The SAM Survey 2024

In 2024 as we approach our 25th anniversary we felt it was a good time to look at how we as a Society are perceived by our members and what we can look at changes to further develop our Society as we look forward to the next 25 years!

This Survey took place in December 2024 and anyone that worked the majority of their clinical shifts within acute medicine was invited to complete this.

We decided to include non-members (defining this as those working in Acute Medicine as their main specialty) as we were keen to look at why some people were not members and explore any barriers to membership.

We have reviewed some areas in more detail and separate reports will be generated on these such as MDT responses and wellbeing.

The results are really useful for us as a Society, and whilst it can be sad to read critique it is important for us. There is a lot of positivity and this is great to see. SAM council are entirely made up of volunteers who do all of the work in their spare time. They are all dedicated to the specialty of Acute Medicine and their passion and hard work is very much appreciated.

Look out for the sections marked *"What we're doing"* to get an idea of how we are responding to your feedback.

One last thing before the detail…

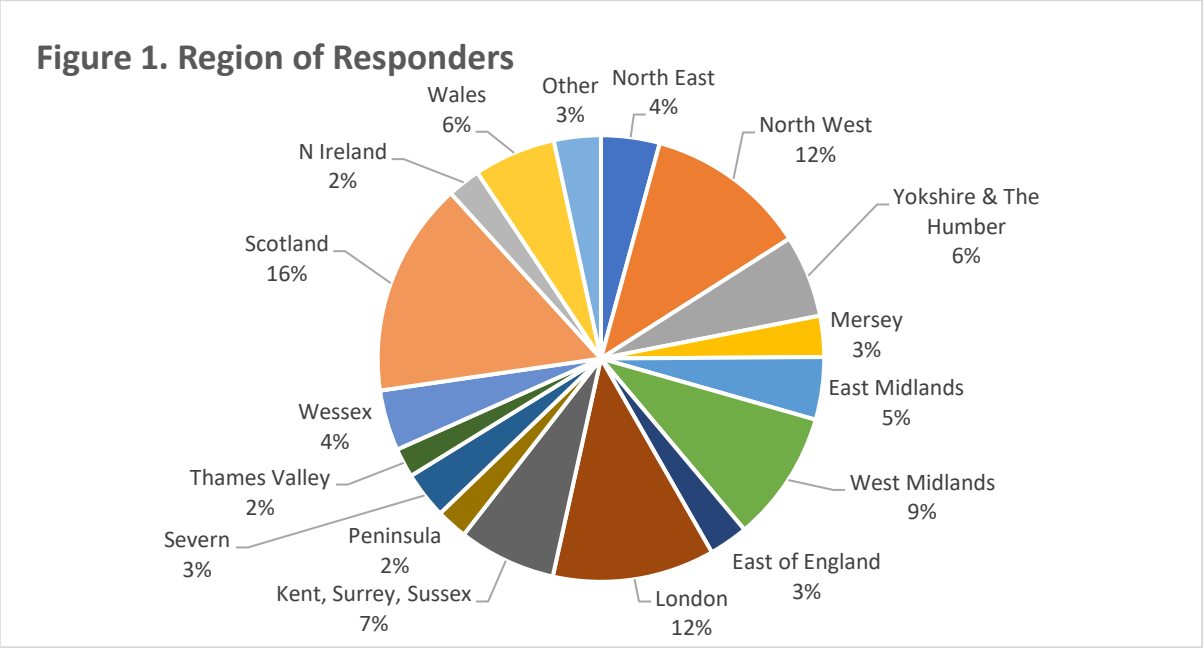
This is the first time we have conducted a SAM survey (previous ones have been trainee focused). Thanks to everyone who completed it and giving us your opinions. We welcome your thoughts on future inclusions on the survey, just let us know. For that and any other opinions or comments, please get in touch at Administrator@acutemedicine.org.uk

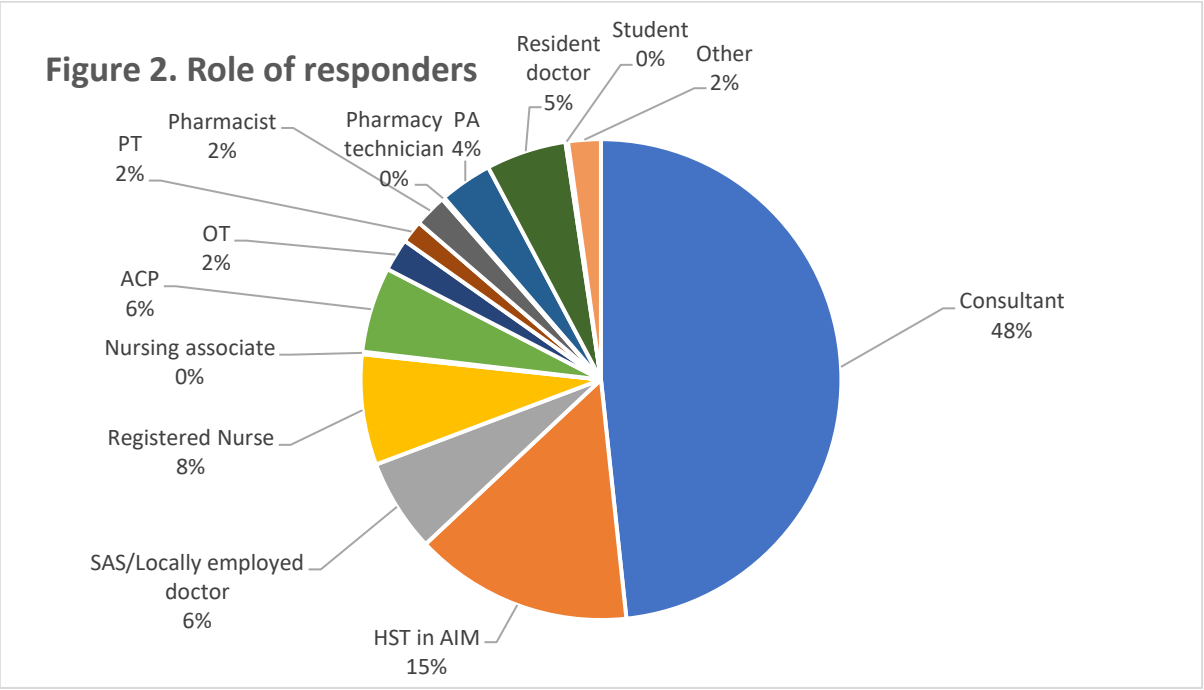
Thank you

SAM Survey Team

Demographics

There were 715 responses (58% of these were SAM members). Figure 1 shows the region of responders, and figure 2 shows their role within the acute medicine MDT.





Membership

Feedback

We asked those who were not members why they weren't. The broad themes in response were:

1. Lack of benefit to joining

When asked what they would like to see in order to join, the responses often mentioned things that SAM already offered such as;

1. Access to free/discounted journal articles, guidelines, and case-based discussions.
2. More online resources like webinars, teaching sessions, and podcasts.
3. Training on acute medicine topics, medication optimization, and evidence-based practices.
4. CPD opportunities and subsidized or free teaching events.
5. Focus on realistic and practical acute medicine practices.
6. Discounted conference rates for members.
7. Conferences that cater to the needs of the wider multidisciplinary team (MDT).

What we took from this is that we need to look at how we promote SAM activities and what we are doing so that it is easier to see for both members and those considering joining

2. "Not relevant"

These comments were from people who didn't work primarily in acute medicine (despite clear instructions on the survey) and the survey wasn't relevant for them so we have discounted these

3. Financial restraints

We understand times are difficult and many people are struggling financially. SAM do offer a tiered membership fee to reflect salary and discount for those LTFT and a freeze during maternity/paternity leave

4. Not as relevant for those that don't work in England

We have representatives covering all of the UK and are keen to make sure we are not "England focused". We do meet with national health leads in all 4 nations and are involved in policy in all countries. Having read feedback, we will be liaising with our reps for Northern Ireland, Wales and Scotland to see how we can ensure members are aware of this work.

Some requests to review things that we currently don't do but are looking at

- Clinical pathways and bundles for common conditions.
- Staffing tools and safer staffing guidelines
- Support for future acute medicine trainees
- Resources on job planning, recruitment and contracts

What we're doing

We have working groups looking at this (also working with NHSE/ RCP) and will be sure to update members with updates on this. Guidelines are a hard thing to put on a website as they need such regular update to ensure kept up to date. We have a small team and this would be a lot of work, that really needs a clinical

person rather than admin. However, we will look at this as it is something that we have looked at trying to do, so good to get feedback that this would be welcomed, and do let us know if you can support with this!

We are doing a lot of work looking at New Consultant role (podcast, finishing school, website resource) and takeAIM have lots of information for future acute medicine trainees including the recent video for those approaching interview. We also have resources on the website for those considering CESR route of training.

Feedback on SAM Additional benefits

Conferences

46.7% have attended within the past year
57% said they were very useful; 30.8% useful; 6.9% indifferent; 3.8% not so useful; 1.6% not useful at all

Feedback included some concern over cost, repetitive content and people suggested more diversity amongst speakers

What we're doing

The feedback has been forwarded to the conference team. We are monitoring the diversity of our speakers and chairs and work hard to represent our full membership. We recognise that we haven't always achieved this but it is something we are aspiring to achieve.

In terms of content and structure – do let us know about inspiring lectures or ideas. We are always open to ideas and suggestions.

We are also introducing a scholarship fund. This will give free conference attendance to those without access study budget for the highest scoring poster abstract in their respective category (we are working on three tiers to cover whole MDT and students) for those who apply for this. Details of this will be sent to all members ahead of the next conference.

Webinars

- 51.4% have watched at least one webinar – of these, 53.8% have only watched 1-2
- 44.1% said they were very useful; 40.8% useful; 9.7% indifferent; 4.3% not so useful; 1.1% not useful at all

Feedback for the webinars was positive and appreciation of the free CPD. There were requests for on demand viewing however we are already doing this.

Podcast

- 32.1% have listened to the podcast
- 31.6% said they were very useful; 40% useful; 20.4% indifferent; 4.8% not so useful; 3.2% not useful at all

Feedback for the podcasts was mainly positive but a lot of people were unaware that we did them.
We will look at raising awareness of these. All individual comments have been shared with the podcast team.
Again, please do share ideas for topics or ways you would like to see these develop.

Website Content

- 20% said this was very useful; 48.6% useful; 18.1% indifferent; 9.7% not so useful; 3.6% not useful at all

There was some criticism of the website, but this was all related to website content prior to the updated website was launched a few years ago (and nearly all from non-members). There were some comments about having more guidelines available and we will take this feedback on board.

Social Media (X/twitter)

- 12.6% said this was very useful; 38.8% useful; 25.9% indifferent; 12% not so useful; 5.5% not useful at all

We are aware that an increasing number of people have stopped using Twitter. We are posting on Bluesky and takeAIM use Instagram. We are keen to find out what Social media members use and any suggestions would be welcome!

Journal

- 36.4% access the journal
- 16.8% said they were very useful; 49% useful; 22.8% indifferent; 9.1% not so useful; 2.3% not useful at all

The feedback for the journal was mixed. Some people found it really informative whereas others found the content a little stale. There were lots of comments about the difficulty accessing it online.

What we're doing

We have fed these comments back to the journal team and we will keep you updated about proposed changes. We have a new editor of the journal so will be working closely with him to feed these comments back. Our admin team have already started work on improving access and links to the online journal, do please let us know if you are still struggling.

Inclusivity

There were a few comments throughout the survey about how SAM was perceived as a closed group with only a few individuals able to take part. This is sad for us to read as we are delighted when people want to get involved. All positions on SAM council are elected (aside from the Lay Representative) and so anyone who has the required experience is open to apply and the members can then vote. As well as this all committees are open to ALL SAM members, irrespective of role or time being a member and we are always looking for more people.

We can see that as the people who are heavily involved in SAM can appear as a closed group. We understand this and some of us felt this way before we joined. Some of this perception is because we do get along well and a lot of us felt a little vulnerable when we first put ourselves forward for election or that first council meeting when we didn't know each other. It is a credit to the open and friendly nature of the society that people are welcomed and feel part of the team so quickly.

The upshot is that we really want people to get involved and everyone is welcome to apply for relevant positions on council or join the committees. Whilst you may not know anyone initially, you soon will!

We will use this information from the survey to emphasize this message.

Physician Associate (PA) Role

Given the recent spotlight on Physician Associates (PAs), we decided to ask some focused questions on this topic. We anticipated some differing opinions and frustrations, but wanted to gain a clearer understanding of our members' views.

Trainee Feedback

Of 90 trainees surveyed, 55.6% reported working with PAs. Among those who had worked with PAs, 32% felt that PAs had a negative impact on their training. We did not ask about positive impact on training which is something we will do in future surveys.

Key concerns raised by trainees included:

- **Reduced Training Time:** "I get less time in SDEC."
- **Limited Clinical Learning:** "Taking away training opportunities" and "restrict training opportunities for resident doctors."
- **Increased Supervision Needs:** "I cannot rely on their work and have to redo it."
- **Resource Strain:** "They require a far greater time and resource input... which takes away from training I could receive."
- **Competition for Procedural Skills:** "Some wish to be trained in procedural skills which also takes away training."

Consultant Feedback

Of 214 consultants surveyed, 53.7% reported working with PAs. Views were generally positive:

- 53.1% **strongly agreed** that PAs add value to the department.
- 23.4% **agreed**.
- 17.1% were **indifferent**.
- 3.6% **disagreed**.
- 2.7% **strongly disagreed**.

Consultants highlighted contributions including:

- **Clinical Assessment:** PAs assess patients under consultant supervision, particularly in SDEC.
- **Practical Procedures:** Performing bloods, ECGs, cannulation (including ultrasound-guided), ABGs, and lumbar punctures.
- **Ward Round Support:** Assisting with documentation and clerking tasks.
- **Administrative Support:** Managing discharge summaries, arranging follow-up investigations, and liaising with relatives and specialty teams.
- **Teaching:** Some consultants noted that PAs also assist in teaching procedural skills

Physician Associate Perspectives

There was, as expected, a voice of frustration from PAs themselves.
One PA described the ongoing discussions about scope of practice as a "living nightmare," highlighting the confusion, frustration, and difficulty many PAs experience in navigating expectations and professional boundaries.

SAM are concerned about the level of vitriol directed towards some healthcare professionals based solely on their role, particularly via social media.

What we're doing

SAM has always been proud to be a multidisciplinary organisation, and recently issued a statement regarding PAs, which is available on our website.

We are actively collaborating with the Royal College of Physicians (RCP) and other national bodies to create clear, role-specific scope of practice documents for PAs, aiming to reduce role confusion and promote better integration within clinical teams.

We will continue to monitor the impact of PAs on resident and SAS doctor training and departmental functioning through annual surveys, adapting our recommendations as required.

We are committed to representing all members; including resident and SAS doctors, consultants and PAs at national discussions and will continue to advocate for safe, supportive and fair working environments for all.

Finally, we welcome the upcoming review by Dr Gillian Leng, which we hope will provide valuable guidance on the future of PAs across the NHS.

SDEC/AEC/ RAC in Scotland FOCUS

For simplicity, from here we have used the term SDEC to represent all units functioning as an admission unit such as AEC or RAC

SDEC is one of the hottest topics and focus of discussion in SAM conferences and local events. It is often referred to as the "only place that works on the acute take" and enables clinicians to provide a safe admission avoidance.

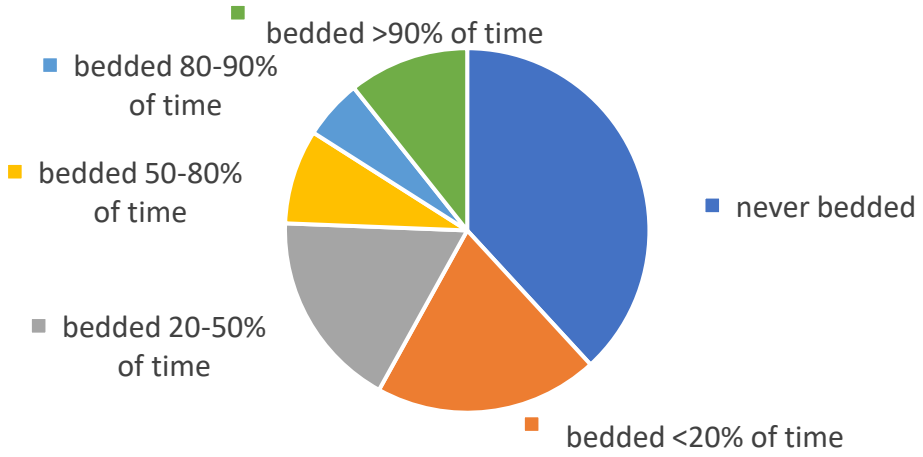
However, SAM have become increasingly aware of SDEC being used as an ED decant for patients that would never have been admitted and that has then compromised the ability to see the more complex admission avoidance (Figure 3).
SAM have published 2 statements on this in 2024 with guidance[i], [ii].

The survey results showed that unsurprisingly the vast majority of acute medicine clinicians work in a hospital with an SDEC (96%)

72.6% of SDECs operate as per the guidelines of 7 days per week

A common frustration is that members talk of the SDEC being bedded at times of stress, the very time when we need them operating.

Figure 3. Bedding of SDEC



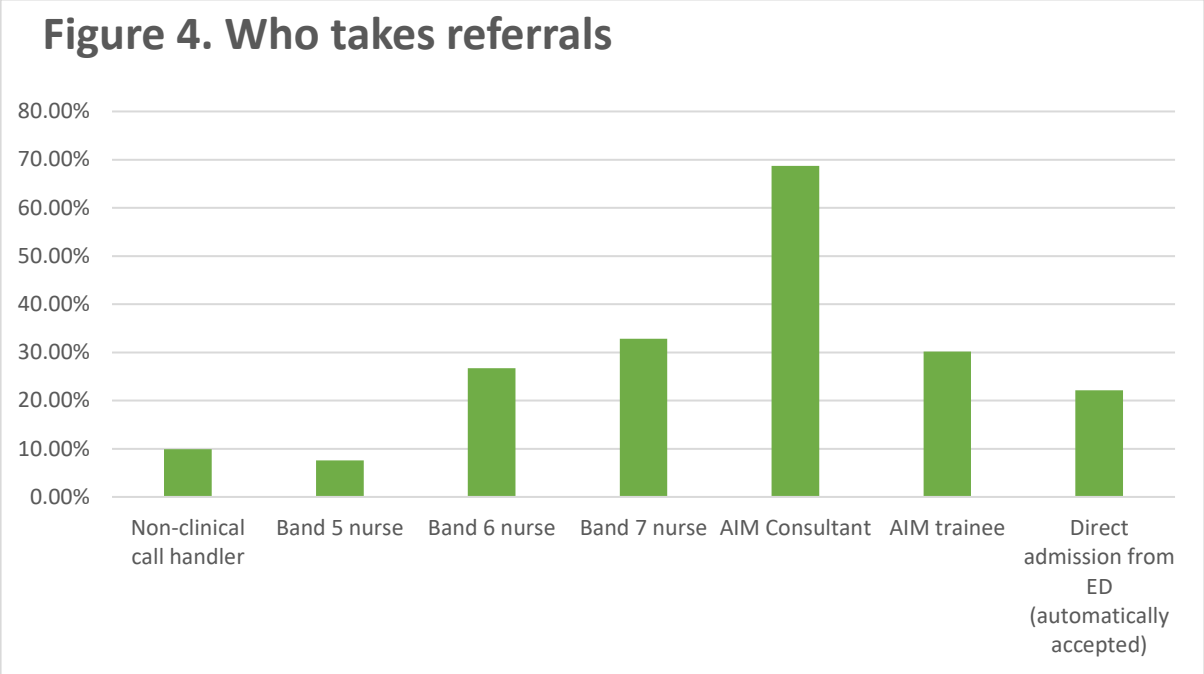
97.7% of SDECs looked after by AIM physicians; 20.3% had input from GIM consultants; 8.8% had input from EM physicians; 6.5% had input from GPs

We asked members to select how their SDEC was used. They could select various different functions.

Use of SDEC	**Percentage**
Direct review of GP referrals	97.3%
Decant of unselected patients from ED (before clinician review in ED)	62.2%
Review of ED referrals (after clinician review)	81.3%
Direct review of referrals from paramedics	58%
Scheduled return for imaging	89.3%
Scheduled return for blood tests	87.4%
Scheduled return for procedures	71.8%
Scheduled return for IV abx	70.2%
Scheduled return for other IV meds	69.9%
Scheduled return for medical review	87.8%

Many members commented on SDEC being perceived as a "dumping ground" for difficult or unselected cases that other departments avoid. Another thing highlighted was members stressing the Importance of ensuring the correct patient selection process, emphasizing a "pull" model rather than a "push."

43 consultants responding were the leads for their SDEC – 62.2% of them had specifically job-planned time for this role. Figure 4 shows who takes SDEC referrals.



ECDS (Emergency Care Data set)

What is ECDS and why ask us about that?

The Emergency Care Data Set is a national data collection effort in all of the UK used to improve patient care, planning, and communication in emergency departments. NHSE mandated that all trusts should use this system to record data for SDEC by 1/7/2024. This has not been achieved, only 60 hospitals in the UK have started to use it.

We have asked this question to see how many people were using this and what people's experience was

18.4% of consultants use ECDS for coding in SDEC
A summary of comments is submitted below but the majority of comments were negative.

- Clinicians are now required to handle coding tasks, which many feel is a **waste of valuable time**.
- Coding tasks take time away from patient care and are described as being **better suited for trained coders**.
- Many expressed frustration over the additional workload imposed without added clinical value.
- Some felt ECDS was **poorly designed** and lacks relevance to clinical work, especially for Same-Day Emergency Care (SDEC).
- It fails to capture a **comprehensive range of medical conditions**, leading to challenges in coding common SDEC presentations.
- Many respondents felt that ECDS adds **no meaningful or useful data** and complicates processes unnecessarily.
- The tool is described as **management-driven**, with minimal consideration for clinical needs or outcomes.
- Transitioning to ECDS was described as **exceptionally challenging** due to IT issues in some trusts.
- Strongly negative opinions about ECDS were frequent, with descriptors like "awful," "bloomin' useless," "terrible," and "waste of time."
- Overall, ECDS is viewed as an imposed system that adds bureaucracy without benefiting patient care or clinical workflow.

What we're doing

The data was not surprising to read. A lot of this has already been addressed within the most recent documents but this helps us represent our members in both strategy documents and when in national meetings.

[i] https://www.acutemedicine.org.uk/wp-content/uploads/Joint-statement-RCEM-and-SAM-regarding-Same-Day-Emergency-Care-SDEC.pdf
[ii] https://www.acutemedicine.org.uk/wp-content/uploads/SDEC-A-need-to-pause-and-reset.pdf