

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.

NICK MURCH

*Consultant in acute internal medicine and training programme director, AIM North Central & East London, UK*

KEVIN O'KANE

*Consultant in acute internal medicine and training programme director, South London, UK*

### 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.*<sup>1</sup>

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.

CARL WALDMANN

*Dean, Faculty of Intensive Care Medicine, London, UK*

ALISON PITTARD

*Vice dean and training lead, Faculty of Intensive Care Medicine, London, UK*

NIGEL PENFOLD

*Training lead, Royal College of Anaesthetists, London, UK*

### 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.

### Stroke mimic diagnoses presenting to a hyperacute stroke unit

Dawson *et al*<sup>1</sup> 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 definition<sup>2</sup> required clinical signs consistent with stroke to be present. However, the recent definitions proposed by the American Heart Association and American Stroke Association<sup>3</sup> included the following:

- > 'clinical evidence of cerebral, spinal cord or retinal focal ischemic injury based on symptoms persisting  $\geq 24$  hours or until death, and other aetiologies excluded'
- > 'an episode of acute neurological dysfunction presumed to be caused by ischemia or haemorrhage, persisting  $\geq 24$  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.<sup>4</sup> 63% were ultimately shown to have had a

stroke in the clinically relevant area on interval MRI, but the remaining third had normal follow-up imaging. These patients were considered likely to have a variety of stroke mimics, as described by Dawson *et al*, or episodes of transient ischaemia lasting >24 hours and sometimes days.

In 2011, an Edinburgh group published a prospective study in which the diagnosis of stroke was made from case records by a panel of experts (neuroradiologist, vascular neurologist and stroke physician) who then reviewed the clinical and brain imaging data 21–52 months later.<sup>5</sup> 246 out of 253 patients were diagnosed with ‘definite stroke’ on presentation. While 81/246 (33%) had negative DWI at presentation, a quarter also had no MRI abnormality on follow-up. The authors concluded that ‘there is a high rate of negative MRI and DWI among patients with minor stroke (a third)’ and that ‘a negative MRI or DWI does not exclude the diagnosis of stroke’.

Therefore, there is now a narrative that stroke can be diagnosed on the basis of symptoms alone. We question this. Dawson *et al* rightly draw attention to the significant consequences of a stroke diagnosis on medical management and social and work activities. While it is recognised that DWI may not detect acute stroke, in our view persistent neurological symptoms and dysfunction are unlikely to be due to ischaemic stroke in the absence of neurological signs or relevant MRI abnormality on follow-up.

### Conflicts of interest

The authors have no conflicts of interest to declare.

RUSSELL LANE

*Medico-legal neurologist, Imperial College London, UK*

ANGUS NISBET

*Consultant neurologist, Queen Victoria Hospital and Western Sussex Hospitals NHS Trusts, East Grinstead, UK*

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### UK Medical Education Database: an issue of assumed consent

Editor – There are some significant misconceptions in the letter on UKMED by Best *et al*.<sup>1</sup> UKMED is a partnership between data providers from across the health and education sectors to evaluate medical career progression. This will help to raise

education standards by enabling us to assess the predictive validity of assessments.

Data protection and privacy considerations have been at the heart of UKMED’s development and the bodies involved take their safeguarding of information extremely seriously. The legislation states that the General Medical Council, which is the data controller for UKMED, must carry out its activities proportionately and use personal data fairly. For this reason, when a doctor or student provides their information to one of the organisations that contribute to UKMED, they are told what that data will be used for, including research of this kind. Each contributing organisation has a privacy notice that indicates data sharing may take place.

UKMED does not provide any identifiable data to potential employers and data are not used to monitor or make decisions about individual doctors. Only anonymised data are shared with approved academic researchers under the terms of a strict contract in a safe haven<sup>2</sup> to prevent attempts at re-identification.

Data are held in UKMED for research purposes only. Doctors’ information can’t be used to make decisions that could impact on their career, either positively or negatively.

We are committed to transparency in the operation of UKMED. Doctors can find out more about the way UKMED is run on the website, including details of the process for accessing research datasets.<sup>3</sup> The British Medical Association represents the interests of medical students and doctors on the UKMED development group.

We hope that medical students and trainees recognise the need for an evidence-based approach to medical education. UKMED facilitates this without infringing on privacy.

STEVE THORNTON

*Chair, UKMED Advisory Board*

*Vice principal (health) and executive dean, professor of obstetrics, Barts and the London School of Medicine and Dentistry, Queen Mary University of London, London, UK*

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### Response

Editor – We thank Steve Thornton for his letter.

We appreciate the aim of the UKMED project, and the need for an evidence-based approach to medical education. However, this should not be at the expense of informed consent.

If the UKMED Advisory Board are committed to transparency, we suggest the organisations that contribute to the UKMED database ask explicit permission from students and doctors before sharing their data with UKMED. This should include checking candidates agree with the linking of