Acute Medicine: Curriculum for Consideration by JCHMT

Introduction

Since the Federation report on the Acute Physician role there has been a move by a significant number of Trusts to recruit physicians who are capable of organising the Medical assessment or admissions unit. This recognises both the increasing burden of the medical take and that many of the patients presenting to hospital in this way are among the sickest. Traditionally, the acute medical take has often been the province of the junior doctor with often cursory involvement of Consultant staff. The Federation document recognised that Consultants need to be more involved in the acute take and suggested that the individuals should have relevant clinical skills, important for the delivery of acute medical care. The clinical governance agenda demands that individuals practising within any specific clinical environment have the appropriate competencies. It is proposed that these skills are best gained within a formal training structure with direct supervision from Consultants who are involved in running acute medicine. This situation is analogous to the development of A&E medicine where the training structure for this speciality developed on the basis of interested individuals who had taken on the role of championing A&E and more recently discussions in Intensive Care Medicine. Issues about 'burn out' of appointments in Acute Medicine have been raised, but there is no reason to believe with appropriate training and organisational support, this would differ from other areas such as Intensive Care or Accident and Emergency.

Background

Trainees in acute medicine may come from a variety of backgrounds but from the experience of members of the Society for Acute Medicine (UK) it is likely that the individuals would be physicians who enjoy an interventional approach to medicine. Such individuals recognise that appropriate treatment at the appropriate time can improve patient outcomes. In the past some of the registrars who have expressed an interest in acute medicine may have gone into A&E medicine, ITU medicine or other specialties as no career pathway existed. What separates the individuals, however, is the desire to maintain some continuing care both within the hospital environment and, to some extent, within the out patients scenario to pursue urgent diagnostic problems. Others would have developed medical sub speciality interests while retaining contact with acute medicine but may find the pressures of practising speciality and acute medicine too arduous. Development of a proper training structure for acute medicine would provide a further option for training within G(I)M.

A potential training program within the present training structure

The basic approach for training will recognise that two types of individual may wish to pursue training in acute medicine::

1. Individuals who require "top-up" training to take account of previous experience and to gain the specific experience necessary to run an Acute Assessment / Receiving unit.

2. For trainees at the start of their SpR career who need to fulfil all the requirements of the G(I)M curriculum as well as gain the extra skills that will be useful in running an acute receiving unit.

In view of this it is proposed that there should be a modular pattern to the training structure with specific elements being required to gain recognition as appropriate training for acute medicine. Within this it is important that competencies are defined and assessed.

The elements that are thought to be crucial are:

1. It would be mandatory that the trainee had completed General Professional Training and achieved MRCP(UK).

2. Experience in a DGH setting for all trainees as recommended for G(I)M. This would include exposure to unselected takes and medical speciality out patient clinics.

3. Experience in an established acute assessment/receiving unit with direct Consultant supervision and adequate infrastructure.

4. Experience in both the in patient and out patient environments of medical specialties that are frequently encountered in the MAU. These include Cardiology (and CCU), respiratory medicine, gastroenterology, and care of the elderly.

5. Experience in specialist out patient clinics according to the trainees specific needs. These may include diabetes and rheumatology clinics.

6. Development of the necessary practical skills that are required in the management of acute medical problems.

7. Development of a specific skill relevant to acute medicine (see appendix 2, section b). This element of training would start early in the trainee's career and be carried through the whole training programme.

8. Experience in other hospital areas that care for acutely ill patients. These will include the A&E department, ITU or HDU and the CCU.

9. Experience in another MAU to gain insight into different structures and processes involved in the management of common emergencies.

10. Audit and research would be encouraged throughout the training programme.

For trainees who wish top-up training the programme should be constructed to include the elements not covered in the current G(I)M training programme.

For newly appointed registrars example job plans are shown in appendix 3 and 4. These show a five year structure to take account of the extra time taken in training in the various critical care environments, to gain adequate breadth of exposure in the key medical specialties and to spend managerial time in an MAU.

This would include experience in organisation and management of a medical assessment/receiving unit in the latter period of HMT, ensure competencies with the additional and mandatory clinical sills, exposure to a critical care environment either in ITU or A/E seeing and managing acutely unwell patients. It is proposed that for the majority of candidates, this would require an 18 month top-up period.

A Potential Training Structure within the Proposed Changes to Training

In the proposed new training structure training in G(I)M will be completed prior to commencing specialty training. If Acute Medicine is to be accepted as a sub specialty of G(I)M the new training structure has to be recognised and appropriate additions to training incorporated.

The new training scheme proposes that junior medical posts are now a continuum between the SHO and junior registrar years leading to a CCST in G(I)M after a minimum of five years during which time acquisition of MRCP(UK) is mandatory. To progress to training in Acute Medicine trainees would have completed this part of training and be eligible for CCST in G(I)M or, indeed, A&E.
To sub-specialise in acute medicine trainees would be encouraged to develop a relevant practical skill as early in training as possible (see appendix 2b).

It is assumed that in achieving CCST in G(I)M the trainee will have gained experience in an Acute Medical Unit early in the training scheme. Furthermore, the trainee must have had exposure to the major acute medical specialties including cardiology, respiratory medicine, gastroenterology and medicine for the elderly. They should also have had training in A&E medicine and critical care. This early clinical experience will facilitate the early development of the required clinical competencies. It is however mandatory that further experience is gained post G(I)M CCST for Acute Medicine sub-specialty recognition. The latter experience would ensure that several further goals are attained:

1. Clinical competencies appropriate to Acute Medicine were achieved prior to completion of training. This must include a recognised program in the management of acute medical emergencies.
2. Experience in organisational and management structures essential for Acute Medical receiving.
3. The development of attributes necessary to lead and work in a multidisciplinary environment.
4. Enhanced exposure and supervision in a critical care environment for a minimum of six months.
5. Three months in an A&E department directly involved in management of medical emergencies and resuscitation.
6. Demonstrate competency in chosen practical skill as defined by regulatory body for that skill with knowledge of the relevant clinical application. This will take a minimum of three months.
7. At least three months experience in another recognised Acute Medical unit.
8. Audit and research relevant to Acute Medicine.

1, 2 and 3 would require experience is a recognised Acute Medical unit for at least twelve months.

It is proposed, therefore, that the G(I)M training should be extended by 24 months for sub specialty training in Acute Medicine.

Appendix 1

Essential Clinical Competencies

See G(I)M curriculum

Appendix 2

a) Clinical skills that are mandatory and additional to G(I)M curriculum

Non invasive ventilation including CPAP
Invasive haemodynamic monitoring to include CVP monitoring

b) Clinical Skills that may be acquired by individual trainees, one of which will be an essential part of sub specialty training

Echocardiography
Upper G-I endoscopy
Bronchoscopy
Invasive haemodynamic monitoring to include arterial line monitoring
Diagnostic ultrasound
Assisted ventilation
Haemofiltration

Appendix 3 Potential Job Plans for SpR training in G(I)M (South East Scotland)

Year		**G(I)M 1**	**G(I)M 2**	**G(I)M 3**
1	8/12	RIE Medical Assessment	DGH Specialties, CRG*	WGH Medicine of the Elderly/Acute Medicine
	8/12	WGH Medicine of the Elderly/Acute Medicine	RIE Medical Assessment	DGH Specialties, CRG*
2	8/12	DGH Specialties, CRG*	WGH Medicine of the Elderly/Acute Medicine	RIE Medical Assessment
3	3/12	HDU	A/E	ITU
	3/12	A/E	ITU	CCU (DGH)
	3/12	ITU	CCU(DGH)	HDU
	3/12	CCU (DGH)	HDU	A/E
4	8/12	RIE Medical Assessment	Options	DGH CRG & Options
	8/12	DGH CRG & Options	RIE Medical Assessment	Options
5	8/12	Options	DGH CRG & Options	RIE Medical Assessment

*CRG – Cardiology, Respiratory, Gastro-enterology

	DGH OPTION
Teach	Anaes
ITU	Cardio
Rural	GI
Tox*	Resp
A/E	Tox*
Anaesthesia	Renal

Appendix 4 (Tayside)

Year		General experience	Activities	Specialty
1	6 months	Experience in Medical Assessment Unit	Involvement in acute take at least 4 per month Urgent outpatient clinic 1 per week Develop practical skill ALS Training for Teaching Audit	Gastroenterology Out patient for 3 months Cardiology Out patient For 3 months
	6 months	Care of the Elderly	Further experience of multidisciplinary working Geriatric Day Hospital	Specialty Care of Elderly Out patient clinics
2	12 months	G(I)M in DGH setting	Acute take experience In patient work in appropriate specialty e.g. cardiology, G-I or respiratory Teaching Audit and research	Respiratory, Cardiology and gastroenterology Out patient for 4 months each
3	3 months 3 months 3 months 3 months	Any combination of ITU/HDU/ CCU and A&E	Continue practical skill in regular clinic setting	
4 5		Acute Medicine with greater individual responsibility in post take round and in unit management Elective period e.g. in anaesthetics, ITU, CCU Experience in another MAU for at least 4 months Management course	At least 4 takes per month Urgent out patients clinic 1 per week Practical skill clinic 1 per week Audit and research	Elective out patient work e.g. renal, rheumatology