Viewpoint

Training in Acute Medicine in 2004

M Jones

There is a school of thought that believes that if something is going right then the downturn is just around the corner! As work progressed to get Acute Medicine recognised as a sub speciality there were many occasions when it was felt that we could still stumble as we came to the final hurdle. Happily that did not occur and by July 2003 Acute Medicine was officially recognised as a new sub speciality within General Internal Medicine. Can we expect any further hurdles? It is often appropriate to recognise the challenges which occur and regard them as opportunities that have to be used for our advantage. Sometimes this is very difficult.

Such is the case with the European Working Time Directive (EWTD) and, especially with regard to Acute Medicine, the recent proposals involved in 'Modernising Medical Careers' (MMC). The challenges set to the medical profession by both changes are large. Indeed, Presidents of some of the Royal Colleges made a plea to the government that MMC should be postponed for at least a year, until the EWTD had been implemented. This is not going to happen. The difficulties in maintaining training opportunities balanced against service delivery, most easily demonstrated by the development of full shift rotas for SpRs, will continue unabated. The EU is, however, now trying to recognise that not all on call duties will be counted as work if most of the on call is spent asleep. This change to the legislation will, however, take at least 12 months to be ratified (if ever).

From the MMC viewpoint there seems to be increasing clarity associated with run-through training, the MRCP(UK) examination and speciality training. When MMC was first introduced it was possible that Acute Medicine might have suffered as a sub speciality. The new scheme makes the future seem a lot brighter. After Foundation Years 1 and 2, trainees in hospital medicine will work in Basic Speciality training until MRCP is attained. There will then be a competitive interview for Higher Speciality training. Trainees will gain experience in general (internal) medicine and, where dual accreditation is sought, their nominated specialty, during this training period. Although the title of each stage of the training process has yet to be established, the route to Specialist or Consultant posts in Acute Medicine seems much clearer than before.

The recent RCPL document reviewing Acute Medicine has recommended that there should be three Acute Medicine Consultants in larger hospital by 2008. If we are to achieve this we must have enough trainees coming through the system. I am not sure that it is achievable but I can record that a large number of training programmes are being developed across the UK. The enthusiasm with which such posts are being greeted by trainees (as judged by applications for posts) also seems to be increasing. We may also see the academic base for Acute Medicine start to develop in the near future

We have come a long way in a short period of time. Although there will continue to be hurdles I think that the future continues to look very bright for Acute Medicine.

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Dr Mike Jones was one of the founder members of the Society for Acute Medicine and is currently vice president of this organization. He is a member of the Joint Committee for Higher Medical Training at the Royal College of Physicians and secretary of the Specialty Advisory Committee in General Internal Medicine. He was one of the driving forces behind the development of the subspecialty of Acute Medicine and the writing of the curriculum for training in this field