

### What is already known on this topic

Caesarean section, in the absence of clear clinical indication, is one of the most contentious issues in modern obstetrics, fuelling debates about the possible need for a randomised trial of delivery methods

Evidence about the extent to which obstetricians support women's requests for caesarean section is conflicting, and views on the need for a trial of planned caesarean section versus planned vaginal birth have not been reported

### What this study adds

A minority of consultant obstetricians and heads of midwifery would support a randomised trial of planned caesarean section compared with planned vaginal birth

### Comment

Our quantitative findings indicate that a minority of professionals would recruit to a trial comparing planned caesarean section with planned vaginal birth. However, the qualitative finding—that midwives who favoured a trial did so because of their confidence in the benefits of vaginal birth—adds complexity because it negates the necessary individual professional equipoise.<sup>4</sup> We explored the opinions of senior obstetricians and midwives simultaneously and nationally, and we identified views about a possible randomised trial. To gain unbiased views, we deliberately did not present participants with a protocol,

rather than give the impression that a trial was planned. We also believe that evidence about benefits and risks is insufficient to develop a protocol.

If caesarean birth were shown to be as safe as normal birth in a non-inferiority trial, the NHS would have to consider whether it would be willing to offer such a choice, given the huge resource implications.<sup>2</sup> If the cost makes offering choice to all women unfeasible then carrying out a trial would be unethical. The ethical, moral, and practical challenges to a trial are considerable and would require involvement of women and society at large.

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Contributors: TL, CK, GG, MG, and JPN designed the study. TL, CK, and AH analysed the data. TL, CK, and AH wrote the paper. TL, CK, AH, GG, MG, and JPN reviewed and amended drafts of the paper. All authors contributed critical comments to the paper. TL is the principal investigator of the survey and principal guarantor of the paper.

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## Ten year follow-up of a randomised controlled trial of care in a stroke rehabilitation unit

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Decreased mortality and reduced disability are well recognised short term benefits of care in a stroke unit.<sup>1</sup> Early organised management improves survival up to five years after stroke.<sup>2</sup> Only one study has examined the effects of care in a stroke unit for longer than five years,<sup>3</sup> and it showed that treatment in a combined acute and rehabilitation stroke unit in Norway conferred benefit even 10 years after stroke. We aimed to examine whether the benefits of a non-acute stroke rehabilitation unit persist for 10 years after stroke. This study was a continuation of the five year follow-up by Lincoln and colleagues.<sup>2</sup>

### Participants, methods, and results

We identified participants who had been randomly allocated to receive treatment in a non-acute stroke unit or on conventional wards (general medical wards or wards for the elderly) as part of an earlier trial.<sup>4</sup> Ten years after that randomisation, we traced them on hospital and

general practice databases. We asked survivors to consent to follow-up with a postal questionnaire. Participants needing help to complete the questionnaire were visited by researchers who were blind to original group allocation and to five year results for individuals.

We recorded place of residence. We used the Barthel index to measure independence in personal activities of daily living<sup>5</sup>: we classified participants as disabled (0-17) or independent (18-20). We obtained age, sex, and date of stroke from previous records. We compared survival for participants in the two groups (stroke unit and conventional ward) over 10 years using Kaplan-Meier survival curves.

In the original study, 176 participants were randomly allocated to receive treatment in a stroke unit and 139 to receive treatment on a conventional

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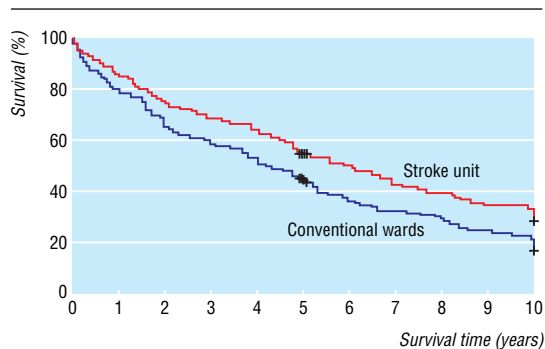
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Survival times of participants in a stroke unit and on conventional wards. Black crosses indicate censored individuals (those for whom no information was available after five year follow-up—see text)

ward.<sup>4</sup> Improvements in databases meant that more participants were identified at 10 years than at five years,<sup>2</sup> with only 15 participants untraced (stroke unit, eight; conventional wards, seven). Eight traced participants (four in each group) refused to give consent for follow-up but were included in the survival analysis.

At 10 years, 122 (69%) stroke unit participants and 111 (80%) participants who had been in conventional wards were known to have died; 31 stroke unit participants (67% of the 46 survivors) and nine conventional ward participants (43% of the 21 survivors) were known to be disabled (Barthel score < 18); and nine stroke unit participants (20% of survivors) and two conventional ward participants (10% of survivors) were known to be in institutional care.

Relative risks and confidence intervals were calculated by assuming worst case scenarios (that is, untraced participants all dead, non-consenting participants all disabled). At 10 years, the relative risks of death (0.87; 95% confidence interval 0.78 to 0.97), death or disability (0.99; 0.94 to 1.05), and death or institutional care (0.91; 0.83 to 1.00) all tended towards more favourable outcome for participants who had received care in a stroke unit. Survival was significantly greater in the stroke unit group (log rank test, 6.63,  $P = 0.01$ ) (figure).

## Comment

The relative risks of death, death or disability, and death or institutional care all tended towards more favourable outcome for stroke unit patients. Survival was significantly greater in the stroke unit group. Although this study was not designed to detect

## What is already known on this topic

Decreased mortality and reduced disability are short term benefits of care in a stroke unit

Only one previous study—in a combined acute and rehabilitation unit—has shown that care in a stroke unit conferred benefit 10 years after stroke

## What this study adds

Management in a stroke rehabilitation unit confers survival benefits 10 years after stroke

differences in long term survival, these findings are consistent with previous work showing that the long term benefits of stroke rehabilitation are maintained over a 10 year period.<sup>3</sup> The reasons for this are unclear, but one explanation is that long term survival is related to early reduction in disability.

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## A patient who changed my practice

### Speak clearly to the bogey man

When performing a cerebellar examination in multicultural Singapore some years ago, I asked the patient to touch the tip of his finger to my fingertip and then to touch his nose. In Hokkien, the latter instruction translated to "Touch your nostril," whereupon the patient touched my fingertip, then dug his finger into his left nostril, and finally touched my finger again. Too shocked to remonstrate (after all, he had complied with my instructions), I completed the examination, after which I surreptitiously went off to wash my hands.

Since then, I have always instructed my patients to touch the tips of their noses, after which they are to touch my fingertip. It was somewhat heartening to hear that a colleague (RCSS) has since learnt the same lesson, to his chagrin (and my amusement).

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