Shaping the future of Acute Medical training

Sir,

I read with interest the Viewpoint article by Dr Chadwick regarding the future of Acute Internal Medicine (AIM) training,[1] particularly the development of Capabilities in Practice (CiPs) and their potential to promote a greater identity within the specialty training. Dr Chadwick highlights the struggle we face in asserting why our specialty is so vibrant and vital. In my experience, Acute Internal Medicine training suffers from an identity crisis whereby the specialty is seen as being permanently on call, with trainees working more shifts as the Duty Medical Registrar (DMR) than on other specialty training programs, without the variability of outpatient and skill-based training. Indeed, the recent Joint Royal Colleges of Physicians Training Board (JRCPTB) statement regarding quality criteria for GIM/AIM Registrars[2] appears to regard the role of the AIM registrar as that of the DMR rather than a specialist in their own field.

The new curriculum for Internal Medicine Training[3] contains CiPs reflecting the skill sets required to ensure a well run medical take and safe team working with patient management and discharge practices, recognising the potential for investigating and managing patients in the outpatient setting. I am pleased to see a particular focus on the importance of palliative care. However, there is more to AIM than running the take, and more to AIM training than triaging to inpatient or outpatient services.

AIM physicians are experts in the management of multi-morbidity, particularly the 'generally unwell patient'. Patients rarely present with an organ-specific issue but with many issues of general deterioration. A specialty CiP focusing on complex presentation and frailty assessment and management would reflect this.

Life on the Acute Medical Unit (AMU) is fast-paced and has a high turnover. A good knowledge of 'flow-ology' is a key skill in the AIM physician's toolbox. Linked to this is the ability to rapidly yet safely triage, especially with the expansion of Ambulatory Care, and the ability to direct patients through inpatient and outpatient areas. A CiP regarding alternative routes to inpatient management should not only reflect the safe identification of such patients but should include the appropriate screening, investigation and onward management of such patients once they reach the department.

AIM supports patients through the first 48 hours of their hospital stay - the most unpredictable part of their admission. Following the NCEPOD report 'Time to Intervene'[4] appropriate and reasonable Treatment Escalation Plans (TEPs) should be made at the point of admission to ensure clear escalation of care for unwell patients and prevent unnecessary harm or discomfort to others. The new AIM curriculum should champion this and encourage important decision making through a dedicated CiP.

Being 'at the front door' demands leaders. These leaders promote adaptability, preparedness, resourcefulness and resilience through role-modelling in personal practice and through encouraging the development of others when leading the medical take or AMU. The AIM CiPs should again champion this and promote the image of the capable and reactive Acute Physician as an aspirational role rather than the hospital workhorse.

Understanding the differential of presenting symptoms is vital and the current curriculum promotes this. However it is often criticised for being a 'tick box exercise' in completing a certain amount of forms in order to pass CCT. In my opinion, CiPs have the opportunity to support the artistry of dissecting the presentation whilst making the approach more patient and performance-focussed, linking to the underlying strengths of the AIM physician.

I look forward to learning more of the future for AIM training and hope it continues to celebrate our breadth and our holistic and multidisciplinary approach.

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References

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