Viewpoint

The current state of Acute Medicine training

B Chadwick

Acute medicine training has come a long way in a relatively short period of time. Acute Medicine was recognised as a speciality by the Royal College of Physicians in 2003, initially as a subspeciality of General Internal Medicine. Acute Medicine was formally recognised as a speciality in its own right in 2009.

Over this period of time Acute Medicine has "grown up" as a speciality. With a continual expansion of new consultant posts in Acute Medicine, an increasing number of trainees in Acute Medicine are completing training and starting these roles as fully trained Acute Physicians.

Acute Medicine training has evolved gradually since its inception in 2003. The concept of the "special skill" as changed from an initial focus on gaining practical skills such as echocardiography, to a much broader definition covering a huge variety of topics. Trainees can now choose from a diverse group of skills, from medical education and medical leadership to palliative medicine and dermatology.

Core to the concept of Acute Medicine training has been an excellent grounding in managing the Acute Medicine Unit, combined with a wide variety of clinical exposure to different medical specialities. All trainees spend time in Cardiology, Respiratory Medicine, Geriatric Medicine and Intensive Care.

Our current curriculum was created in 2009, and was last revised in 2012. It has formalised the strengths of training up to that point, and provides a good structure for those currently training in Acute Medicine.

Assessment of the curriculum has become increasingly scrutinised as it places a lot of emphasis on Structured Learning Events (SLEs) being linked against curriculum competencies to provide evidence of progression. There are a large number of curriculum competencies that require evidence, and this has lead to a feeling that there is more of an emphasis on "ticking off" competencies, as opposed to more holistic experiential and reflective learning.

Dr Andrew Brereton has written in this edition of the journal about some of these issues, and now is a good time to look to the future and think about how the Acute Medicine curriculum should change. The Shape of Training report is bringing some fundamental change to the way the Physicianly specialities will be trained. A new Internal Medicine (IM) curriculum will start in August 2019, replacing the current Core Medical Training curriculum. As part of the same process, a new Acute Medicine curriculum will start 3 years after this, in 2022.

This gives us a golden opportunity to define what is special about Acute Internal Medicine, and how we are different from Internal Medicine. Currently the General Internal Medicine and Acute Internal Medicine curricula are very closely linked, and share great similarity. As a young speciality we perhaps sometimes struggle to assert our identity and express why our speciality is so vital and vibrant.

With the new curriculum we are moving towards more holistic judgement of trainees, assessing them against Capabilities in Practice (CiPs), rather than lists of competencies. There will be a total of 14 CiPs in the Internal Medicine curriculum, and each speciality will be asked to design a new curriculum around an additional 6-8 speciality CiPs. This will be the same for all specialities, and perhaps for the first time gives Acute Medicine the same distinct identity that the more mature specialities such as Respiratory Medicine and Gastroenterology have enjoyed for a long time.

Work has already begun work of these speciality CiPs in the Specialist Advisory Committee (SAC) at the Royal College. I'm very excited to have the opportunity to lead the development of the next stage of Acute Medicine training and I'd welcome any ideas about how we can make Acute Medicine a distinct, attractive and forward looking speciality.

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