Who Should Care for Stroke Patients?

To the Editor:

We read the discussion on the management of stroke in the November 2003 issue of *Stroke* with great interest.

In general we agree with Prof Caplan’s point of view and disagree with Prof Lees’s suggestion of establishing a stroke subspecialty. It is not clear to us whether the background for disagreeing with Prof Lees’s suggestion of establishing a stroke subspecialty. It is not clear to us whether the background for

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Holistic Care Is Necessary

The fact that every neurological patient needs holistic care is widely accepted. The problem is how to deliver it. Neurology is probably the most interdisciplinary field of current medicine and, as such, requires close collaboration with other specialties.

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Medical Education and Administrative Needs

In this discussion we are faced with 2 problems: (1) the structure and “philosophy” of medical education and (2) the administrative and financial needs of different health systems.

Changes are necessary, but in what direction? The structure of medical education has been changing over the past 100 years, and in discussing the issue of further changes we should analyze the effects of any suggested modifications on both long-term patient care and the career development of young doctors. In recent decades the changes have focused on either (1) improving the care and management of certain diseases or (b) changes forced by purely administrative requirements. The changes suggested by Prof Lees appear to be in the second group, since the idea of introducing a new subspecialty solely responsible for stroke care reflects the notion of tailoring medical education to the current structure of hospital stroke care. If we follow this path, subsequent changes will result in dividing strokology into real strokologists and TIA-ologists, because if we look at it from the hospital manager’s point of view, the management of TIA and stroke patients differs, doesn’t it?

We believe that the issue of a new subspecialty comes down to the problem of expanding educational opportunities and improving care in narrow fields within the same specialty, whether it is neurology or internal medicine.

In his article, Prof Lees’s statement that “elderly patients infrequently are admitted to acute neurological wards” is astonishing. Age being one of the strongest risk factors for stroke, elderly patients in Poland constitute the majority of stroke unit patients. Not admitting such patients to stroke units on the basis of their age is obviously discriminatory.

Current trends in university education tend to broaden the horizons of curricula. This approach protects young professionals from the changes resulting from the technologic and administrative changes that will undoubtedly occur in the future.

Narrowing educational fields by the concept of subspecialist education seems in opposition to current trends.

Dividing Medical Care According to Anatomic and Functional Aspects Is Probably Not the Answer to the Problem

Establishing a specialty that deals with one disease of one organ does not seem to be a reasonable idea. Other specialties that have focused on a single organ, tissue, or disease are facing the problem of miscommunication caused by lack of common ground on which cooperation with other specialists could take place. This “no overlap” principle may soon become a serious issue because it can make a holistic approach to patient care impossible. As practicing clinical neurologists have a reasonable insight into patient health as a whole, it seems illogical to alter the current situation.

Prof Lees wrote: “few neurologists play a direct role in the management of blood pressure or atrial fibrillation, use of statins, PFO closure, carotid stenting, or endarterectomy.” This seems to be misunderstanding, as neurologists do treat raised blood pressure and administer anticoagulants in the prevention of primary or secondary stroke as recommended currently. Furthermore, we believe that they should know the indications for therapy with statins, but conversely do not see why they should perform endarterectomy (with or without stenting) or PFO closure. Similarly, intra-arterial thrombolysis—an emerging and promising therapy—will probably be the domain of the interventional radiologist and not of the neurologist or “strokolologist.”

Stroke Care Should Be Coordinated by Neurologists

We seriously doubt whether ER staff could really easily differentiate between encephalitis, complicated migraine, or transient global amnesia and stroke or TIA.

In smaller hospitals, the need to establish neurological and “strokolological” staff who would divide neurological patients into stroke and no stroke cases could easily lead to serious fragmentation of services and organizational chaos.

The care of stroke patients should, in our opinion, be provided at stroke units and be the province of neurologists. Certainly, at such units there is a strong need for close cooperation with specialists in internal medicine and rehabilitation.

However, some countries suffer from a lack of qualified personnel and this may be the reason for additional training of internal medicine specialists, although it should not lead to narrowing the horizons of young doctors in training.

Education Is the Answer

What then could be done to improve the medical care of stroke patients?

Education is the answer. Unfortunately, we are now seeing a tendency to shorten the period of residency training. In Poland, for example, residency time was recently shortened from 6 to 5 years. This 5-year training (which has to include all the other nonneurological rotations) definitely seems to be too short.

Conclusions

Dividing neurology into subspecialties is not the remedy for poorly educated neurologists.

We need continuous education programs for neurologists and full cooperation with other specialists and paramedical staff. This should be an efficient solution for both stroke patients and the medical professionals who care for them.

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