British-trained PAs in emergency medicine has increased from 6 to 13,[2] despite the closure of two of the four programmes educating PAs during this time frame. As of July 2014, several universities are opening new PA programmes and existing programmes are expanding their intake of students. From a nadir of 36 entrants in 2012, there should be at least 150 students entering PA education programmes in 2015. As emergency medicine is one of the most popular specialties for UK-trained PAs, the number of PAs available to practice in accident and emergency should continue to grow.

The data show that most PAs in the UK are not yet performing more invasive clinical procedures used in emergency medicine. This is consistent with the experience of PAs in the USA and is related to their relative inexperience in emergency medicine (1–2 years in post). PA practice rests on a concept of 'negotiated performance autonomy' in which doctors provide their PAs with training for increasing skills over time and allow the PA to perform these duties autonomously once the PA has demonstrated competence to the doctor's satisfaction.[3] As not all PAs are equally skilled at all tasks, the delegation of autonomy to the PA is granted by the doctor on an individual basis over time. It is also possible that the unresolved legal status of PAs is causing uncertainty among doctors about whether or not they are allowed to delegate these more invasive tasks to PAs.[4] If the regulatory issues are resolved and PAs continue to gain experience in emergency care, evidence from the USA suggests that PAs will be able to increase their contribution to the emergency medical team.[5]

The NHS desperately needs to evaluate new methods for delivering emergency care. The short postgraduate educational pipeline (2 years) for PAs, their generalist training and their ability to expand their skill set over time should make the government seriously consider regulating these professionals and expanding the number of PAs in training. ■

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Editor – As you have correctly identified, the risk of 'alternative, less stringent, models of training' is very real. The absence, at present, of any accreditation standards or external review processes for PA programmes, or even the lack of the basics of mandatory educational standards for PA programmes could very well undermine the overall progress of the profession to date. This is especially true now, given that there are three new programmes coming online in the next 6 months and several more under consideration for the next year.

Further, while it is my hope that the registration, along with programme accreditation standards by the Health and Care Professions Council, are forthcoming, they are neither a certainty nor anywhere on the near horizon. As an interim solution, I along with experienced American and British PA educators from the UK and Ireland Universities Board for Physician Associate Education are currently finalising a 'best practice' document which can serve as a template (although with voluntary compliance) for those universities considering a PA programme.

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The future of general medicine

Editor – Dr John Firth wrote thoughtfully in August's *Clinical Medicine*[1] about the future of general medicine. However, by explicitly not exploring its relationship with acute and geriatric medicine, he has inadvertently missed the most important component of the story.

He acknowledges that the acute care of largely older adults with frailty, multiple comorbidities, dementia and social vulnerability accounts for a large proportion of today's acute medical take and an even bigger proportion of occupied bed days. While he then praises geriatricians and their multidisciplinary team colleagues for being good at discharge planning, I do not believe that this is the only skill we have that general physicians fall short on, nor that we have access to some magic set of supports that other physicians cannot access. In reality, any general physician can become fairly skilled and knowledgeable in the area of post-acute rehabilitation, discharge and community services if they choose to. But too often, they regard it as an unworthy 'social' endeavour and someone else's job, and label older patients as having 'acopia' or 'social admissions', or being 'bed blockers'.[2]

Geriatricians add value to patient care in a variety of other ways by being skilled diagnosticians in the care of frail older people (such as the 'older woman who has had a funny turn' he describes). In addition, if as Dr Firth claims, the assessment of such patients is often more challenging and complex than single diseases in younger adults, it does make me wonder why generalism should be seen, as he claims as being less prestigious.

Comprehensive geriatric assessment delivers a range of benefits to patients.[3] Ensuring older people are seen at the front door of hospitals by geriatricians, as well as a relentless focus on discharge planning, can deliver big efficiencies and improved outcomes.[4] It is geriatricians who have led the way in developing the evidence base for previously neglected syndromes, such as falls or delirium, and in care of inpatients with comorbid dementia. We are also generally dually accredited in general internal medicine (GiM) and deliver more of it than most other specialities.

And despite Firth's claims of low status or popularity, we are the biggest GiM speciality in the Royal College of Physicians with the highest number of trainees.

A big proportion of the acute take in less frail patients can be handled by outpatient clinics or with discharge within 48 hours if patients are admitted. Most patients who remain are then either mainstream geriatric medicine or fit more or less into one of the main organ specialities, without that much unclassified general medicine left. So the relationship between geriatrics and acute medicine is not a sideshow – it is key.

Finally, I must express disappointment that Firth feels that those doing general and geriatric medicine are regarded as 'second rate' and of lower status than those focusing on single organs or diseases. This is not a situation we can allow to continue.

As NHS doctors, we are trained and paid by the taxpayer. As such we have a duty to embrace the care of the patients who actually come through the door (generally older and medically complex) not those we might find more glamorous. Looking after these patients should be seen as a vital role to be proud of and one which is 'core business' for those of us working in general hospitals. Even tertiary referral centres like Addenbrookes Hospital (Cambridge, UK) are still the district general hospital for their local community.

I have to ask, who is giving out the message that expert generalism is a poor relation? I feel our medical schools have a big responsibility with values and curriculae not focusing nearly enough on the care of older people and those with multimorbidity.[5] Postgraduate training often reinforces this. I do not think that the Royal College of Physicians' scheme to make more doctors do medical registrar on calls will make people who are not interested in general medicine or geriatrics any more interested, nor that creating a 'chief of medicine' post, as set out in the Future Hospitals Commission Report, will shift values. We really need to send out the message that care of the unselected medical take and non-elective inpatient work is the key to solving the problems hospitals face, and therefore the most important job of all. ■

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The history and future of intensive care units

Editor – I very much enjoyed the fascinating review on the history and future of intensive care units (ICUs) (*Clin Med* August 2014 pp 376–9) but wanted to highlight two points. Firstly, the author's comment that cooling patients to 33°C is now common. A recently published targeted temperature management trial showed no benefit from cooling to 33°C versus maintaining controlled normothermia at 36°C.[1] Indeed, the International Liaison Committee on Resuscitation put out an update statement acknowledging local ICUs may choose to aim for controlled normothermia as opposed to hypothermia.[2] This is our local practice. Secondly, the authors state the formation of a stand-alone intensive care medicine (ICM) certificate of completion of training (CCT) should make training more accessible to physicians. However, the current Faculty of ICM (FICM) guidelines only accept dual CCT with a limited number of specialties namely; respiratory, renal and acute medicine (as well as anaesthesia and emergency medicine).[3] Therefore, although the new system opens ICM registrar training to those from the core-medical training, it has shut the door on dual qualifying with varied specialities. Specifically, one cannot currently qualify in cardiology and ICM, which was stated as a possibility in the article. Furthermore, there is currently no linking of the curricular or portfolios for the dual CCTs between the FICM and Royal College of Physicians. This means undertaking this training route is associated with an enormous administrative burden merely to prove competency. ■

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