compared with the percentage that thought that white coats did.

In Table 2, in the white coats week, 61% of respondents were happy with doctors wearing white coats, in the ordinary clothes week, 21% were happy with ordinary clothes, but 22% would have preferred white coats. In the theatre greens week, 20% were happy with theatre greens, but 18% would have preferred white coats. Looked at in another way, excluding those that do not mind, only 2% were unhappy with white coats during the theatre greens week, whereas 23% were unhappy with ordinary clothes and 19% were unhappy theatre greens. In this way there appears to be quite a striking preference expressed for white coats.

The authors justification for concluding that there were no preferences for any particular style is presumably because in each of the ordinary clothes and theatre greens weeks, there were roughly the same percentage of respondents who were happy with that style as would have preferred white coats. This was taken as evidence in favour of their conclusion, despite the weight of other evidence against it. The explanation for this particular finding is probably that many people will accept what is in front of them and be reluctant to criticize.

The findings from Table 1 that I mentioned above, and those from the visual analogue scale all showed trends towards a preference for white coats. To ignore these trends on the basis that they do not achieve statistical significance and to conclude therefore that the study shows that patients 'do not mind what is worn' is not a proper use of the statistical term 'significant'. It is likely that the preferences expressed were generally modified by some reluctance to criticize, in any case.

More generally I would make the criticism that no data were given on the proportions of patients and relatives who failed to complete the questionnaires each week, in order to consider 'non response bias'. No explanation was given either as to why there were twice as many questionnaires completed in the second week compared with the first.

I do not think that the conclusions made in this article can be drawn from the data given, and that the conclusion that patients preferred doctors to wear white coats is more likely to be valid.

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Trauma team concepts in the UK: tailoring resources to meet demand

In his audit of trauma teams in Trent,¹ Dr Highley raises a number of important issues which merit comment, especially as our Unit was presumably one of those audited.

Interestingly, he fails to define what constitutes an ideal team or who should lead it. Essentials of good trauma management include: appropriate triage by the emergency medical services (EMS), advanced warning to the receiving department, a team of dedicated medical and nursing staff involved in specific delegated tasks,² a common language of trauma management (ATLS), and clear logical documentation. Immediate accessibility of experienced personnel to provide definitive care, the regular audit of the workings of the trauma team (video review and debrief), and on-going audit of outcome (ideally by involvement in MTOS) are also essential.

We would agree with Dr Highley that a parallel approach to trauma management is necessary in the seriously injured patient as shown in Driscoll's work.² However experience in our unit (as assessed by video audit review) and in others is that the supposed *en masse* effect of surgical and orthopaedic clinicians (often junior because seniors are busy in theatre) tends to produce a less than favourable outcome. As mentioned, the proportion of juniors in the UK who are ATLS providers is at present low. We would disagree with Dr Highley that having a number of consultant anaesthetists trained in ATLS in a particular hospital is a good indicator of standards of trauma management amongst junior surgeons and anaesthetists.

At the Leicester Royal Infirmary, the trauma team consists of a team leader [Registrar/Senior Registrar in accident and emergency (A&E)], two A&E senior house officers (SHOs) and an intensive therapy unit (ITU) registrar, on a 24-h basis, all of whom have specific allocated tasks. All A&E SHOs are taught trauma management along ATLS principles (including moulages) during their 2-week induction course. Nursing staff in the A&E department have a similar team approach with clearly defined roles. Patients suffering potential serious injury are all managed

along standard guidelines. Triage and pre-warning is carried out by the ambulance service allowing the team to prepare. Recognition and treatment of life threatening injury is carried out rapidly, with early involvement of other appropriate personnel (registrars/senior registrars in General Surgery and Orthopaedics) for definitive care. Audit and review of trauma videos allows the medical and nursing teams to develop their organisational skills, as well as graphically highlighting inappropriate delays to definitive care.

So, although we do not seem to meet Dr Highley's 'standards', the necessary components for dealing with such emergencies are certainly in place and work well for the Leicester Royal Infirmary. However, whereas at our institution over 1000 patients are admitted annually following trauma (80–90 of whom will have injury severity scores >15) and such organizational structures are required, other smaller units may not have the same needs or resources to develop along such lines.

Rather than concentrate solely on the number or type of speciality present in a trauma team, we would suggest that much more attention should be given to developing a response appropriate to the needs of the institution based on the available expertise in acute trauma resuscitation. The methods of auditing the work of the team and actual accessibility of experienced personnel to provide early definitive care is also vitally important.

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Announcement

The IV Congress on Burns and Fire Disasters and Symposium on Plastic Surgery will be held on 18–20 September 1995 in Košice, Slovakia.

An internationally recognized group of burn injury and disaster medicine experts will be present to deliver lectures on a variety of current topics including burn shock – sepsis, fire disasters, skin banking and reconstructions in plastic surgery.

Chairman: J. Babík. Guests include: S. Gunn (USA), M. Masselis (Italy), R. Hermans (Holland) and A. Munster (USA).