Stroke medicine: a new subspecialty

Ian Starke

The specialist management of patients with stroke has assumed increasing importance over the last 10 years. In recognition of this the Specialist Training Authority has accepted stroke medicine as a subspecialty. The scope of the training programme and the route into it are described.

INTRODUCTION AND BACKGROUND

Stroke is the third most common cause of death and the leading cause of long-term disability in the UK, and accounts for over 5% of NHS resources. Until relatively recently, patients with acute stroke admitted to district general hospitals were often consigned to the far end of a medical ward, and matters were allowed to take their course.

Shining exceptions to this were to be found in a number of specialist stroke units and over recent years these units have been instrumental in establishing a strong evidence base for the effectiveness of multidisciplinary specialist stroke care, both during the acute phase and throughout rehabilitation (Stroke Unit Trialists' Collaboration, 1998).

The *National Service Framework for Older People* (Department of Health, 2001) and evidence-based guidelines from the Royal College of Physicians of London (2000) and the Scottish Intercollegiate Guidelines Network (2002), coupled with a series of National Sentinel Audits of Stroke, have emphasized the importance of specialist management of this complex condition. As a result, enthusiasm has been generated to establish specialist stroke services in NHS acute trusts.

This need was highlighted by a benchmarking survey from the British Association of Stroke Physicians in 2003 which showed that to provide specialist stroke services in all district general hospitals in the UK would require 187 new acute stroke units and 158 stroke rehabilitation units (Rogers et al, 2003).

Dr Ian Starke is Consultant Physician in Stroke and Medicine for the Elderly, Department of Medicine for the Elderly, University Hospital Lewisham, London SE13 6LH

CREATION OF A SUBSPECIALTY

As part of the specialist multidisciplinary management of stroke there is a clear need for trained specialist stroke physicians, and the Specialist Training Authority in the UK has recently approved the establishment of a subspecialty of stroke medicine and a 1 year subspecialty training programme. This subspecialty is hosted by the General (Internal) Medicine specialty advisory committee of the Joint Committee on Higher Medical Training, but has its own subspecialty advisory committee (SSAC). Trainees in a number of other established specialties will have access to subspecialty training in stroke medicine.

ENTRY CRITERIA AND DURATION OF TRAINING

Entry is open to specialist registrar trainees holding a national training number (NTN) in a medical specialty. Trainees in geriatric medicine, neurology, rehabilitation medicine, clinical pharmacology and therapeutics, cardiology or general medicine may apply for a 1-year training programme in stroke medicine.

Where a trainee has already obtained significant previous experience in stroke care as part of the base programme, for example in geriatric medicine, the period of subspecialty training may be reduced at the discretion of the regional training committee. It is also possible that a trainee may need to have more than 1 year's training if there has been no previous exposure to stroke medicine, and an individual trainee may spend time in more than one post. A precise evaluation of each trainee's requirements in the subspecialty will therefore be needed when entry to stroke training is being considered.

TRAINING PROGRAMME AND CURRICULUM

The subspecialty curriculum for stroke is designed to ensure that the core competencies necessary to function as a consultant with a special interest in stroke medicine are achieved. Thus, the subspecialty curriculum must be considered in conjunction with the curriculum of the trainee's parent specialty.

Trainees will need to show their competence in the knowledge, skills and attitudes that are expected of a modern stroke specialist physician in the three key areas of stroke prevention, acute stroke management and stroke rehabilitation. Training posts and programmes will require approval from the SSAC for stroke medicine, following the advice of the regional specialty adviser in the subspecialty.

At the end of the training programme trainees will be able to offer primary and secondary stroke prevention strategies, individualized according to a person's prognosis and need. This will include experience in the management of major stroke risk factors including hypertension, hyperlipidaemia and atrial fibrillation, and experience in the assessment of patients in neurovascular or transient ischaemic attack clinics for carotid endarterectomy and other procedures.

Trainees will have experience in assessing and managing patients with acute stroke, including interpretation

of radiological investigations, the assessment of patients for thrombolysis and the management of acute medical complications. They will also acquire knowledge and skills in the multidisciplinary rehabilitation of stroke patients using different techniques, and in the prevention and management of later complications of stroke including pain, spasticity, depression and poor nutrition.

During training specific attachments may be offered in coronary care, neurology, neuroradiology, psychology or palliative care according to training needs, and trainees will learn about the development and organization of integrated stroke services.

ASSESSMENT OF COMPETENCE

At present the core means of assessing competence is through the subspecialty training record, which identifies the competencies expected of the trainee, and is signed off by the educational supervisor. Some of the necessary competencies may already have been acquired through the parent training programme. Other forms of assessment, including 360° appraisal and direct observation of clinical examination and procedural skills, are currently being piloted by the Royal Colleges of Physicians, and these could complement the present training record.

Assessment of satisfactory training will take place, at an appropriate time, by an independent trainer nominated by the stroke medicine SSAC. Once that has been completed the trainee might have completed the full specialty and subspecialty programme, or might have to return to the parent specialty to complete training.

ADVANTAGES AND DIFFICULTIES

There is a clear need for properly trained consultants with a special interest in stroke medicine. Career prospects are excellent at present, and there is evidence that stroke patients should be managed together on specialty stroke units in order to provide appropriate specialist care, which also provides effective specialist training. However, there is a risk that, in those trusts where defined stroke training exists, experience with stroke patients for those outside the subspecialty will be significantly diluted. Managing patients with acute stroke is an essential part of general and acute medicine, and we will have to be careful to ensure that adequate experience is provided for non-stroke general and specialty medicine trainees at other points in their rotations.

There is also considerable enthusiasm among current trainees for experience in stroke medicine: an unpublished survey by the Stroke Medicine SSAC (2003) found that 75% of 198 trainees in geriatric medicine, 51% of 68 neurology trainees, and 87% of 31 trainees in rehabilitation medicine would be interested in undertaking an additional year of subspecialty training in stroke medicine.

Thirty new NTNs have been allocated for stroke medicine but there is, as yet, no new funding available. Thus it will be for individual trusts to use the funding from existing posts to support stroke training.

CONCLUSION

The emergence of a recognized subspecialty of stroke medicine will result in the development of physicians with the breadth of experience and understanding necessary to treat this complex and challenging condition. The training programme will serve as a basis for continued professional development throughout a career in the delivery of stroke care whether as clinician, academic researcher or manager. HM

Conflict of interest: none.

Department of Health (2001) Standard 5: Stroke. In: *National Service Framework for Older People.* Department of Health, London: 61–75

Rogers H, Dennis M, Cohen D, Rudd A (2003) British Association of Stroke Physicians: benchmarking survey of stroke services. *Age Ageing* **32:** 211–17

Royal College of Physicians (2000) *The Intercollegiate Working Party for Stroke. National Clinical Guidelines for Stroke.* Royal College of Physicians, London

Scottish Intercollegiate Guidelines Network (SIGN) (2002) *Management of Patients with Stroke.* Royal College of Physicians, Edinburgh

Stroke Unit Trialists' Collaboration (1998). Organised inpatient (stroke unit) care for stroke (Cochrane Review). In: *The Cochrane Library*. Issue 3, 1999. Update Software, Oxford

KEY POINTS

- Stroke is the third most common cause of death and the leading cause of disability in the UK.
- Specialty multidisciplinary care and rehabilitation significantly reduce mortality and morbidity.
- Properly trained physicians with a specialty interest in stroke medicine are key to the delivery of a modern stroke service.
- Stroke has recently been approved as a subspecialty by the Specialist Training Authority.
- There is a defined training curriculum, and potential training posts may be submitted to the stroke medicine subspecialty advisory committee for approval.
- No new funding has yet been made available, so trusts will need to convert existing posts to the new subspecialty.