Shaping a Healthier Future' programmes in west London[6] propose a reduction in the numbers of acute admitting units and, as of August 2016, two units in the region are no longer accepting unselected acute or emergency medical patients. This change in the local health economy reduces the opportunities for the acute medicine aspects of GIM training and increases the workload of the remaining acute medicine units. With national policy driving centralisation of services, and with closure or downgrading of smaller, local hospitals, this trend is likely to represent a microcosm of the national picture.

The local changes to the health landscape, the *Shape of Training* review[7] and proposed changes to internal medicine training from the Joint Royal Colleges of Physicians Training Board (JRCPTB) will require significant alterations in training patterns and provide the opportunity to look at the provision of GIM training in the context of service delivery.

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In an attempt to gauge the opinions of both trainees and trainers in the region, we carried out a two-phase questionnaire. The aim of phase I was to identify areas of concern and opportunity for GIM training and in phase II we tested the acceptability of differing training models among trainees and their perceptions of deliverability in the training units within the region.

Methods

We circulated an initial open-ended, email-based questionnaire to specialty registrars in dual-accrediting medical programmes in north-west London and regional and local training leads posing a single question about their perceptions of the delivery of GIM training, including the governance and delivery. The question required free text responses in order to allow open-ended answers and, thereby, allow expression of all views by the respondents. The GIM training leads, directors of medical education and the heads of school of medicine for London reviewed these results.

We then carried out a second structured survey (SurveyMonkey), which posed the specific questions synthesised from phase I (Box 1). It was circulated to all core medical and dual-accrediting specialty trainees and trainers and acute medicine service leads in the region. The qualitative data were analysed by the first author and reviewed separately for agreement by the second. This survey offered three possible models of GIM delivery (Table 1). Each maintained the current duration of GIM training as defined by the GIM curriculum.

This study was deemed a service analysis and therefore did not need ethical approval. Individuals were invited to take part and were aware that all responses would be confidential.

Results

Survey 1

In total, 13/30 trainers (43%) and training leads and 24/222 specialty trainees (11%) responded to the initial question. While concerns about a wide range of aspects of training were voiced, three key themes emerged (the quotes are from trainees).

Table 1. Preferred model of general internal medicine (GIM) training in a dual accreditation programme

Model	Core and acute care trainees	Specialty trainees	trainers
Current model (GIM throughout a 5-year dual programme)	28%	39%	40%
Fixed blocks of GIM comprising 50% in years 1, 2 & 5, 100% specialty in years 3 & 4	36%	32%	37%
Front loading, 70% GIM in years 1 & 2, 25% in year 5, 100% specialty in years 3 & 4	36%	29%	23%
Any new model	**72%**	**61%**	**60%**

Box 1. Survey 2 questions

Would you support a separate ARCP process for general internal medicine organised by the GIM training committee with appropriate trainer and administration support? If so, how frequently should this occur?

Which of the following options would you prefer for the delivery of GIM training?

1. Blocks of 'pure' GIM of 3×4/2×6/1×12 months in the first 2 years, followed by 'pure' specialty over 2 years with a further period 6 month GIM block at the end of training.
2. Front loading of the first 2 years of training (increased exposure to GIM compared with specialty, eg 70:30 split) with pure specialty training for the next 2 years, and exposure to GIM in the final year, with GIM delivered in short blocks throughout the year.
3. Maintenance of the current model of GIM experience in the all training years.

Does the unit in which you currently work or provide training in deliver the requirements for GIM training as detailed below and have the ability to provide this to an increased number of trainees?

- An average of 40 patients per month (480 per year) (this relates to the requirement to care for 1,000 patients over a 3-year training programme).
- Capacity for a greater number of trainees (possibly up to an additional 50% in each unit).
- Appropriate educational supervision by trainers actively partaking in GIM.
- Educational engagement of GIM staff to provide appropriate workplace-based assessments/learning episodes to allow for sign off, including direct clinical review of patients rather than administrative or coordination of patient pathways.
- Administrative support to ensure that trainees are free to review and manage patients.
- Opportunities to gain experience in alternative delivery systems, eg ambulatory medical care.
- Access to appropriate outpatient experience to provide the GIM training (eg hot clinics).
- Quality improvement opportunities within the GIM setting.
- Continuing professional development opportunities specifically for GIM (either internal or release for external programmes).

ARCP = annual review of competence progression; GIM = general internal medicine

Annual review of competence progression (ARCP) processes for GIM

I challenge you to find a doctor who finds they get constructive feedback from either ePortfolio forms or the appraisal (ARCP) itself.

A dedicated GIM ARCP is likely to improve quality of GIM training, identify deficiencies in training environment and focus trainees on their GIM training.

Table 2. Separation of specialty and GIM annual review of competence progression

Grade	Separate ARCP		If so, when?		Format	
	Yes	No	Annually	Once before PYA	Face to face	*In absentia*
Core medical/acute care trainees	70%	30%	75%	25%	87.5%	12.5%
Specialty trainees	36%	64%	65%	35%	65%	35%
Trainers and service leads	74%	26%	83%	17%	83%	17%
All respondents	52%	48%	75%	25%	78%	22%

ARCP = annual review of competence progression; GIM = general internal medicine; PYA = penultimate year assessment

Impact of service changes on the ability to 'train' while on call

Daily consultant ward rounds… has stripped the medical registrar of opportunities to gain experience and complete the competencies required.

You simply do not have time to clerk patients yourself, let alone examine, initiate management, investigations, and review everyone else's patients.

The result is that no fewer than 5 consultants run the post-take ward rounds per day. It is impossible to present sufficient patients to individual consultants to have an ACAT assessment completed. Second problem is that the take is so busy … The medical registrar is not 'in control'.

'The registrar is too busy to see any patients if answering the phone all day to GPs.'

Models of GIM training in the region

My feeling is that the first year should be GIM heavy to allow adaptation to specialty training

I agree that the initial one or two years as a registrar should be generic training, with a focus on specialty in years 3+.

A solution would be fragmenting the training rotation into two with clear agreement as to whether the next year was a GIM or a non GIM year.

Survey 2

In total, 23/176 core medical trainees (13%), 63/224 specialty trainees (28%) and 34/41 trainers and service leads (83%) provided a complete response to the questionnaire.

Format of a GIM ARCP

Table 2 describes the responses to these questions by group with respect to the availability, frequency and format. In summary, 52% of all respondents supported a separate GIM review, 75% preferring this to be on an annual basis, and 78% were in favour of a face-to-face rather than *in absentia* review.

Deliverability of increased GIM training

Table 3 details the responses of trainees on the availability of each GIM training resource by hospital site. The overall responses for trainers across all sites are given for comparison. While the majority of respondents reported that the units in which they worked had acute medicine workloads that would be appropriate for an expansion of training (83%), their opinion was that the key educational aspects of the posts were lacking. Of note, the trainers and service leads report a higher level of confidence in the ability to deliver training than their trainees do.

Structure of GIM training within a dual programme

Table 1 outlines the favoured models of training across the three groups. A small majority of both trainers (60%) and trainees (62% of specialty trainees and 78% of core and acute care trainees) favoured a new model of GIM training (either with front loading or with fixed blocks). There was no specific preferred new model.

Thematic analysis

Twenty trainees (23% of respondents) provided free text responses. Of these, three (15%) focused on the ARCP process, two (10%) on the lack of family friendly rotas and four (20%) on the inability to see sufficient patients because of administrative and organisational demands when on call – 'signposting' of referrals to appropriate resources and delivery of service within target times were identified as key issues. Four trainees (20%) raised the issue of 'acute service provision' not equating to delivery of training or as interfering with training opportunities. Two trainees (10%) expressed concern that GIM training did not effectively prepare them for the consultant role.

Discussion

Our data and the conclusions reached are limited by the overall sample size and response rate for both surveys. This raises the possibility of respondent bias as individuals who have suffered a poor training experience will have been more likely to respond than those whose training is progressing well. Nevertheless, we believe that there are important outcomes from this survey that deserve further discussion and study.

When asked about the development of a separate ARCP for GIM, the majority of both core trainees and trainers were in favour, and there was a clear preference for a face-to-face format on an annual basis. This is at odds with the move towards *in absentia* ARCP processes, which are the preferred model for Healthcare Education England in some regions. We note that specialty registrars are not in favour of separating the specialty

Table 3. Trainees' views on the ability of individual units to deliver aspects of GIM training

Site	40 patients per month per trainee	Capacity to increase number of trainees	Access to Ed Sup	Access to WBAs or SLEs	Admin support for on call	Alternative delivery of care models	Acute clinics in GIM	QuIP in GIM	Access to GIM CPD
DGH1	83%	66%	83%	66%	50%	83%	33%	50%	50%
DGH2	83%	66%	33%	50%	33%	50%	33%	50%	50%
DGH3	60%	33%	33%	33%	33%	33%	33%	33%	33%
DGH4	60%	60%	40%	80%	20%	40%	20%	40%	40%
DGH5	89%	55%	89%	78%	22%	66%	66%	22%	66%
DGH6	85%	70%	74%	74%	48%	74%	33%	56%	67%
TH1	66%	42%	58%	75%	58%	58%	50%	58%	50%
TH2 S1	83%	50%	50%	33%	16%	16%	16%	33%	33%
TH2 S2	33%	25%	33%	48%	42%	42%	25%	25%	50%
TH2 S3	86%	36%	79%	79%	57%	50%	29%	50%	64%
Trainees overall	**83%**	**54%**	**71%**	**74%**	**47%**	**62%**	**38%**	**49%**	**62%**
Trainers	**88%**	**82%**	**76%**	**79%**	**50%**	**85%**	**53%**	**68%**	**82%**

The categories reflect the criteria in Box 1. Response rates (% of responding trainees) have been flagged (orange<50%, yellow = 50–75%, green>75%) for clarity. Because of the small numbers of respondents per site, the training units have been anonymised and classified as teaching or district general hospital units. Responses from trainers have not been divided by site because of low numbers.
CPD = continuing professional development; DGH = district general hospital; Ed Sup = educational supervision; GIM = general internal medicine; QuIP = quality improvement project; SLE: systematic learning event; TH = teaching hospital; WBA = workplace-based assessment.)

and GIM ARCP, and their free text responses suggest that this is due to the perceived increase in administrative paperwork.

Multiple models of acute on-call working exist within the UK. In our own sector, the majority of units offer 'blocks' of 2–4 weeks on call within which GIM training is based. These blocks comprise 35–50% of the entire working year. The pressures of service delivery result in trainees providing acute medical take in the majority of training years on a dual-accreditation programme. Anecdotally, trainees comment that this acute medicine commitment significantly impacts on their specialty training.[3] Our data suggest that the trainees who responded to the survey were in favour of a greater proportion of the early years of training being based in a general and acute setting, allowing later years to focus on specialty training; 72% of core trainees and 61% of registrars opted for these models. Both would require a mixed specialty and GIM final year prior to the award of a Certificate of Completion of Training (CCT). There was no clear preference between the two proposed models.

The increasing numbers of acute admissions to a smaller number of emergency departments in our region has resulted in the need to consider either changes to the delivery of GIM or increases in the numbers of trainees in the remaining units. The trainers responding to the survey felt that their units were able to deliver such an increase in training and deliver the additional educational content required. The trainees felt that there were sufficient patient numbers; however, they reported that other training opportunities were not as widely available, with half of our respondents suggesting that access to quality improvement projects, alternative models of care and acute clinics was not in place.

When asked about access to core education processes, workplace-based assessments and educational supervision, there was a wide range of responses, with some units reported as offering significant opportunities to access these resources and others not. Given the small numbers of respondents per unit, it is not appropriate to comment on this range of responses further. Finally, the current GIM curriculum requires trainees to record 100 hours of continuing professional development in order to complete training. Our survey suggests that access to this continued external learning is limited in our training units.

Conclusion

While our data should be taken in the context of a low response rate (a common problem with such studies), it does raise concerns that our ability to deliver GIM training remains focused on the acute setting, with little access to ambulatory and outpatient-based learning. They also suggest that, at least in our respondents' eyes, we do not have the capacity to increase GIM training significantly in our units and struggle to deliver basic training requirements, such as educational supervision and access to workplace-based assessments.

Some of these data seem at odds with the results of the national General Medical Council (GMC) trainee survey, highlighting the fact that the latter does not meaningfully separate specialty and GIM feedback.

These preliminary results lead us to believe that a larger scale attempt to gauge the opinions of our trainees on their GIM training experience, whether through a modified GMC trainee survey or a college run process, would be appropriate. Furthermore, there is a need to identify and agree the components of GIM training in order to differentiate it from acute medicine and to trial alternative models.

Given the concerns about the attractiveness of the medical registrar role raised by phase I of our survey and elsewhere, we feel that there is a place for a nationally coordinated but locally delivered process to assess trainees' opinions on the deliverability of GIM programmes and their preferred models

of training. This would support the development of the proposed internal medical training programmes and the format and delivery of the ARCP process for each specialty and GIM, while ensuring that the voice of the trainees is heard. ■

Conflicts of interest

The authors have no conflicts of interest to declare.

Author contributions

GVS designed the surveys, carried out the analysis and wrote the manuscript. CM reviewed the data and the manuscript. JW supported the development of the survey and reviewed the manuscript.

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