Response to the report *Shape of Medical Training: securing the future of excellent patient care* (launched 29.10.13)

The Society for Acute Medicine concurs broadly with the draft RCP response dated 20.12.13.

However we wish to highlight the following areas:

1. The proposed change to Full Registration at the point of graduation from Medical School should not occur until measures are in place to ensure the clinical skills of medical school graduates are sufficient to ensure patient safety.
2. A UK wide delivery group should be convened and must include adequate representation from GIM, AIM and Geriatric Medicine.
3. Core Medical Training can already be considered as broad-based and any dilution of experience in the specialties contributing to the Acute Medical Take should be opposed as there already exists concern that ST3 appointments are short on these skills.
4. Patients should be looked after by the appropriate specialist at all times. On arrival of unselected acute medical patients this should be a specialist in AIM. Any move towards a USA style Hospitalist model should be opposed.
5. More clarity is required about what ‘broad-based specialty training’ means. It is essential that the GIM experience is in parallel and not sequential and must be recent (within last 12 months) and relevant at the time of CST award.
6. Credentialing comes with opportunities but the Specialties (including AIM) must be directly involved in the development of such training.
7. We strongly agree that a CST award holder must have competence at least as high as a current CCT holder and resist any move to the creation of a sub-Consultant post.
8. We are concerned at the RCP proposal to develop new models for deploying specialty skills at the hospital ‘front door’ and would seek further clarity. Most emergency medical patients do not have a clearly defined diagnosis at initial assessment and it is for that reason that the specialty of AIM developed. It has led to significant improvements in patient care and must be supported to...
thrive and survive. AIM retains close links with specialties at local levels with inreach to AMUs and this should be encouraged. Direct access to specialty for a small number of clearly defined patient groups (eg AMI/PCI, stroke thrombolysis) is desirable but the vast majority of patients will benefit from an AMU model adequately resourced and staffed by Consultants and trainees in AIM.

9 Proposed changes to specialty training are unlikely to be successful if they result in shortened training time, especially if also devoting increased time to GIM. Specialties will need to think hard about what aspects of their curricula can be removed.

10 Introducing a third year to CMT would be welcomed but not at the expense of a reduction in subsequent training time.

Yours sincerely

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