To continue to move forward action is probably needed at a number of levels. A resurgence of government interest in reducing injury morbidity would provide valuable leadership and help in delivering resources to tackle the research agenda. Although injury prevention initiatives should always be pursued it is probable that the consequences of road traffic crashes will provide challenges for emergency physicians in the foreseeable future. While we try and move forward it is also important that we do not slip back; maintaining the current level of consultant involvement in major trauma and ATLS training is crucial. We must continue to invest in our future and in the next five years. Large trauma registries may be able to provide some evidence based. However, this is a difficult area. There are complex ethical issues surrounding the recruitment of patients who are not fully conscious into randomised controlled trials. Trials inevitably have to be large and multicentre as although major trauma remains the commonest cause of death in young people it is still a sporadic disease in individual emergency departments. Multicentre trials require significant investment and as emergency physicians rarely own the whole of a major trauma patient for longer than a few hours, efforts to collaborate with orthopaedic and neurosurgical colleagues (who will be responsible for the ongoing care of most of these patients) are also necessary. It is therefore difficult for emergency physicians to initiate trials to answer questions such as the time frame within which it is acceptable to deliver operative intervention for specific injuries. This makes it unlikely that many large multicentre trials will deliver the answer to therapeutic dilemmas within the next five years. Large trauma registries may be able to provide some comparatively high quality observational evidence, however, most rely on mortality rather than disability outcomes. The mortality for major trauma patients reaching hospital alive is low, between 5% and 10% in most registries on both sides of the Atlantic, 6 perhaps a reflection of improvements in care before the mid-1990s). Therefore the ability of trauma registries to determine the efficacy of single therapeutic interventions is limited by considerations of power. The data presented in this journal do show however that although nationally outcome is static, there is a large degree of variation in outcome between different hospitals suggesting that some deliver better trauma care than others. For the reasons discussed it is less than clear what the key features in improving outcomes are.

REFERENCES


4 Cochrane Injuries Group Albumin Reviewers. Human albumin administration in
Trauma care in England and Wales: Is this as good as it gets?

F E Lecky

doi: 10.1136/emj.19.6.488

Updated information and services can be found at:
http://emj.bmj.com/content/19/6/488.1

These include:

References
This article cites 14 articles, 6 of which you can access for free at:
http://emj.bmj.com/content/19/6/488.1#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Topic Collections
Articles on similar topics can be found in the following collections

- Ethics (396)
- Resuscitation (606)
- Spinal cord (24)
- Spinal cord injury (19)
- Trauma (1047)
- Trauma CNS / PNS (298)

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/