

Academy of Medical Royal Colleges

Academy Response to a Department of Health consultation on the proposal to recognise Acute Internal Medicine as a new medical specialty.

1. The Academy is pleased to have the opportunity to make a response to this consultation on the proposal to recognise Acute Internal Medicine as a new medical specialty.

Preparation of the response

2. This response draws freely on those made by the specialties of medicine represented by the Royal College of Physicians, by the College of Emergency Medicine, and by a number of doctors in training. The Royal College of Physicians is most directly concerned with the standards of training and practice of physicians who have care of acutely ill adult patients; the College of Emergency Medicine is concerned with the management of patients presenting with injury of all severities, children, mental health problems and the entire spectrum of illness and injury seen in the Emergency Department.

3. The response should be read alongside statements submitted by these bodies, together with reports of recent meetings of JRCPTB and PMETB. An Annex contains additional points.

Summary

4. There is broad support in principal for the proposal across these bodies but their statements bring out differences in emphasis and shades of opinion, together with variations in terms that call for fuller discussion and resolution.

5. Respondents have emphasised the importance of a clear understanding of the nature of acute medicine (to be renamed acute internal medicine, AIM) and its relationship to medicine undertaken in the Medical Assessment Unit (MAU)/Clinical Decision Unit (CDU), Critical Care, High Dependency Care and for acute patients in other inpatient wards. They draw attention to the range of physicians who already practice acute medicine both alongside and within their particular specialty, comment on the training of physicians for these several complementary roles, and the service requirements of different acute hospitals.

Royal College of Physicians and doctors in training.

6. The following points are taken from responses made by specialties represented by the Royal College of Physicians and by doctors in training.

Service matters

7. Among a range of views expressed are that:

- Many physicians in acute medical specialties are already trained in acute medicine and run the MAU, high dependency unit and provide care in the first 48–72 hours of acute illness. It must be possible for those dual accredited in future i.e. in their speciality and in General Internal Medicine (GIM)* to be key members of an MAU as now. They do not run an inferior service just because they do not hold a CCT in acute medicine.
- Acute Internal Medicine should be integrated into wider medical and critical care within a hospital, to ensure the richness of partnership working.
- There is strong support for the concept and need for training in GIM to CCT level to enable physicians to be able to safely manage the bulk of acute admissions on a general basis with the knowledge of when to ask for specialist help
- Acute Internal Medicine is not a sub-section of Critical Care
- Acute Internal Medicine needs to support quality of care for acutely ill patients, with training in critical care, Level 2 support and working with outreach ITU.
- There should be flexibility across the Acute Medicine/GIM/Speciality roles of consultants as now, maintaining skills, interest and morale.
- Acute internal medicine physicians, who are well placed to co-ordinate care for acutely ill medical patients when they present as emergencies, should involve the appropriate specialists in the care of patients who present with acute problems in that speciality

And a specific view that

- Acute physicians working with respiratory physicians need to care for Level 2 beds, non-invasive ventilation (NIV) and undertake management of the MAU.

Training matters

8. In respect of training the points made and questions raised included:

- Strong support for the concept of and need for training in GIM to CCT level to enable physicians to manage the bulk of acute admissions on a general basis safely, knowing when to ask for specialist help
- A view that the current system for accreditation in GIM at Level 2 is confusing and non-viable.
- The AIM curriculum specifies GIM plus an extra year focused on acute MAU skills. However it is reported that training in many posts gives little involvement in core GIM on the wards with continuing medical care (and therefore differs from training in GIM and specialty. It should be clear whether Acute = MAU & GIM or a different training altogether, and whether the outcomes in respect of consultant posts are to be similar.
- Is there a way that SpRs/STs who enjoy acute internal medicine could also achieve recognition in Acute Medicine? Could there be Acute Internal Med/GIM as dual or even triple Acute/GIM/other specialty?
- A transition phase or process is important to ensure current trainees are not disadvantaged.
- The proposal will draw specialist educators and academic researchers into the speciality of Acute Medicine.
- There needs to be planning to allow some of those who have a post dually accredited in Acute Internal Medicine and another specialty to move later into posts that are less frantic.

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The College of Emergency Medicine

Service matters

9. The College of Emergency Medicine Strategy document *The Way Ahead 2008-2012*, defined the relationship between Emergency Medicine and Acute Medicine. The key point is that these specialties are complementary with some modest degree of overlapping activity. However, it is vital that the specialties are not regarded as interchangeable as each has specific and discreet areas of expertise, not provided by the other.

- Emergency Medicine Consultants provide high quality care in managing acutely ill patients. Many patients may be discharged home after a period of investigation and observation on the Emergency Department Clinical Decision Unit, thus not requiring admission to colleagues in Acute Medicine. The role of the Emergency Medicine Consultant commences the continuum of care for those patients who require hospital admission and outpatient follow up, subsequently managed by colleagues in Acute Medicine.
- Acknowledgement of these complementary respective roles will allow adequate investment be provided to allow each specialty to develop and thus realise the immense potential which Emergency Medicine and Acute Medicine each have to offer.
- The CEM suggests that there is much to be gained by sharing common acute care pathways and clinical governance outcomes with Acute Physicians and the development of the AM curriculum should ensure this.

Training matters

10. The current College of Emergency Medicine Strategy training programme has been recognised by PMETB as consisting of two years Acute Care Common Stem (ACCS) and four years Emergency Medicine. During ACCS a trainee must achieve level I competency in Acute Medicine, which, to date, has allowed an Emergency Medicine trainee to complete an additional year of Acute Medicine to gain level two competency. A working party set up several years ago (between the RCP and CEM) recognised that Emergency Medicine trainees with level two competences would be able to manage patients on the acute medical take, but not to continue care beyond the first day of admission. This is not formally recognised on the specialist register but is acknowledged by both colleges.

11. The continuing care of acute medical admissions can only be managed by those with a CCT in General Internal Medicine (AM), for which Emergency Medicine trainees would have to complete the whole General Internal Medicine programme. Allowing Emergency Medicine trainees to gain experience to level two was an excellent initiative which we would seek to preserve. However we recognise that level two training opportunities vary from region to region.

Conclusion

12. The Academy supports the formal recognition of Acute Medicine as a specialty whilst observing that further work needs to be done to clarify and resolve points raised in these responses.

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Annex

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General Internal Medicine

General Internal Medicine (GIM) is the core of medical knowledge, skills and attitudes common to a variety of medical based specialties and is essential for physicians who initiate management of individuals with acute medical conditions. GIM no longer exists as a discrete specialty in its own right, but remains an essential component of many medical specialties.

The curriculum for the specialty of G(I)M (Acute Medicine) that has now been approved by the PMETB has been constructed to take account of the need for specialist MAU physicians and those trained to participate in the acute take. Trainees wishing to specialise in leading the MAU will be required to complete training all three levels of the curriculum in G(I)M (Acute Medicine). Those seeking to acquire a CCT in a main specialty but with the relevant competencies to participate in the acute take will be required to complete training to level 2. It should be noted that level 2 G(I)M (Acute Medicine) does not generate a CCT. As a consequence of this change, trainees will fall into two categories. Firstly those already enrolled in training (SpRs) who will complete training for a CCT in G(I)M with sub-specialty Acute Medicine, and secondly those enrolling in the future (StRs) who will either complete training (level 3) for a CCT in G(I)M (Acute Medicine) destined to lead an MAU or a CCT in another specialty (e.g. Cardiology) with level 2 G(I)M (Acute Medicine) enabled to participate in, but not lead the MAU.

Joint Royal Colleges of Physicians Training Board (JRCPTB)

G(I)M and Acute Medicine: current status

In the run up to the introduction of the run through grade, specifically during 2006, the JCHMT produced revised curricula for all specialties. These were put to PMETB approvals panels in the autumn / winter of that year ready for the new grade that began on 1st August 2007. For a number of complex reasons the G(I)M curriculum was rewritten and re-titled as G(I)M (Acute Medicine), containing three levels – L1 the CMT curriculum applicable to all specialties, Level 2 for those in acute specialties wishing to offer competencies at a level permitting participation in the acute take & Level 3 which is the CCT (note in GIM). The purpose of creating L2 was to get over the problem understood at the time that training in parallel for two CCTs was not possible. L2 allowed training sufficient to permit trainees to attain MAU skills without the need for a CCT. It is perfectly legitimate to be appointed to a consultant post including participation in the acute take on the basis of a CCT in a specialty backed by L2 certification.

It is not clear that dual CCTs were ever impossible but there was certainly an understanding that training for two CCTs would require consecutive training periods rather than running concurrently. There was also a prevailing view was that the MMC team were looking to shorten training periods where possible, and that single CCTs were more likely to achieve this.

PMETB will now permit training in more than one CCT where the training can be acquired concurrently and with only modest prolongation of the overall training period. Accordingly the JRCPTB has acted proactively to create a new specialty in Acute Medicine and to re-establish a CCT in GIM thereby re-enabling dual training in a specialty and GIM. In making these proposals JRCPTB was acutely aware that this would be seen as disadvantageous to those who entered training in 2007 and 2008

who would not receive a dual CCT unlike their predecessors and successors. JRCPTB has arranged a meeting with the PMETB and officials from the DH on 5th February, specifically to discuss how we can come to an agreement which would allow the 2007/08 cohorts in medical specialties to be transferred onto the new dual CCT pathway.

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Joint Royal Colleges of Physicians Training Board (JRCPTB) 1 February 2009

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