

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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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 – 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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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