

## FAQs for G(IM) ST3-7– London

Disclaimer – this is generic advice written to be understandable and helpful. It contains opinions and recommendations from TPDs based on their expertise, but due to the variety of training in GIM may not apply directly to your situation. It is based on the current state of training in mid-2016. Refer to the GIM curriculum 2009(2012) and ARCP decision aid if in doubt. But, to be fair, this is easier and more interesting to read.

### *How much CPD counts towards GIM?*

You should have 100hrs of external clinical CPD for GIM spread through your specialty training. It can be done during your GIM years (but doesn't all have to be, you can do some during a specialty year too) and must broadly represent the GIM curriculum. The best way to ensure that is to attend the regional GIM training days. You can augment these with online CPD (up to 15hours) and other relevant courses from bodies such as the RCP, RSM and BMA. Note that most training days count for **6** hours of CPD not 8. Or, you know, 15.

### *What CPD doesn't count?*

Your specialty training doesn't count towards this unless there's an explicit GIM section. Internal training (grand rounds, dept meetings etc) are a separate requirement and don't contribute to the 100 hours. ALS and generic courses (management, teaching etc) are also a separate requirement. A 5-day specialty conference in viral hepatitis with 35 CPD credits is unlikely to be regarded as entirely GIM relevant so don't try to count that.

### *Which clinics count towards GIM?*

Most medical specialty clinics. But not your fancy high-falutin' subspecialty clinics. Typically they should involve a broad spread of patient types (different ages, varying levels of comorbidity) and diagnoses, and some general ward follow-up patients. Ideally you should also get some experience in acute medical clinics such as ambulatory care or 'hot' clinics. If your specialty isn't particularly clinic-based (eg geriatrics) then another option to accrue consultative experience is with GIM ward reviews (5 reviews = 1 clinic).

### *What's the point of doing another audit?*

You are training for two CCTs and each set of requirements should be considered as equivalent. The rationale for doing *another* audit is that, as a future GIM consultant, you should be engaged with your acute medical service in a leadership and quality improvement role. An audit (or QIP) is a simple way to begin that process. You can lead it and get some junior doctors to help out with the data collection – that's a useful skill too.

### *Why can't I count my specialty audit which included the acute medical unit?*

First because then almost nobody would do a GIM audit. Secondly, being intrinsically engaged with the improvement of your acute medical service is different from externally

assessing the acute team's competence at managing a specific problem related to your specialty. Make it easy for your GIM TPD by doing an audit that's clearly not related to your specialty – there are loads of other specialties out there!

*Do I have to close the audit loop?*

Yes, otherwise it's a proper rubbish audit and not befitting the standard of a senior trainee. However, you do not have to do all the leg work yourself – supervising an audit process is entirely acceptable (if not more relevant to your future role). Alternatively you could do a quality improvement project. However the audit/QIP should have some genuine governance over it, with evidence that it was registered, properly conducted, results presented and actioned, and change evaluated.

*What makes an 'adequate' ACAT?*

It must include at least 5 cases from an acute admissions process (with presentations specifically listed, not just "Acute take patients x 10) and have some evidence of feedback and learning related to them. Then link it to up to 8 curriculum items to which said feedback related. You can also use them as a feedback tool for your ward round leadership skills later in training. Ask your consultant if you can lead the post-take WR and make the decisions for patients you didn't admit yourself, then get feedback on this skill using the ACAT.

*Can I cross-count my SLEs from my specialty?*

Maybe, a bit. Previous advice has been that a maximum of 1/3 of the GIM SLE requirement can be cross-counted although this is no longer explicitly stated. However any that you are counting have to be clearly GIM-relevant (eg GIM problems on your specialty ward/clinic). This is largely applicable to cardiology or renal trainees who are cross-counting a notional year of their specialty training as GIM. Note that ACATs, pretty much by definition, are unlikely to be GIM-relevant outside of the acute medical admissions process.

*What about those DOPS? They're a royal pain in the a\*\*\*\**

Language, please. But OK, this is a tricky one. You are required to demonstrate your procedural competence *during* your registrar training. It's expected that you achieved some competence in your CT years but this needs to be maintained or progressed with evidence to show that. The expected method for doing this is with DOPS, and I suggest you look at the GIM ARCP Decision aid (Google it) on the JRCPTB website which shows every procedure you're required to do, to what level (including live vs skills-lab) and how you record it. Some of this you can knock out in an hour in your education centre and save yourself a lot of bother later on. Other stuff can be a bit more tricky as you do need to find someone to sign you off – but you do have several years to pick this stuff up and if you really need to you should be able to arrange getting yourself along to a rheumatology clinic for a

knee aspiration or a theatre list for an art-line. You don't want to be doing this stuff in your last 6 months when you should be looking for consultant jobs, so get on it early.

*What's the point of linking and signing off the curriculum?*

Good question, because it does seem like a huge amount of pointless clicking, doesn't it? Rest assured we find quite a lot of it fairly irritating too. There's no doubt that eportfolio has flaws – some conceptual, some practical. However it's what we have and you can rest assured that the software you'll use for appraisal evidence once you're a consultant is likely to be at least as bad, so consider it training. But what is it supposed to represent? Ultimately it's to provide some assurance that you've had experience and training across the full range of the curriculum (and if you haven't, to highlight that to you and us). When you link an ACAT to a few items on the curriculum (maximum of 8 links for ACATs, and 2 for CbD/CEX, mind) that is supposed to represent the fact that you've had experience and meaningful feedback in relation to those particular items. Your ACAT patients may have had many more pathologies or presentations than the 8 you've linked to, but it's unlikely you discussed every one of those issues.

Progressively over time, you should therefore gradually build up evidence that you've had experience and related training across the curriculum. Some things you'll pick up quickly if they're common or related to your specialty – these you can self-sign off in the curriculum and have your ES counter-sign them, perhaps even within the first year of training. Others may take longer to accrue or require targeted experience or education. By PYA you should expect to have most (but not necessarily all, you've got time!) of your competences evidenced, signed off by you **and** countersigned by your educational supervisor(s). So do it in tranches across each year of GIM training, not all at once – your ES will be grateful.

*Why am I doing all these on-call shifts if they might not 'count' as GIM training?*

Confusing, yes. Due to the highly varied nature of GIM training across multiple specialties and local health systems, the national curriculum cannot be particularly specific about what 'counts' as GIM. There are more specific requirements such as the 1000 patients / 186 clinics one, but the time component remains. The GIM curriculum requires you to do 3 years (2+1 in some specialties where one year cross-counts as GIM) of general medical training, which should usually be based around unselected acute medical admissions with ongoing experience of caring for patients after the acute admissions period (typically on your specialty ward).

Your training may include alternative models of delivering acute care, but at least 1 year must be unqualified acute, unselected medical admissions. Hospitals that have lost their emergency departments and are now taking selected admissions (that have already been seen by other physicians) clearly don't provide this. The description of a unit as not 'providing GIM' does not mean that **no** GIM experience can be accrued here, but is set in order to give specialty training program directors clarity about which years will unequivocally 'count' as GIM, particularly for trainees who may only do 2 GIM years outside their specialty.

The more simple answer is that you're banded, paid and contractually obliged to provide some on-call requirements when you've been appointed to a training program that includes GIM (even if you've decided to drop GIM). More importantly, throughout your career you will acquire additional experience and skills that aren't explicitly recognised, and that's not really a bad thing.

*Who do I ask to do an MCR?*

The MCR in GIM was designed to obviate some of the challenges with shift-working where your specialty consultants / ES may only rarely see you working in GIM, if at all. The MCR should therefore be sent out to at least 4 other consultants with whom you have done GIM on-calls – typically outside your specialty unless you work in a team-based system with your own consultants.

*Why do I need two separate ES reports?*

Because you're getting two CCTs at the end of your training and both need appropriate supervision, feedback and governance. Frequently a 'combined' report is 90%+ about the specialty with scarcely a mention of GIM. As GIM has a separate curriculum and separate requirements for experience, SLEs, procedures, CPD and audit, to name a few, some focus should be given to it set apart from the specialty. Thus also GIM reports that simply say "See specialty report" are not adequate (although there may be a few areas that this is acceptable eg research and management).

*But do I need a separate GIM Educational Supervisor?*

Probably not. Most specialty consultants have sufficient knowledge and experience of general medicine to fulfil the ES role even if they are not currently engaged in the acute medical rota. However in some specialties there may be supervisors who do not do acute or general medicine, have not done so for some time, and do not feel comfortable acting as an ES for a GIM trainee. If you and your ES feel this is the case, you should discuss whether another consultant within the specialty could fulfil the role. If you need to look outside your department for a supervisor, trusts may have a local system for this (eg some acute physicians will take on this role) but typically it may need some mediation from your specialty TPD and / or the GIM TPD to ensure that other consultants are not overloaded with trainees requiring GIM supervision.

*What other things do people forget to do before their PYA then have to scramble to sort out before CCT?*

Good question. In your last year you want to be concentrating on honing your skills, building your CV and talking to people about jobs, not plugging holes in your eportfolio. Common blind spots include having an up to date ALS qualification (needs to be maintained

throughout clinical training at least up to the date of CCT) with the certificate uploaded, having at least one adequate MSF covering GIM (with a range of assessors including non-clinical roles, nurses, AHPs, trainees and consultants), and keeping a record of the numbers of acute and OPD patients seen (you can use the Firth Calculator from the JRCPTB website to do this). If you've done those things, as well as your CPD, linked your curriculum, acquired GIM ES reports and all the other things mentioned here, you're probably going to be OK.

*Who do I ask if I have more GIM questions?*

Wow. Well, I applaud your curiosity. For local matters you should speak to the clinical or educational lead for your acute medicine department. There will also be a GIM trainee rep who will make themselves known periodically. For admin stuff, usually your main point of enquiry will be the London Deanery (which changes its name every few months to something new and incomprehensible, but is essentially the main administrative centre for postgraduate training). [GIM@southlondon.hee.nhs.uk](mailto:GIM@southlondon.hee.nhs.uk) should work.

Sometimes you will need to speak to the GIM Training Program Director (TPD). Beware, for their time is short and list of unread emails is long – but if you need to discuss a difficult, complex matter; advising you on it is (probably) their job. If you don't know who to contact, check with the Deanery, who may be able to answer your question in any case.

Currently some aspects of training (eg training days) are managed locally by a 'lead provider'(LP) which is likely to be your biggest local teaching hospital (ie most trainees in NW London are managed by Imperial). Your GIM LP will be the same one as your specialty. Within a year or so most LP functions will be absorbed back into the deanery though, so you can probably ignore that last paragraph. Sorry for wasting your time.

Good luck!