EDITORIAL

From apoplexy to stroke: plus ça change...

Medical literature reviews usually encompass a few decades of knowledge. Indeed, our recently found fascination with systematic reviews and meta-analysis is constrained by the short history of the randomized trial. In this issue of Age and Ageing, Pound and her co-authors [1] have chosen a much more ambitious literature review format: to trace and describe changing concepts and practice of stroke care over more than two millennia. Their review contains much of interest for contemporary professionals involved in stroke care: terminology, theories of causation and treatment fashions.

Most of us would admit only to a vague appreciation of the contributions of our medical forefathers and quickly consider the acquisition of a more profound understanding a questionable exercise. Simplistically, it is of interest to note that the Hippocratic description of "... a Stagnation or Station of the Blood..." does not seem so far off the mark. Yet, Pound et al. argue that more general relevances can be found and that an improved understanding of the traditions of our medical past can have useful resonances for the present.

We are reminded that, whatever the prevailing medical theory, its application to the individual patient requires skills which go beyond the purely conceptual. The human dimension — the art or practice of medicine — is a thread which links together the passing traditions. Indeed, a previous careful analysis concluded that, contrary to our common intuition, the ancient Greek physicians "did not possess scientific training, scholarly attitudes or social standing" and argued that they were "above all, craftsmen" [2]. A nervousness with and within our contemporary health service has necessitated professional introspection to restate the values and purposes which underpin our work and craft [3].

The ancient physicians had communication problems with which we might sympathize today, for there was an obvious tension between the naturalistic explanation of disease in the Hippocratic corpus and popular traditional understandings centred upon supernaturalistic beliefs [2]. A challenge in stroke practice today is to bridge the patient information gap surrounding the technology of the acute medical ward, increasingly complex explanations of stroke causation, brain repair and disability recovery. (Is there a reliable method to explain post-stroke sensory neglect syndromes to patients and families?)

The literature of the eighteenth and nineteenth century physicians describes an honesty and frankness in their approach to communication. Pound and colleagues suggest that modern day communication difficulties may stem from our uncertainty over prognosis. Certainly, improving individual outcome prediction has been an area of research endeavour, with regression models, scoring systems and clinical classifications being proposed. All this work has been confounded by most stroke patients receiving some (and variable) treatment programmes. Unravelling the differences between spontaneous recovery and the contribution of physical treatments has so far defeated us and, in truth, we are often left tentatively awaiting the outcome of a 'trial' of rehabilitation — not an inspiring circumstance on which to base a doctor-patient relationship ('Am I going to walk again doctor?')

Perhaps the honesty and frankness which characterized earlier physicians is preferable to vagueness and vacillation. We would do well to remember the importance of information provision and disability education, which are easily overlooked or done badly (see [4]). They are highly valued by patients and may be effective in reducing disability [5].

Another interesting perspective highlighted by Pound et al. is the alternating focus of stroke variously as a 'person disorder' or as a 'pathology with changing medical paradigms. Where do we stand today? One notion expressed in contemporary literature is stroke as a disorder with profound implications for the whole family. Yet, although we proudly congratulate ourselves on our 'holistic' approach to stroke care, we all too easily slip into the narrow focus of the seventeenth century medical paradigm of mechanisms and reductionism. For example, the argument over the health contribution of routine head CT scanning in stroke, still hotly debated, appears less consequential when viewed from the vantage of a patient 1 year into his stroke disability career. And our fascination with the optimum preventative dose of aspirin, generously aired in contemporary literature, has rather limited quality-of-life impact for the patient.

We now quietly scorn at the long-lasting therapeutic dominance of blood-letting. It survived because it was 'known to work in practice' — a reminder that opinions, dogmatically held, are dangerous. But it is salutary to reflect upon current stroke opinion and practice. On what will medical historians of the future...
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pour scorn? Perhaps that we happily obliged our patients to be confined to chairs for nearly their whole waking day as part of their ‘active’ rehabilitation [6]. Or that we relied on generalized, blunderbuss physical treatments for groupings of impairments. (Will each impairment have a specific remedy in the future—e.g. attention training for unilateral neglect? [7])

The lesson of venesection is one of obdurate survival against changing theory and empirical evidence. Then, as now, clinical behaviour was hard to change. Dexamethasone to reduce cerebral infarct related oedema is still prescribed despite lack of evidence for effectiveness [8, 9]. Less specifically, stroke care in the UK remains sub-optimally delivered [10] and preventative treatments inadequately implemented [11]. Letting go of ineffective treatments and promoting effective ones is a constant duty for physicians which links our past, present and future.

"History is at bottom simply a form of story telling" [12]. The story told by Pound et al. uses an historical backdrop to place our contemporary stroke care in a more relevant context. Ideas, theories, practices and treatments have come and gone: we should not hold too tenaciously to the present.

JOHN YOUNG

Bradford Hospitals Trust,
St Luke’s Hospital,
Bradford,
BD5 0NA,
UK.
Fax: (+1274) 365260.

References