Future Healthcare Journal 11 (2024) 100148

Contents lists available at ScienceDirect

Future Healthcare Journal

journal homepage: https://www.sciencedirect.com/journal/future-healthcare-journal

Programme evaluation of the general internal medicine training programme

Elizabeth Estabrook[a,*], Chloe Langford[b], Sally Curtis[c]

[a] Consultant in General Internal Medicine at University of Southampton Hospital Trust, Tremona Road, Southampton SO16 6YD, United Kingdom
[b] Medical Education Lecturer at University of Southampton, University Road, Southampton SO17 1BJ, United Kingdom
[c] Professorial Fellow in Medical Education at University of Southampton, University Road, Southampton SO17 1BJ, United Kingdom

ARTICLE INFO

Keywords:
Workforce
Generalism
Specialty training
Internal medicine

ABSTRACT

General internal medicine (GIM) has predominantly been perceived as a joint specialty to be completed alongside specialty training in the United Kingdom. The Internal Medicine (IMT) Stage 2 curriculum was released in August 2022;[1] in October 2022 the Round 2 Specialty Training recruitment included applications for the pilot GIM training programme, and in February 2023 NHS England commenced the 3-year programme.

The GIM programme aims to provide run-through training for GIM to Certificate of Completion of Training (CTT). This report establishes the initial recruitment demographics of trainees, as well as an analysis of the successful applicants' perspectives on the programme and their motivations for applying.

Introduction

While many NHS trusts across the UK have inpatient wards for GIM patients, there is a lack of consistency on who provides care for this broad group of patients. Patients aged 18–80 years old with a clearly identified single illness leading to their hospitalisation are typically managed by specialists such as gastroenterologists or respiratory physicians; however, with increasing multimorbidity, there is a large proportion of patients who do not fit this model. As a result, many trusts have recruited physicians from various backgrounds to manage their care. These include acute medicine consultants, other specialists with an interest in general internal medicine, and physicians who trained abroad with generalist skills. Currently many medical specialties require dual training in GIM alongside the primary specialty, enabling a large proportion to gain generalist skills. However, most consultants are subsequently recruited into their specialty field but only contribute to general medical on call as a small part of their job plan. As there is not a clear pool of physicians dedicated to GIM to recruit from, there is often a reliance on locum physicians. Following the success of the IMT Stage 1,[2] it is thought the development of the IMT Stage 2 training will enable the development of specialists in GIM to fill this gap in the consultant workforce. This report focuses on the initial recruitment outcomes of the GIM programme.

Methods

A mixed methods analysis of the GIM pilot programme included quantitative analysis of application demographics from Round 2 of Specialty Recruitment in October 2022 (Cohort 1) and Round 1 October 2023 (Cohort 2). Those recruited to positions starting in February 2023 (Cohort 1) were invited to participate in an interview reflecting on their experiences of the programme. Recruitment data were obtained from the NHS England Physician Higher Specialty Training (PHST) application database for analysis.

Anonymous semi-structured interviews were conducted with ten of the 13 specialty trainees who comprised Cohort 1. Three were either unavailable or did not respond to requests for interviews, no specific reasons were given. Trainees were approached initially via email and invited to attend in-person interviews; those unable to attend in person were interviewed over Microsoft Teams. Interviewers were senior registrars or consultant physicians and interviews were conducted between May and July 2023. Questions focused on the participants' prior experiences of clinical work, their initial experiences of the training programme and their future career plans (Appendix 1). The in-person and Teams interviews were recorded via Teams and transcripts created. Transcripts were reviewed for accuracy and errors corrected before analysis. A reflective thematic analysis was completed from the responses

This article reflects the opinions of the author(s) and should not be taken to represent the policy of the Royal College of Physicians unless specifically stated.

* Corresponding author.
E-mail address: elizabeth.estabrook@uhs.nhs.uk (E. Estabrook).

https://doi.org/10.1016/j.fhj.2024.100148
Received 3 April 2024; Received in revised form 4 June 2024; Accepted 4 June 2024

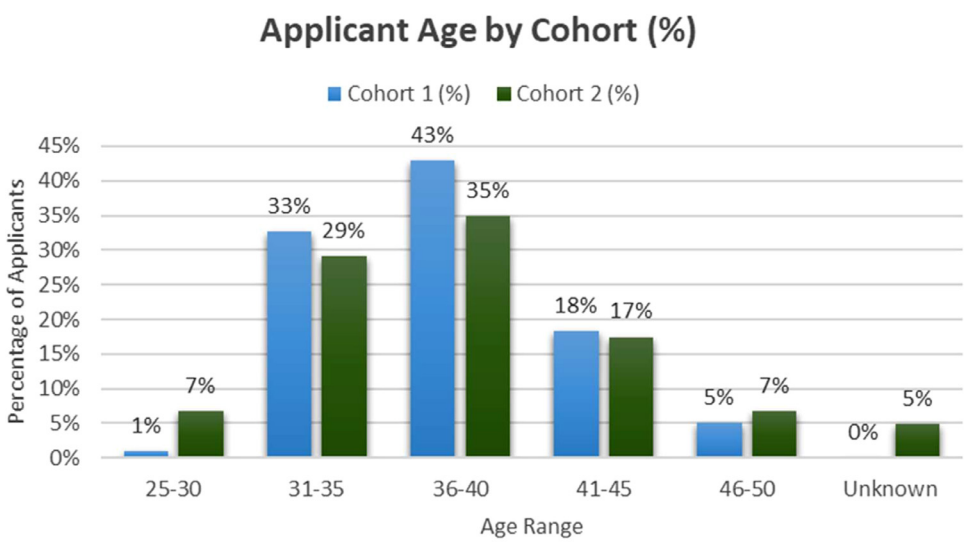

Fig. 1. Applicant age for Cohort 1 and Cohort 2 as a percentage of all applications.

Table 1
Application outcomes.

	Cohort 1	Cohort 2
Total number of applications	**98**	**103**
Number shortlisted	58	62
Number of posts offered	16	29
Number who accepted	**13**	**17**
Longlist unsuccessful	27	30
Shortlist unsuccessful	11	11
Interview DNA or withdrawn	5	13
Interview unsuccessful	18	6
Offer declined or expired	17	12
Applicant accepted another post	4	12

Table 2
Specialty accepted by trainees who withdrew from Cohort 2.

Specialty	Number
Endocrine and diabetes	8
Geriatric medicine	5
Acute internal medicine	3
Gastroenterology	2
Other	2

using Braun and Clarke's six-step process of thematic analysis.[3] Initial codes were reviewed in an iterative process to establish key themes. These were reviewed by the research group, which consisted of the authors and three of the interview panel members, before final themes were identified.

Results

Application outcomes

Two application rounds were reviewed from PHST Recruitment databases. These were Round 2 recruitment cycle in October 2022 who made up Cohort 1, and Round 1 recruitment cycle October 2023 who made up Cohort 2. These received 98 and 103 applications respectively, with 13 and 17 recruited to a potential of 16 and 29 places offered. All outcomes are listed in Table 1.

Those applicants who applied to Cohort 2 and declined or withdrew from GIM to accept other posts typically accepted other medical specialties, of which diabetes and endocrinology was the most frequent, followed by geriatric medicine and acute internal medicine (Table 2).

Applicant demographics for Cohort 1 and 2 are demonstrated in Table 3. Graphs shown in Figs. 1–5 show comparisons between cohorts and additionally, those who were successfully recruited.

Interview results

Thematic analysis revealed major themes of uncertainty and identity. These were highly visible when reviewing responses to questions about participants' current training and future career expectations. Minor themes of motivation and experience were seen when considering the trainees' preparation for the role. When considering their current training, the minor themes of autonomy and support were established. A graphical depiction of the interplay between these themes can be seen in Fig. 6.

Uncertainty

The main challenges identified by trainees related to uncertainty around their training and future careers. Several noted that there was uncertainty about the shape of the training programme over the coming 3 years and felt unclear about what rotations they would be expected to complete in order to meet the learning outcomes.

> *'It's still just vague, but it should be clear […] I know it's difficult because it's just a pilot but still, it would be more attractive.'*

Additionally, several conveyed a desire to have a broader range of training opportunities than those currently offered. They believed that a generalist should have the opportunity to gain experience in multiple specialties to ensure that they had the confidence to manage the medical complexity expected of a GIM consultant.

> *'In Stage 1 [of the internal medicine curriculum] the trainee will go through some specialities […] so why not in Stage 2?'*

Identity of role

Several GIM trainees felt that there was a lack of recognition of what a GIM consultant role was. They gave several examples of people who questioned their role and the purpose of their training.

> *'Because it is a new programme […] they don't know about it. Even the consultants. What is GIM? What is your role? What you will be after 3 years?'*

> *'Another consultant asked me: You will be jack of all trades, master in none, be a master in something!'*

On commencing the programme, several trainees indicated that they were supervised by consultants with other specialty roles who were less familiar with the general internal medicine curriculum. As a result, they felt that they needed to give their supervisors direction on what their curriculum required.

Table 3
Applicant demographics.

	Applicants to Cohort 1: N (%)	Accepted to Cohort 1: N (%)	Applicants to Cohort 2: N (%)	Accepted to Cohort 2: N (%)
Total	98	13	103	17
Sex				
Male	65 (66%)	9 (69%)	70 (67%)	12 (71%)
Female	31 (32%)	4 (31%)	28 (27%)	4 (24%)
Unknown	2 (1%)	0	5 (6%)	1 (5%)
Age range				
25–30	1 (1%)	0	7 (7%)	0
31–35	32 (33%)	4 (31%)	30 (29%)	8 (64%)
36–40	42 (43%)	4 (31%)	36 (35%)	3 (18%)
41–45	18 (18%)	3 (23%)	18 (17%)	5 (29%)
46–50	5 (5%)	2 (15%)	7 (7%)	0
Unknown	0	0	5 (5%)	1 (6%)
Prior training				
IMT Stage 1 Current or Complete	13 (13%)	2 (16%)	38 (36%)	7 (41%)
Alternative Certificate	85 (87%)	11 (85%)	65 (63%)	10 (59%)
GMC registration date				
2020 onwards	55 (56%)	6 (46%)	40 (39%)	5 (29%
2017–2019	24 (24%)	3 (23%)	34 (33%)	9 (53%)
2010–2016	10 (10%)	4 (30%)	20 (19%)	3 (18%)
Before 2010	0	0	1 (1%)	0
Unknown	9 (10%)	0	8 (8%)	0

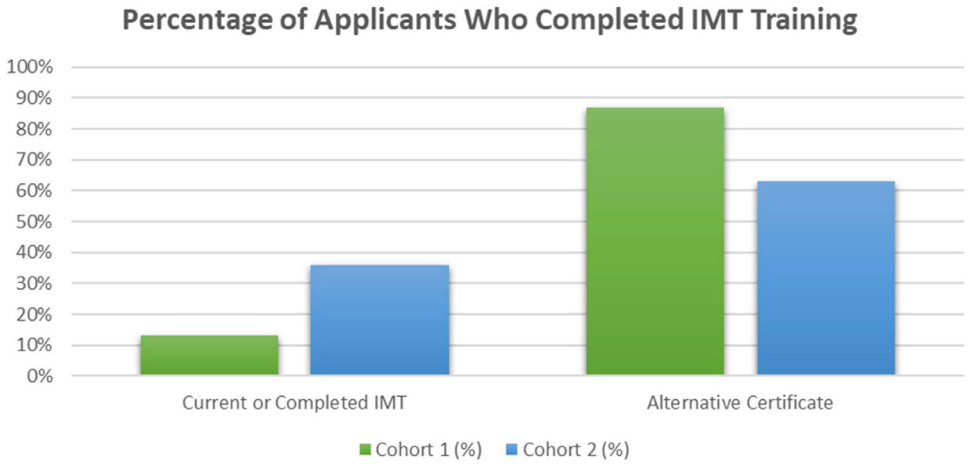

Fig. 2. Percentage of applicants who were enrolled in or had completed IMT Stage 1 and those who obtained an Alternative Certificate.

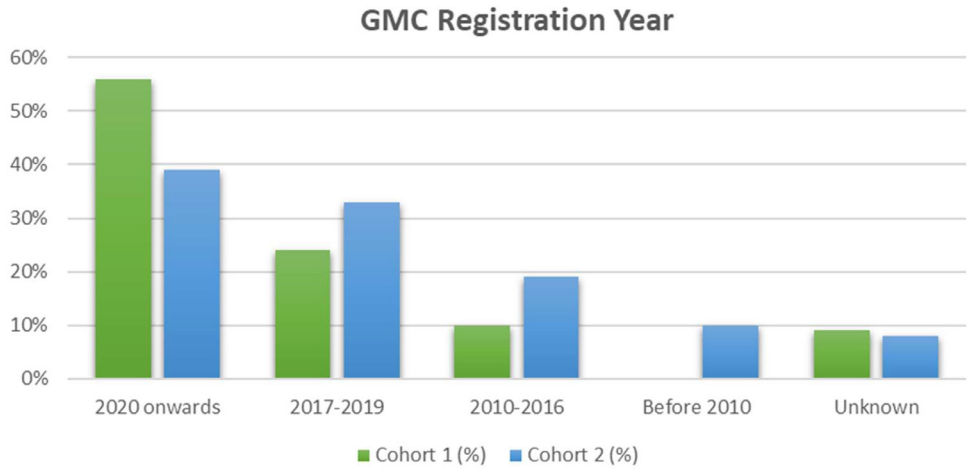

Fig. 3. Year of GMC registration for all applications.

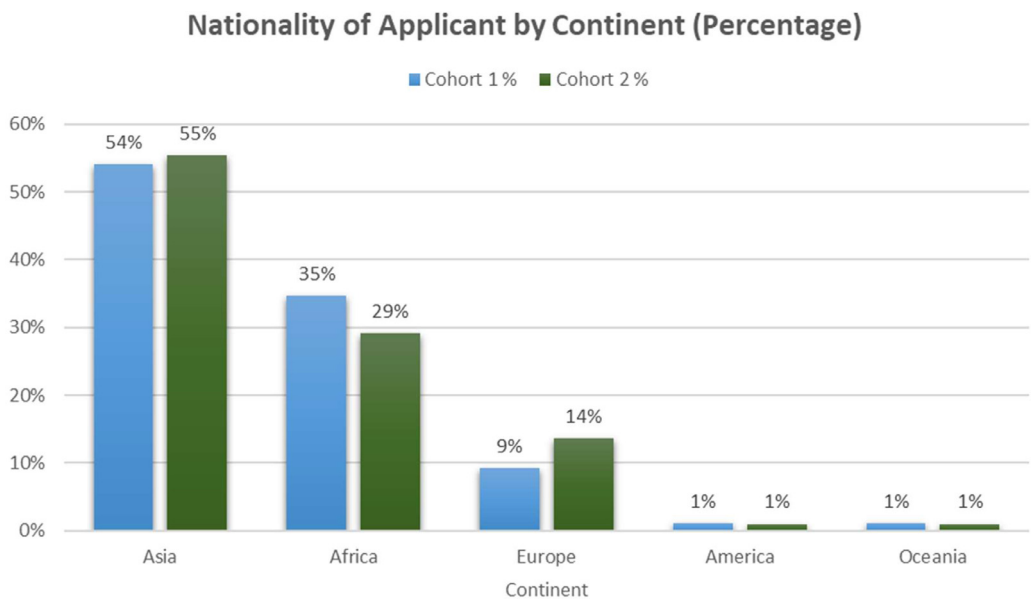

Fig. 4. Applicant nationality by continent for all applications Cohort 1 and Cohort 2.

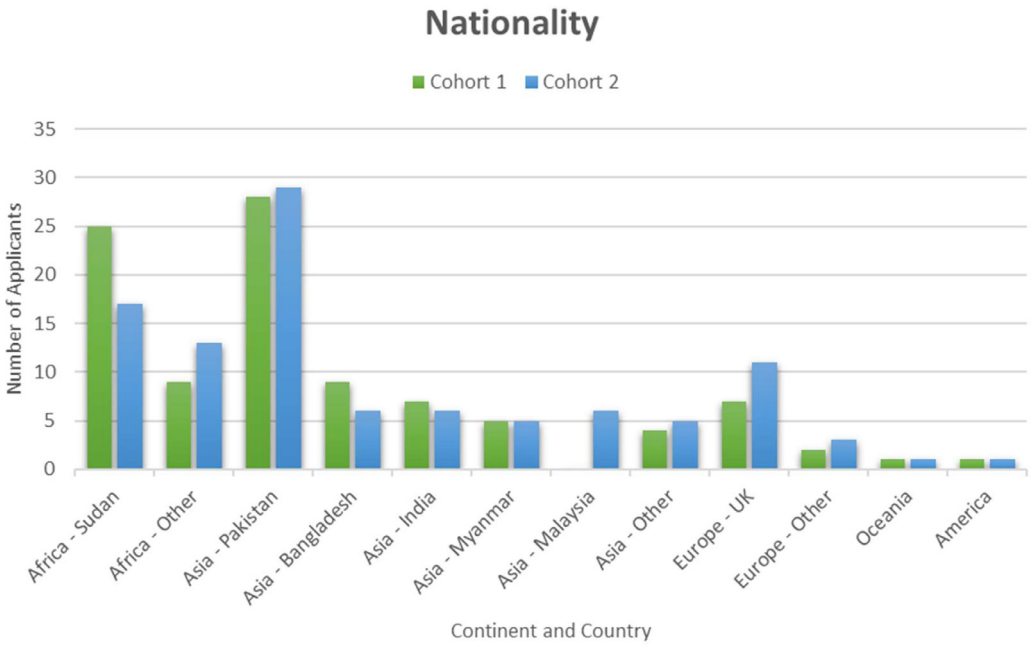

Fig. 5. Applicant nationality by continent and country for all applications.

'I think it's about making the supervisors more aware and more knowledgeable about the curriculum, what they need to do to support us as trainees.'

Motivation and experience

Most stated their prior experience in general internal medicine as a strong motivator.

'From my graduation, I'm a generalist, so I worked in internal medicine all of my career since I graduated.'

'When the programme was advertised, I was very happy because initially we didn't have pure CCT programme for GIM.'

Others reported a perception that the programme would offer a more stable working environment. Given the limited number of training sites offered and that the training was 3 years, this was seen as favourable for at least two trainees.

Autonomy and support

Several trainees expressed gratitude for their educational supervisors who have made efforts to recognise individual training needs and tailor the educational opportunities to meet these. Most had prior experience at registrar level prior to commencing the programme and as such were able to use opportunities to maximise their experience in a broad range of clinical areas.

'They are supporting me on everything – my personal life, clinical perspective, my own goals and everything […] I enjoy working there.'

Some also expressed a sense of increased autonomy over their training, which they attributed to being part of a pilot.

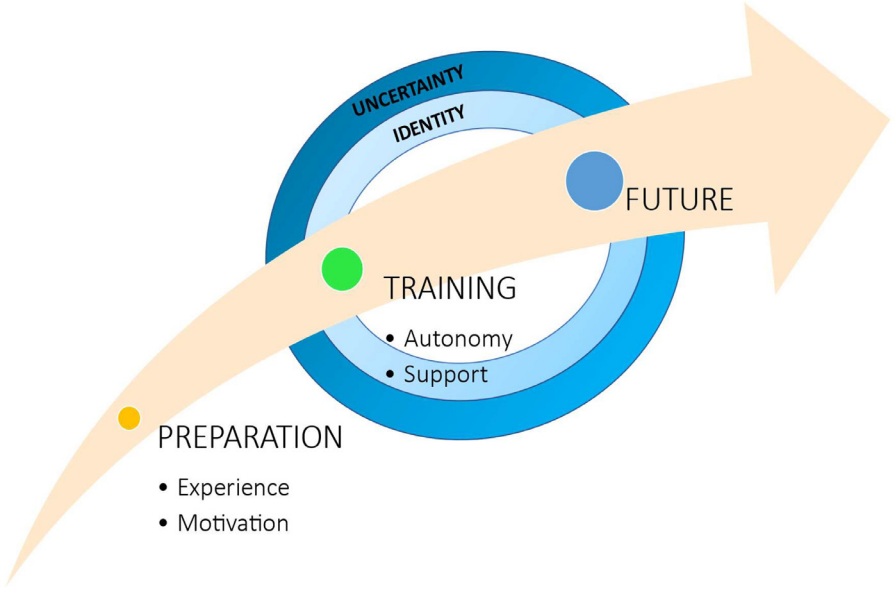

Fig. 6. Themes from trainee interviews.

Future

Overall, there was a strong commitment to becoming a GIM consultant in the future. In addition, several expressed an interest in maintaining or developing a specialist interest alongside their GIM role, mostly in diabetes and endocrinology.

> *'I'm planning to do a master's degree in diabetes and endocrinology […] I'll be committed to GIM and then in part time I'll just do the master's degree.'*

We interviewed two trainees who have since chosen not to continue the training programme in order to take up another training post. Both expressed an interest in maintaining their generalist skills as their primary motivation for applying for GIM training; however, they had both applied for their chosen specialty prior to starting.

Discussion

The general internal medicine single accredited specialty training programme has been successful in recruiting a highly motivated group of trainees with a broad range of backgrounds. Most trainees had prior experience in GIM and were planning to maintain their practice in the future. Those who did not take up offered posts tended to accept posts in diabetes and endocrinology that traditionally had GIM roles within most NHS trusts, or those that had other generalist components such as acute and geriatric medicine.

Prior work has established the significant impact of role transitions on personal and professional identity as well as the essential role of personal and professional relationships in this development.[4,5] Trainees in this evaluation have a unique challenge of transition into a less well-defined professional role. Transition to the medical registrar role is recognised as a liminal experience with opportunity for both positive and negative impact on trainees' wellbeing and growth.[6] A shortage of supervisors, and therefore role models, who currently practise GIM as a single specialty appears to be a strong contributor, thereby leaving some trainees expressing an increased reliance on self-direction. This programme evaluation reveals that support for identity work and strengthening of professional relationships would likely promote successful recruitment and retention. Uncertainty regarding the training delivery and their future roles appear to have significantly impacted the trainees' experience so far. Strong support from clinical and educational supervisors, including those with dual accreditation in GIM and another specialty, was found to have a significant positive impact on the trainees.

The trainees interviewed demonstrated their commitment to their future role as a GIM consultant and many were considering additional training to support their future role. Future evaluation of this unique group of trainees at the time of transition to their consultant role would provide valuable insights into their identity development and on the outcomes of this training programme.

Conclusion

This programme evaluation suggests that trainees entering single accreditation GIM training experienced uncertainty and struggled to find a clear identity. Trainees would benefit from a greater understanding of the GIM consultant role within the NHS for both themselves, and the wider healthcare system. Successful retention is likely to benefit from additional professional support for transition into the role. General internal medicine consultants have the potential to provide high-quality generalist care to hospitalised patients and fill a gap that is currently seen in the NHS workforce. It will be essential to ensure that there is clear development of the role of the GIM consultant in workforce planning and a strategic plan from NHS leadership that looks to develop this diverse and motivated group of future consultants.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Elizabeth Estabrook: Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Chloe Langford:** Writing – review & editing, Supervision, Methodology, Formal analysis, Data curation. **Sally Curtis:** Writing – review & editing, Supervision, Methodology, Formal analysis.

Acknowledgements

The authors would like to thank all the programme participants and the wider research team who contributed to the interviews: Dr Amanda Barclay, Wye Valley NHS Trust; Dr Angharad Chilton, University Hospital Southampton NHS Foundation Trust; Dr Roopa Chopra, Royal Wolverhampton NHS Trust; Dr Hebattullah Elmedany, Royal Wolverhampton NHS Trust

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.fhj.2024.100148.

References

1. JRCPTB curriculum for general internal medicine (Internal medicine Stage 2) Training https://www.thefederation.uk/sites/default/files/Internal%2520Medicine%2520%2528Stage%25202%2529%25202022%2520curriculum%2520FINAL%2520200522_0.pdf.
2. Internal medicine recruitment fill rate: https://www.imtrecruitment.org.uk/documents.
3. Clarke V, Braun V. Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *Psychologist.* 2013;26(2):120–123.
4. Monrouxe LV. Identity, identification and medical education: why should we care? *Med Educ.* 2010;44(1):40–49.
5. Gordon L, Rees CE, Jindal-Snape D. Doctors' identity transitions: choosing to occupy a state of 'betwixt and between. *Med Educ.* 2020;54:1006–1018.
6. Kerins J, Smith SE, Tallentire VR. Just pretending': narratives of professional identity transitions in internal medicine. *Med Educ.* 2023;57(7):627–636.