Consensus, the College and cerebrovascular medicine

Consensus is something you reach when you can't agree
Margaret Thatcher [1]

The pathway of care for patients with stroke, from primary prevention through acute care and secondary prevention to rehabilitation, crosses more specialist boundaries than many illnesses. This, in addition to the diversity of patients in terms of age, disability and the underlying pathological process, means that reaching general agreement about the management of the disorder will always be difficult. It is almost inevitable that each specialist group will have its own perspective of the disorder and consequently the relative importance of the various parts of the care pathway. It might be argued, therefore, that it is for disorders such as stroke that attempts by other bodies to find areas of consensus have most value.

In 1988 the King's Fund published its consensus statement on the management of stroke [2] and the following year a College working party produced its report entitled *Stroke : towards better management* [3]. In the preface to the College report, the President described it as an attempt to 'bring together new ideas about its clinical management . . . draw attention to any perceived need for changes in, or additions to, existing services within the NHS . . . and provide a stimulus to much-needed research into several important practical aspects of management'. Although some of the recommendations were aspirational rather than evidence-based, it is easy to forget that at the time issues such as the treatment of hypertension in the elderly, the place of carotid endarterectomy, the use of anticoagulants in patients with atrial fibrillation and the benefits of coordinated care and rehabilitation for patients with stroke were not resolved. Nevertheless, these two 'consensus' reports are widely acknowledged to have raised the profile of cerebrovascular disease and, when taken alongside the huge social and economic burden of the condition, provided the necessary impetus to move the disorder up the medico-political agenda. This role has since been taken on by the Health of the Nation and NHS Research and Development initiatives so it is perhaps an appropriate time to consider what should now be on the College's agenda for cerebrovascular medicine.

The paper by Lindley *et al* in this issue of the *Journal* (pages 479–83) notes, among other things, that a significant number of physicians were unaware of the value of aspirin for secondary stroke prevention even when the evidence of benefit was beyond reasonable doubt. The reasons for this apparent gap in their knowledge are not known but it is the exceptional clinician who can develop, and keep, expertise in all the areas that are potentially relevant to cerebrovascular disease. One might argue, therefore, that a major role for the College should be to develop broadly based CME for cross-specialty disorders such as stroke. The organisers of such CME programmes will have the difficult task of attracting clinicians with different specialty backgrounds to meetings where a substantial part of the programme may not be directly related to their particular area of interest. However, clinicians should remember that 'CME works when you don't want it (and) when you want CME you don't need it' [4].

One of the recommendations of the original College report, which was developed by the Stroke Association [5] and has since been taken up by many health authorities and trusts, was for the creation of consultant posts which include a specific responsibility for stroke services. Physicians applying for such posts ideally should have had a broad training which might include exposure to public health medicine, general practice, rehabilitation medicine and clinical pharmacology as well as the more traditional general medical specialties. Whether the proposed Calman training programmes for specialties such as geriatrics, neurology or rehabilitation medicine will, in practice, be flexible enough to accommodate the needs of such trainees is open to question and there are those who would favour developing a specific training scheme for cerebrovascular medicine. Clearly the College might have a role in fostering this debate.

Getting research into practice involves more than just the transference of knowledge through CME. The paper from Gariballa *et al* in this issue of the *Journal* (pages 485–7), taken alongside the findings of Lindley *et al,* suggests that there is a considerable gap between 'knowing' and 'doing'. Clearly this is the province of audit. The College's Stroke Audit Group has produced standards for the process of care of patients during the acute phase of their stroke and also produced a simple computer program to facilitate the audit process. Even clinicians who question the relationship between what is documented and what happens in practice have been chastened by the results of such audits which, in general, seem to echo the findings of Gariballa *et al.* The *Stroke audit package* [6] available from the College also contains a specimen clerking proforma which junior medical staff generally find both educational and easy to use. The use of the proforma will, almost

J M BAMFORD, MD, FRCP, *Consultant Neurologist and Cerebrovascular Physician, St James University Hospital, Leeds.*

inevitably, improve one's performance on an audit of process, but it is not unreasonable to hope that there will be a beneficial knock-on effect on the actual quality of care that is delivered.

Unfortunately, consensus is still lacking in the area which is probably of most interest to patients, carers, clinicians and health care planners—the assessment of outcome after stroke. The lack of agreement about what should be included in a standard battery of outcome assessments hinders the development of large scale trials of rehabilitation techniques whilst the complete absence of any routinely collected data about outcomes other than death makes planning services for those disabled by stroke very difficult. This should be regarded as one of the most important problems facing those interested in cerebrovascular medicine. Although preliminary attempts by the College and others to broker a consensus have faltered, the issue should remain high on their agenda.

References

1 Ingham B. *Kill the messenger*. London: Harper Collins, 1991;384.
2 *Treatment of stroke*. A consensus conference. *Br Med J* 1988;**297**:126–8.
3 Royal College of Physicians. *Stroke: towards better management*. A working party report. London: RCP, 1989.
4 Sackett DL, Haynes RB. On the need for evidence-based medicine. *Evidence-Based Medicine* 1995;**1**:5.
5 *Positive 'steps'*—A progress report on district stroke services. London: The Stroke Association, 1995.
6 Royal College of Physicians and UK Stroke Audit Group. *Stroke audit package*. London: RCP, 1994 (includes software).

Address for correspondence: Dr John Bamford, Consultant Neurologist and Cerebrovascular Physician, St James's University Hospital, Beckett Street, Leeds LS9 7TT.

SETTING PRIORITIES IN THE NHS
A framework for decision-making

Report of a working party of the Royal College of Physicians

There have been difficulties in containing costs within the NHS without compromising standards. Many medical procedures have been increasing in sophistication and cost, and not all are affordable within the budget allocated to health care. Furthermore, the scope for releasing resources through efficiency savings is becoming increasingly limited. Within the immediate pressures of delivery of health care there is a need to protect and co-ordinate staff training and research and development. To ensure that health care continues to be available on an equitable basis to the population as a whole in the face of competing demands, choices will have to be made and the criteria for making them agreed by those who fund, organise, deliver and receive health care. It will be inevitable that in order to maintain services, the common good will sometimes take precedence over individual freedom of choice.

These and other issues surrounding the allocation of resources and maintenance of standards are considered in this report.

Contents

◆ Role of the NHS ◆ Allocating resources: theory and practice ◆ Present concerns ◆ Setting priorities: the need for a framework ◆ Appendix 1: Development of the National Health Service ◆ Appendix 2: Training, research and development ◆ SUMMARY AND RECOMMENDATIONS

Price £7.50 (overseas £10.00). ISBN 1 86016 020 4. A4 report, 38 pages.
Cheques made payable to the Royal College of Physicians

ROYAL COLLEGE OF PHYSICIANS OF LONDON