

Letters to the editor

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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 ‘wiggle 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 physician 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

year is severely restricted. Furthermore, the wide geography of the London ACCS posts and lack of a dedicated training programme director for several years contribute to a lack of professional identity for the group. There appears to be little joined up thinking regarding the ACCS and AIM higher specialty training programmes, which may have contributed to the lack of progression in the manner expected.

We contend that the AIM ACCS programme offers valuable training opportunities that should be strengthened, with greater collaboration with AIM higher specialty training, rather than disbanded. Finally, we cannot ignore the wider contemporary environment which makes a career in acute specialties less attractive to many doctors.

Conflicts of interest

Both authors are members of the AIM Specialty Advisory Committee.

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- 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 – we read with interest the article *Where did the acute medical trainees go? A review of the career pathways of acute care common stem acute medical trainees in London* from Gowland *et al.*¹

Most specialties are facing recruitment issues, with acute specialties the hardest hit. Therefore, in intensive care medicine (ICM) and anaesthetics we greatly sympathise with acute internal medicine's (AIM) difficulties of both recruitment and retention. When the Faculty of Intensive Care Medicine designed the ICM CCT programme, we recognised the importance to patient management of AIM and made sure that 12 months were set aside for hands-on medical experience.

We would fully support the wish to include more ICM exposure in the core programmes of medical trainees. However, the optimal time and structure required for trainees to gain something beneficial from that exposure would be specific objectives achieved over a (minimum) 3-month period.

Such training opportunities have been strengthened by the acute care common stem (ACCS) programme, which has given trainees a truly broad experience. Preparing doctors to manage a wide range of clinical situations has significantly improved the effectiveness of the acute pathway in hospitals. We see this as an immense benefit to all of our patients' journeys, and it is their needs and the needs of our services that should be at the heart of training programmes. ACCS has shown itself as fit for purpose by producing doctors who are multiskilled and able to manage patients, door to discharge.

It would, therefore, be a shame for doctors and patients if AIM opted out of ACCS based upon concerns that trainees may see that the grass is greener elsewhere. There is a growing move, both through national initiatives like Shape of Training and through the local tenacity of doctors themselves taking advantage of standalone fellowships, to ensure that training careers have flexibility. The challenge for all acute specialties is to counter any demoralisation with improvements in training and support. If the elements of pastoral support and mentorship found in ICM and anaesthetics are attractive to trainees, it would be invaluable to see how similar initiatives could enhance AIM training. We would hope that there is merit seen in reviewing how the medical components of ACCS acute medicine could be uplifted in this way before, to use the trending phrase, a 'conscious uncoupling' happens.

Conflict of interest

The authors have no conflicts of interest to declare.

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- 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.

Stroke mimic diagnoses presenting to a hyperacute stroke unit

Dawson *et al*¹ provide valuable data on the prevalence and nature of stroke mimics. We wish to draw attention to the evolving concept of 'magnetic resonance imaging (MRI) negative stroke' – persistent symptoms diagnosed as stroke but with no confirmatory neurological signs or imaging abnormality. In particular, we are seeing an increasing number of insurance claims for 'stroke' where there is no objective evidence of brain injury.

The original World Health Organization stroke definition² required clinical signs consistent with stroke to be present. However, the recent definitions proposed by the American Heart Association and American Stroke Association³ included the following:

- > 'clinical evidence of cerebral, spinal cord or retinal focal ischemic injury based on symptoms persisting ≥ 24 hours or until death, and other aetiologies excluded'
- > 'an episode of acute neurological dysfunction presumed to be caused by ischemia or haemorrhage, persisting ≥ 24 hours or until death but without sufficient evidence to be classified as another type of stroke.'

In 1999, Ay *et al* identified 27 'clinically definite stroke' cases with normal brain diffusion-weighted imaging (DWI) MRI on admission.⁴ 63% were ultimately shown to have had a