Adopt a disease; make this the year of stroke

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The specialty of Emergency Medicine has come a long way in 36 years. As our specialty has changed so have others. In the early years of the NHS, most hospital consultants were broadly ''general''. The general physician, surgeon, and pathologist were the backbone of senior doctors in district general hospitals. Sub and full specialisation gradually developed. A perusal of the contemporary list of specialties recognised by the General Medical Council and the Medicolegal Societies tells its own story.

As Emergency Medicine has prospered so its skill set and clinical territory has grown in tandem, although the growing pains have sometimes been painful. Skills traditionally owned by a specific group of doctors (or other healthcare professionals) are now shared or relinquished to varying degrees. Many of our founding fathers in Emergency Medicine had an interest in soft tissue injury, hand injury, and minor fractures. Nowadays we manage, independently or in true collaboration with others (not an exhaustive list), cardiac, trauma, and paediatric resuscitation, reperfusion in acute coronary syndrome, arrhythmias, the airway, procedural sedation, thromboembolic disease, pyelonephritis, community acquired pneumonia, head injury, poisoning, non invasive ventilation, and basic ultrasound scanning. These conditions and procedures are handled safely, skilfully, with ease, and with the support of our hospital colleagues, in departments across the nation.

The focus on reperfusion in acute coronary syndrome became a consistent activity when the government became interested; targets were set and audit data were collated into the Myocardial Infarction National Audit Project (MINAP). The success of the various Life Support Courses are initiatives that had central support—be it governmental or Collegial. Many other clinical initiatives have arisen from local individual or collective interest, without necessarily having central support.

Our new college has a responsibility to be involved, as coworkers or leaders, in national public health issues. Stroke is the third biggest cause of death in the UK and the largest single cause of severe disability. Each year more than 110,000 people in England will suffer from a stroke, which costs the NHS over £2.8 billion. The Department of Health included specific milestones in the National Service Framework (NSF) for Older People launched in 2001. The Government has announced an 18 month programme to produce a National Strategy to modernise care and treatment for stroke. By 2010 it wants to reduce the death rate from stroke and related diseases in people under 75 years by at least 40%.[1]

A National Stroke Strategy Conference in London on 1 March 2006 at the London Hilton Metropole looked at this project in detail. Our next clinical challenge as a specialty awaits us. We need leadership, a prominent profile, and a commitment from the College of Emergency Medicine to be involved. We need to help the Government and the Department of Health meet the targeted reduction in mortality and morbidity from this dreadful illness. The ''chain of survival'' is a dictum applied to improving outcomes after cardiac arrest, indicating the many teams who contribute to successful cardiac arrest treatment. It can equally be applied to the management of acute stroke. We have a role to play.

We are now in the Chinese Year of the Dog. Perhaps one of the next couple of years can be the College Year of (the) Stroke.

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