

Teale essay prize 2026: the future of general internal medicine training

The Teale essay prize is awarded annually by the RCP to recognise outstanding writing by resident doctors in the physician specialties on key issues facing the profession. Dr Dorinda Chandrabose wrote the 2026 winning essay on the future of general internal medicine (GIM).

Resident doctors were asked to write an essay on how GIM training should evolve over the next decade to produce skilled NHS physicians who are confident working across both generalist and specialist medicine.

In her winning entry, Dorinda argues that GIM training must evolve to better equip resident doctors to care for an ageing population with an increasing number of health conditions. While recognising the strengths of the current model, she highlights the need to strike a better balance between generalist and specialist training to ensure high-quality, holistic patient care.

Read her award-winning essay below*:

Introduction

The current model of general internal medicine (GIM) training has undergone substantial changes over the last few decades. The Calman report (1993) resulted in increased structure in higher specialist training with clearer time-points to delineate progression.¹ The Donaldson report (2002) resulted in the implementation of 'Modernising Medical Careers' which introduced defined competencies and a smoother transition to specialty training.¹ GIM care in the UK is currently delivered by a diverse range of doctors including acute medicine physicians, geriatricians and other specialty doctors that cover GIM alongside their primary specialty. With an ageing, increasingly multi-morbid population, coupled with rapid advances in medicine, it is vital to carefully consider how GIM training could be enhanced to meet the complex needs of the population whilst maintaining a high standard of medical care.

Current model

Currently, GIM training involves entry at ST4 level usually combined with a primary specialty (e.g. cardiology) resulting in dual-accreditation. There are additional routes such as single-accredited GIM or GIM combined with sub-specialty stroke medicine.² The GIM curriculum aims to provide a broad generalist training in core medical specialties, thereby enabling trainees to competently

run the acute medical take as well as manage chronic conditions on the wards.² Medical diseases often do not exist in isolation, therefore maintaining a broad knowledge of conditions is vital for the delivery of high quality care.

In addition, there are a variety of key skills underpinning GIM such as clinical reasoning, managing uncertainty and awareness of when to obtain specialist input.³ These skills are honed through accumulating clinical experience in managing diverse cases and necessitates sufficient time for development. This can be difficult to confidently achieve in the current training format as the curriculum suggests an equivalent of 12 months of dedicated GIM training. This is a relatively short amount of time compared to time allocated to the primary specialty, therefore an increased time requirement could expand GIM clinical experience. However, a counter-argument is that as medicine becomes increasingly sub-specialised and complex, it is vital to ensure that trainees are supported to meet the curriculum requirements of their primary specialty so this is not compromised. There is therefore a delicate balance to be sought between developing the breadth of a strong foundation in GIM in addition to acquiring the depth of knowledge and skills for specialist medicine.

Clinical reasoning

The practice of GIM is underpinned by combining findings from comprehensive history-taking and thorough clinical examination with relevant investigations to formulate differential diagnoses. Good clinical decision-making also relies on a strong foundation in clinical reasoning and there is evidence to suggest that this can be explicitly taught and developed.⁴ GIM training should evolve to incorporate dedicated time focussing on clinical reasoning through educational initiatives covering problem representation (e.g. using semantic qualifiers), logical diagnostic frameworks to approach clinical problems and the consolidation of illness scripts centered around core pathologies.⁵ These skills are often passively learned with clinical experience, however they are vital for the development of confident generalist as well as specialist clinicians and it would therefore be beneficial to incorporate these into GIM training.

Another important aspect of clinical reasoning is appropriate test selection aided by reviewing test performance characteristics such as specificity, sensitivity, false positives/negatives and likelihood ratios.⁵ Clinical

investigations underpin medical practice and therefore GIM training should promote knowledge of the strengths and weaknesses of various tests. It should also encourage decision-making that incorporates other important aspects such as patient preferences and efficient utilisation of resources. In addition, training in metacognition ('thinking about thinking') could help to further improve decision-making.⁶ This encompasses areas such as the 'dual process theory' which highlights the differences between fast, intuitive Type 1 thinking and slower, analytical Type 2 thinking.⁶ Awareness of this model could help GIM clinicians optimise their clinical judgement particularly when facing rare or unusual presentations. Encouraging a switch to Type 2 processing of clinical information could help to reduce medical errors and increase awareness of common cognitive biases (e.g. premature closure and diagnostic momentum).⁷ It is clear that a solid grounding in the fundamentals of clinical reasoning should be integrated into GIM training to provide the skills for future physicians to logically approach both generalist and specialist problems in a considered manner.

Reflection

Clinical reflection is already embedded within the GIM curriculum, however there is scope for enhancement to make it a powerful tool for clinician growth. Case-based learning has been shown to be an efficient teaching tool through making clinical information relevant to real-life scenarios and relatable through exploration of a patient narrative.⁸ Peer-led reflective sessions have also been shown to be an effective teaching modality as well as having beneficial effects on trainee wellbeing.⁹ Increasing opportunities for peer-led case-based reflection amongst trainees from different specialties could improve clinical reasoning, provide exposure to rare cases and develop understanding of human factors. This could also foster a culture of collaborative working between specialties and provide an avenue for approaching a clinical problem from different specialist angles as well as a core generalist approach.

Feedback

Constructive feedback on clinical practice is an essential component in the development of any skilled physician. The current curriculum provides opportunities for formal feedback through workplace assessments, however more regular, informal feedback may provide more practical and specific guidance for clinical development. For example, opportunities for observed 'reverse ward rounds' could be a unique chance to obtain feedback on running a ward round. However, in a pressured setting such as an acute ward, this often relies on the senior clinician having

additional time available which in reality can be a scarce resource. A more consistent and actionable method for obtaining regular feedback could be through providing opportunities for trainees to independently follow up on cases that they have been involved in. This would enable reflection and feedback on clinical judgement and decision-making through following the patient journey from initial presentation to final diagnosis, management and outcome. Reducing barriers by providing a defined period of time for case notes review has been shown to be invaluable in identifying areas of good clinical practice and highlighting areas for improvement.¹⁰

Intergration

It is clear that the integration of generalist medicine alongside specialist medicine is crucial to cater for a complex, multi-morbid population as well as keeping updated with advances in medical sub-specialties. Many medical diseases affect multiple organ systems which can lead to overlap between some specialties. This emphasises the importance of maintaining generalist oversight of a clinical presentation even in a sub-specialist clinic as signs presenting in one organ (e.g. anterior uveitis) could herald the start of a multi-system disease (e.g. Crohn's disease). It is therefore crucial that trainees maintain a broad knowledge of GIM and pharmacology to avoid 'tunnel-vision' thinking when working within their primary specialty.¹¹ By cultivating a generalist approach, trainees will be able to 'connect the dots' of a presentation with multiple symptoms to reach an over-arching diagnosis that may not necessarily be the remit of their specialty. This also highlights the importance of trainees developing a sense of when to refer to other specialties and when conditions can be managed by a GIM physician.

Collaboration

Multi-disciplinary teams (MDTs) are increasingly important in guiding decision-making especially as alterations to the treatment of one organ system could unsettle the balance of another. It has become impossible to be fully up-to-date in every specialty due to rapidly expanding fields and therefore the need for specialists is continually growing. As medical procedures and technology become increasingly advanced and intricate, it is vital that specialty trainees are given adequate time to learn and develop these skills to enable career progression. Furthermore, data has shown that appropriate specialty triage does improve patient outcomes in medical emergencies.¹² There is a clear need for increased collaborative working between different specialties to reduce fragmentation of care, address clinical problems using a multi-faceted approach and create a more streamlined patient pathway. An example of this is the expansion of peri-operative medicine involving geriatricians, anaesthetists and surgeons which has been

demonstrated to improve clinical outcomes.¹³ GIM training should evolve to incorporate MDT working between specialist trainees to enhance patient care and promote a culture of cohesiveness between specialties.

Conclusion

In conclusion, GIM training should emphasise the importance of both a generalist and a specialist approach to daily clinical practice. As patients become increasingly complex and polypharmacy more prevalent, it is essential that physicians have a solid foundation in GIM including diagnostics and clinical reasoning which in turn will enable their specialist knowledge and skills to be optimised. Focussing on areas such as clinical reflection, feedback, integration and collaborative working form core elements of professional growth. The aim of GIM training should be to produce skilled 'dual-identity' physicians with the cultivated mindset of both a generalist and a specialist, thereby empowering them to combine these to deliver truly holistic patient-centred care.

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**This essay and references were not edited for RCP house style and read as submitted for the Teale Essay Prize 2026.*

Teale essay prize

The Teale essay prize is expected to reopen in 2027. The prize is eligible to:

- > Anyone in internal medicine training (IMT) or in physicians higher specialist training (HST). You must be a current subscribing member of the RCP.
- > Any other resident doctor (including foundation, locally employed doctors).
- > Not open to medical students.

For more information, visit the prize page or contact the development officer:

- > Email: fundingandawards@rcp.ac.uk
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