Society for Acute Medicine
Trainee Newsletter July 2010

Dear Trainees,

This edition of the Acute Medicine trainee newsletter comes to you a few weeks after the Spring conference in Yarm. This was an extremely successful meeting with a lot of educational content, and we were delighted to see so many trainees there.
In response to feedback we received after the last newsletter we're changing our method of email delivery. This should ensure that the email displays correctly on all computers but, more importantly, it allows you to take control over what you receive from us, your representatives. As time goes on, we are receiving more requests to send out adverts for courses and job adverts. Some of you may be interested in these whilst others won't be. With our new system you'll be able to choose exactly what you want to receive which will hopefully please everybody.

Contents

Training & Portfolio

Curriculum issues

The Acute Internal Medicine 2009 curriculum is now available to download from the JRCPTB website. It has been designed to allow a more structured training in Acute Medicine, and contains more specific instruction on managerial, organisational and leadership roles than can be found in the 2007 GIM (Acute) curriculum.
Unsurprisingly, there is still quite a lot of confusion amongst trainees about which curriculum they should be following. This issue was raised at the last AIM Specialty Advisory Committee (SAC) meeting in April; currently, the situation is as follows:

- Trainees who started in 2007 or 2008 can remain on the GIM (Acute) curriculum if they want to. They will gain a CCT in GIM*.
- If 2007/2008 trainees want to switch to the new curriculum, they would transfer across to AIM 2009, giving them a CCT in AIM.
  When switching to the AIM 2009 curriculum, trainees must also decide whether they want to dual accredit with GIM, which will add a year to their training time. These trainees will come out with a dual CCT in AIM and GIM.

- The situation for trainees who started in August 2009 has been reviewed recently. The most up-to-date information we have on this is as follows: “all trainees who started on a training programme in 2009 expecting to follow acute medicine will *automatically* be on the 2009 A*cute Medicine (AIM) curriculum* and should be assessed according to the objectives within it. If they wish to CCT in GIM *and* AIM they should notify their deanery that they wish to do so, and this request should be accommodated whenever possible.” This information comes from Mike Jones, chair of the Specialty Advisory Committee in Acute Medicine.

We are frequently asked about the benefits and disadvantages of switching to the new curriculum. The problem for us when responding to these queries is that an advantage for one person can be a disadvantage for another! The table below helps to set out some of the differences.

GIM (Acute) 2007	**AIM 2009 alone**	**AIM + GIM 2009**
An older curriculum with less emphasis on management and leadership skills	An updated curriculum with defined AIM clinical and organisational competences	As AIM, but with additional need to demonstrate GIM 2009 competences
4 year training programme in most deaneries	4 year training programme	5 year training programme
GIM CCT recognised worldwide	AIM CCT not recognised in Europe or Australia/NZ (but entry onto specialist register is)	AIM CCT recognised in the UK + GIM CCT recognised worldwide
Qualifies you to look after patients for any length of time and to follow up patients with chronic conditions	Technically only qualifies holder to look after patients for 72 hours. (Whether or not you actually look after patients for longer than this is entirely at the discretion of your employing trust.)	Qualifies you to look after patients for any length of time and to follow up patients with chronic conditions
Amount of training in medical specialties (eg: cardiology, respiratory, ICU etc) depends on deanery	Amount of training in three medical specialties (Cardiology, Respiratory and Medicine for the Elderly) fixed by curriculum	Amount of training in three medical specialties (Cardiology, Respiratory and Medicine for the Elderly) fixed by curriculum
No requirement to keep logbook or do mandatory workplace based assessments (DOPS, MiniCEX, CbD etc), though the latter are recommended	Logbook requirement for 1250 patients seen on Acute take + 300 patients seen in Ambulatory Care (but no need to see patients in an OP clinic). Workplace based assessments are mandatory	Logbook requirement for 1250 patients seen on Acute take + 300 patients seen in Ambulatory Care + 150 new outpatient referrals + 1500 outpatient clinic follow-up patients. Workplace based assessments are mandatory
AIM SCE not mandatory	Mandatory AIM SCE	Mandatory AIM SCE

Many 2007/2008 trainees are concerned that if they don’t transfer, they will be at a disadvantage when it comes to applying for consultant posts. The SAC made it clear that this should not be the case. A trainee who demonstrates level 3 competence on the GIM (Acute) curriculum is as qualified as a trainee fulfilling the requirements of the AIM 2009 curriculum. It is unlikely (but still possible) that an interview panel wanting to employ an Acute Medicine consultant will discriminate between the two qualifications. We also recognise that there are still a few people left on the pre-2007 GIM plus acute medicine subspecialty curricula. We haven’t heard much from this group, but we would be happy to help if anyone is experiencing training problems.

Logbook

Those of you planning to switch to the new curriculum should all be collecting patient information for your logbooks. (You can download a sample logbook from here.) The definition of “seeing” a patient on take has been discussed at the SAC meetings and, on the basis of this, our advice is to log the patient if you have had enough involvement to write in the notes.

Specialty Certificate Examination

For those of you planning to take the SCE later this year, the new date for the exam is November 24th 2010. There is a lot of useful information to be found on the MRCP website. Have a look at the sample questions and see how you do! Instructions on how to apply can be found on there also. One aspect of the application process that is worth highlighting is the fact that it is a two-stage process. Firstly, you sign up with the RCP to sit the exam. You will then be sent an email that confirms you will be able to sit the exam. At this stage you will have to click on a link (either in the confirmation email or a second accompanying one) which will allow you to book where to sit the exam. You must complete this second stage or you will not be able to sit the exam. This two stage process has come into play because, unlike MRCP where you could only sit the exam in a few centres, the SCE will be sat in PearsonVue test centres, PearsonVue being the company that provides all the test centres for people taking their driving theory test. Apparently this means that you should only have to travel about 20 minutes maximum to get to your nearest test centre.

Special Skills

One of the issues that came up from meeting with trainee representatives across the country (see below) is that training in special skills is wildly variable across deaneries. Sadly, it will take time to rectify this and develop the expertise within the Acute Medicine community to allow us to reliably train people in the more popular specialist skills but we are working on this. No doubt this comes as cold comfort to those of you who are currently struggling to get consistent training and accreditation. Nevertheless it is a mandatory requirement for all Acute Medicine trainees who started in or after 2007 to learn a special skill so if you haven't sorted out what yours is going to be then please start now. Certainly by the end of your ST3 year you should have a plan for what you are going to do and how you will achieve it.

SAM & Trainee Representation

TRAM

Following on from our trainee representative meeting at the Autumn conference last year, we held another TRAM (Trainee Representatives in Acute Medicine) meeting at the recent Spring conference. Fourteen reps from deaneries across the UK attended, and we discussed a wide breadth of training issues. It is of great importance to us that we represent as many trainees as possible, and that we represent you as faithfully as we can; your deanery trainee rep can act as your voice if there is a training issue that you want to discuss with the society. (You can always email us directly, of course!)
One of the projects that TRAM members will be undertaking over the next six months is a direct comparison of the AIM and GIM (2009) curricula. There will be multiple benefits to this:

- it will clearly identify what makes an Acute Medicine trainee different from a GIM trainee, at least from a curricular perspective;
- it will highlight the special training needs of Acute Medicine trainees and so enable trainee representatives to work with their training programme directors to ensure that these needs are met;
- it will act as a focus for AIM training days so that subjects unique to AIM are covered;
- it will aid those who dual certificate to link competencies to each curriculum in their e-portfolio, without the need for excessive replication.

We will let you know the results of this comparison when the project is completed.

SAM Spring Meeting

The trainee session kicked off the conference in Yarm with talks from Nicola Irvine about the transition to becoming a consultant. The talk was lively and full of useful ideas about how to prepare for the next stage of our careers and what to expect when we get there. We also had a talk from Julia Gamaleldeen, the SCE project manager, about the process of applying for the SCE, and from Phil Dyer about what is likely to be in the exams. One of the things can came across strongly from Phil's talk is that the exam is meant to test that you have the knowledge that a newly qualified consultant would be expected to have and just doing the job is unlikely to be enough to pass the exam. There will be a strong emphasis on

knowing specialist guidelines and scoring systems so now would be a good time to start reading those NICE guidelines, just like you always meant to.
One thing we're hoping to do is create a page of links on the new SAM website that gathers together some of the more important guidelines to help with your revision. Obviously we have no idea exactly what will come up in the exam but hopefully this will provide a good start to your revision.
The SAM International Meeting will be held in Edinburgh this year on the 7th and 8th of October. For this conference we will run the trainee meeting as a parallel session on the Friday starting at 9am. Apologies to those of you who wanted a later start time but there just wasn't space anywhere else in the programme. To give more time for speakers we are replacing the traditional Q&A session with an 'trainees' clinic' held from 1:30 to 2:30pm on Friday where anyone can come and ask us about any aspect of training and receive an answer individualised to them.
At this stage we would love to be able to tell you what the exact programme will be for the trainee session but we are yet to finalise all the speakers. Our main deficiency is in trainee speakers. We are keen to ensure that the talks in the trainee session are inspiring, entertaining and informative but more than that these sessions should be golden opportunities for Acute Medicine trainees to present at a national level. So if you have an idea for a talk that you would like to deliver (or even an idea for someone else to speak on) please let us know.
For Edinburgh we would like to spend some time talking about a topic close to the hearts of many of you, training in special skills, so if you are prepared to give a brief talk on your skill and how you trained in it please get in touch and get in touch soon. If we don't get enough people responding in time then we will have to look elsewhere for speakers, which will be a great shame.

New SAM website

It's been a long time coming, but by July we are assured that the new SAM website will go live on 1st July. The new site will be much more user-friendly, and we will have our own trainee pages which will be completely rewritten and stuffed full of useful information for you. We will have a lot of control over the contents of the trainee pages, so once things are up and running do let us know if there is something else you think we should include. All objective and unbiased content will be considered!

Europe

Tim attended the first meeting of the EFIM (European Federation of Internal Medicine) Young Internists (YI) assembly which was held in Oslo as part of the bi-annual meeting of the EFIM Council Members. The YI group exists to create a network of trainees/just-qualified consultants across Europe with the idea that such a network could collaborate together on research projects, improving training and education, developing exchange programmes and provide a forum where trainees excited and enthused by Acute/General Medicine can find other like minds. Last, but not least, it's a good way to meet new people and make new friends.
At this stage the group is in its infancy and there is much work to be done to build links, strengthen the network and develop projects that all can participate it but at the same time it's a great opportunity, especially as we are hopeful that in time the post of UK YI representative will be funded by the Royal College of Physicians. The next meeting will be in Lucerne in September and the following one in Athens. If anyone is interested in the post of being the UK representative for General Medicine then please let us know. It is vital for a strong and vibrant Acute Medicine community that such posts are held by a wide cross-section of trainees, and we want to ensure this happens.
If the prospect of trainee representation is too much but you quite fancy meeting other Europeans and you are musically inclined then another avenue you might like to explore is EMSOC (European Medical Students' Orchestra and Choir). This summer in they are meeting in Manchester from 31st July - 9th August with the aim of putting on the following concert at the end: Brahms: Academic Festival Overture (with choral ending),Prokofiev: Piano Concerto No.1, Mendelssohn: Symphony No. 2 - 'Lobgesang. Money raised will be going to help the Teenage Cancer Trust so it's all in a good cause. If you are interested you can find more details on the EMSOC website.

The Wider Angle

Remote Medicine, Antarctica and Team Working

by Charlotte Routh, ST5 Acute Medicine, charlotterouth@nhs.net

Remote and rural medicine appears on our curricula as a special interest, little else is said in the curriculum to expand on this. From 2005 to 2007 I worked remotely for the British Antarctic Survey Medical Unit (BASMU) and during this time completed a Diploma in Remote and Rural Healthcare form Plymouth University and Peninsula Medical School. After my recent talk at SAM I have been asked to expand on the benefits of this to training in acute medicine.

Working for BASMU comes with the benefits of a very comprehensive pre-deployment training programme. This is tailored towards your medical background but for all of us involved ATLS, dentistry, anaesthetics, physiotherapy, radiology and basic laboratory testing. As I came from a medical background I also completed the basic surgical skills course, spent time in eye casualty and emergency theatre. We were also given the opportunity to chose time gaining experiences that maybe useful; for this I chose GUM, dermatology and A+E minors.

I also was fortunate to be trained in other non-medical skills; pest control, oil spill management, avalanche awareness to name a few but becoming a fully trained jet boat coxswain was one of the highlights. But beware, the training you get from BASMU is extremely comprehensive, this is certainly not universal in other remote placements or expedition medicine. Thus if you embark on work in a remote environment you should consider the gaps in your skills and knowledge before committing. There are a few Expedition Medicine courses advertised in the BMJ and these are a good introduction. Also think about other courses that may benefit you; this may however come at your own expense.

Following 6 months of training, I went on to spend 15 months working on the remote island of South Georgia and a further 2 months onboard the RRS Ernest Shackleton. To be an independent practitioner and live in a small group where everyone is a potential patient is hard at times but very rewarding. Boundaries have to be set, trust gained and the doctor/ patient relationship adjusted. Confidentiality is key. You need to be honest to both yourself and your patients about your medical capacity, capabilities and work within limited resources. You also have to be all of the MDT in one go and this has given me greater respect for the specialities which support us daily in the NHS.

The opportunity to expand your training outside your chosen speciality is rare these days and I would recommend remote medicine as time well spent. My time spent working remotely and without resources has developed my self-confidence, problem solving, communication, and leadership skills. These are all skills which make a good acute medic and have improved my shop floor persona. I also have a much broader medical knowledge base which is always useful when liaising with other specialities. Working alongside non-healthcare professionals gives you a different perspective on team working skills and teaches you to think outside the box.

The diploma has subsequently ticked a number of boxes in the e-portfolio as besides the remote modules there were also modules on research methodology, critical thinking and leadership. There are lots of opportunities out there for remote practise even within the UK – so think laterally and you will find. I did not take time out of programme, but took a career break and this will obviously be something to take into consideration.

So as you can see there is much to gain medically and personally from remote healthcare. Oh and I nearly forgot, you get to go to some fantastic places, meet some great people and do some amazing things! For those interested in BASMU contact their unit at Derriford Hospital, Plymouth and visit their website. I'm happy to expand on my words of wisdom if you email me.

Closing Remarks

That's all we have for you for this quarter's edition of the newsletter. As always please email us if you have ideas, concerns (or even expectations) that you wish to share. We look forward to seeing many of you in Edinburgh.

Best Wishes,

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* The sharp-eyed, amongst you will have noticed that the CCT is in GIM, not GIM(Acute). This is because, until the advent of the new AIM curriculum, Acute Medicine was considered a sub-speciality of General Medicine in the same way that intervention and electrophysiology (EP) are sub-specialities of Cardiology. So, just like a cardiology trainee may spend a long time specialising in EP but still only have Cardiology on his CCT certificate, rather than Cardiology(EP), we will have GIM rather than GIM(Acute). When it comes to applying for jobs that cardiology trainee will make it abundantly clear on his CV that he/she has focused his training on EP and by the same token you should emphasise your training has been directed towards Acute Medicine.

^ Go back up

** This piece of information is new and may mean that should you envisage working in Europe or the Antipodes then perhaps a GIM CCT is not required. We didn't have time to verify the GMC's assertion prior to sending this newsletter out so if this is an important issue to you our advice would be to seek further advice from people in the country that you're planning on working in.

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