Management of major trauma

EDITOR,—With major trauma comprising 1 per 1000 emergency cases in Britain there is limited opportunity to develop expertise in the primary trauma management and treatment. Many of these patients arrive at hospital during unsocial hours when accident and emergency (A&E) departments are often staffed by inexperienced junior doctors. To provide an effective initial resuscitation there should be instant availability of experienced doctors from A&E, anaesthesia, general surgery, and orthopaedic surgery as required, and adequate radiology facilities including 24 hour computerised tomography. Unfortunately many district general hospitals are unable to provide an appropriate service from these specialties. The problem is compounded by the general apathy to trauma shown by many senior surgeons. While we would agree with Leaman that all hospitals involved in trauma care should submit data to MTOS, we would not expect the results to be encouraging. Recent analysis of data submitted both to MTOS and to the Scottish Trauma Audit Group showed mediocre results, with delays in treatment despite senior staff involvement in initial resuscitation.

It is obvious that Leaman is not a protagonist of aeromedical helicopter transport; however, in his local region 22% of patients were flown by helicopter and the time from initial treatment had decreased. This is important for regional trauma units where there have been improvements in interhospital transfers. We suggest this service should continue to be used for transfers involving significant distances, where severe traffic congestion on motorway networks may result in prolonged journeys by land ambulances and for those patients whose clinical condition benefits from this method of transport for example in severe spinal injuries. The Glasgow Clinical Shock Study Group provides the gold standard for interhospital transportation; however, as they point out, the development of an integrated transport system involving experienced doctors is unlikely to become a realistic option in Britain due to the financial implications involved between different hospital Trusts.

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Decision support for telephone advice

EDITOR,—We read with interest the paper by Stranges et al. Since we have been researching telephone advice in A&E and general practice and have developed approaches to standardising patient assessment and advice. This includes piloting a telephone consultation skills training package within a computer based decision support system. Our findings, based on an analysis of 340 calls to an A&E department, concur with those of Stranges et al. We found that 2% of patients attending A&E, 21% to attend their GP, and 31% given home care advice. We found similar support from the nursing staff using the system. We also found that 53% of patients were not aware that the nurse was using a computer, and the majority (75%) believed it to be a good idea to use computers to provide clinical
decision support. These results provide further evidence of both professional and public support for this approach.

As Srinivas et al point out, the weakness in telephone consultation lies in the area of history taking. It is in this area of patient assessment where decision support is of greatest value. For the record of the consultation to be of most use, particularly if litigation were to arise, it would seem highly desirable to have a complete record of the questions asked and the responses given. Provisional analysis of research that we are undertaking using simulation of calls has identified that nursing staff form a hypothesis as to the nature of the patient’s problem early in the consultation. This is then followed by a process of backward reasoning, gathering evidence to support the hypothesis rather than forward reasoning from symptoms to hypothesis. The approach to the assessment is related to the complexity of the task—the more complex the assessment, the less systematic the approach.1 If decision support in telephone consultation is to be of value it should delay the hypothesis generation and promote forward reasoning; it should also be designed to help the user to structure more complex consultations. Decision support systems need to be developed to enable this, while being sufficiently user friendly to be acceptable to staff.

Correction
An uncorrected scanning error occurred in the title of the abstract “Prehospital diazepam: an audit of use” in the last issue (volume 14, page 126), where “adult” was printed instead of “audit”. Also the name of one of the authors (H Cosgrove) was omitted. The authors have informed us of an error in their analyses, which means that the data presented are incorrect, though the conclusions are unaltered. We understand that they will be submitting a definitive paper on this subject to the journal. This will be peer reviewed in the usual way.

Trauma Care (UK) 1st Biennial Conference
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This conference and future conferences will promote integration of trauma care by establishing “Total Trauma Care”. The conference will provide access to relevant advances and current thinking in all aspects of trauma. Trauma care professionals are all aware of the advances being made in their respective areas of involvement with the trauma victim and the conference will recognise those parts of the chain of care which, often repeatedly, break down. The conference will allow both local and national professional groups to work together on an equal basis, through a common doctrine, to a single goal. Professionals attending the conference can then understand the whole chain of care concept, with a view to reducing morbidity and mortality associated with trauma.

Details available from Total Trauma Care, c/o Conference Secretariat, Index Communications Meeting Services, Crown House, 28 Winchester Road, Romsey, Hampshire SO51 8AA. Tel: 01794 511331/511332; fax: 01794 511455.

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Decision support for telephone advice.

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