Letters to the editor

OVERVIEW

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Where did the acute medical trainees go? A review of the career pathways of acute care common stem acute medical trainees in London

Editor – Gowland *et al* raise issues about the acute care common stem (ACCS) training programme.[1] They have achieved excellent follow-up of their acute care common stem acute medicine (ACCS AM) trainees in London and found that only a minority progress to higher training in acute internal medicine (AIM). This may also be the case in other parts of the country. However, we were unable to find the source of their statement that London has the highest competition ratio for ACCS AM (5.6–7.1 applicants per post), making London the 'most competitive area of the country' with 'the most competitive and driven trainees'. In addition, we should clarify that the figure of 'only 65 [ACCS AM] trainees nationally' is the number of year 1 posts in 2015, rather than the total number in the programme.

The purpose of the ACCS AM programme has always been broader than simply trying to develop physicians for higher specialty training in AIM. It is, therefore, not a failure of the programme that 21% of London trainees are pursuing a career in intensive care medicine or that a number have chosen higher training in other medical specialties. About half of the trainees completing core medical training (CMT) don't pursue higher training in any medical specialty, but this isn't a 'failure' of CMT either; however, we do need to understand the reasons in more detail. We were disappointed, therefore, to see the repeated suggestion that ACCS AM should be disbanded, with posts absorbed into CMT; this is missing the point entirely.

Closer consideration should be given to what experience in acute medicine the ACCS AM trainees had. Perhaps part of the reason for this group not pursuing higher training in AIM is that their exposure to AIM was not attractive, whereas their experience in anaesthetics or intensive care medicine might have been. It has been suggested that some ACCS AM trainees in fact have less exposure to the acute take than their CMT counterparts; we wonder what the programme's quality data tell us about the 6-month placements of acute medicine training for these cohorts.

As AIM trainers, who have been closely involved with ACCS AM from the start, we are grateful for the authors opening up this area for discussion. We hope that it will lead to an improved understanding of ACCS AM and an enhanced quality of delivery of programmes across the country, including an optimal experience of acute medicine, and perhaps ultimately more people entering higher training in AIM.

Conflicts of interests

MM is a member of the Intercollegiate Committee for ACCS Training. MJ is immediate past chair of the AIM Specialty Advisory Committee.

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Reference

1 Gowland E, Le Ball K, Bryant C, Birns J. Where did the acute medical trainees go? A review of the career pathways of acute care common stem acute medical trainees in London. *Clin Med* 2016;16:427–31.

Editor – As the training programme directors for higher professional training in acute internal medicine (AIM) in North Central/East and South London, we read with interest the 2016 article by the office of the Head of School for Medicine for London reflecting on the perceived value of the AIM Acute Care Common Stem (ACCS) programme. Had any acute physicians been involved, the conclusions might have been different.

In our opinion, the paper takes too narrow a view of the ACCS programme. The programme is designed to produce trainees solidly grounded in acute specialties and allow them a degree of 'wriggle room' before committing to higher specialty training, which might – or might not – be in one of those specialties. Strengths of ACCS include breadth of training and the opportunity to change specialty with experience. Regarding AIM, it was always intended that ACCS should be the equivalent of core medical training (CMT) in terms of subsequent access to other physicianly specialties and, conversely, that CMT alumni would be eligible for specialist training posts in AIM.

The authors are an anaesthetist and three geriatricians. We think it unlikely that many AIM physicians would support their suggestion that the AIM ACCS stream be disbanded and the posts incorporated into CMT.

There have also been local difficulties in the London ACCS programme, which may make national extrapolation inappropriate. Not all first year London ACCS trainees are allocated to AIM rather than general internal medicine posts and the range of medical subspecialties available in third