LETTERS TO THE EDITOR

Identity crisis

EDITOR,—What do we call ourselves? Before we add our voices to the growing debate,¹ we would like to point out that any name change will need to add additional costs, changes to stationery, telephone directories, computers, and signs as well as salaries for those who will execute the modifications. And neither the NHS nor the various faculties and organisations concerned are financially unconstrained. We will also have to provide patient education, especially to the elderly. All potential patients will need to understand, for example, that they should still attend the newly designated emergency department with a laceration. Although it is an accident, they might not be sure it qualifies as an emergency.

We can eliminate the terms "casualty" and "accident", as these are only some of the emergencies we deal with. Since we are all trained to deal with emergencies and we are all qualified physicians, we should be known as "emergency physicians": a physician is "one who practises the healing art including medicine and surgery"² and we work in the "emergency department".

What we do . . . Now, there is a problem. Is it "emergency medicine"? Medicine is defined as the art of restoring and preserving health . . . as opposed to surgery and obstetrics.² We have just as much to do for patients with medical problems as we do for those with surgical, obstetric, psychiatric, and other non-medical conditions. We need a term to encompass all specialties. Although "medicine" as a term can be used as a collective noun for all its branches including that of medicine itself, it will still lead to confusion and even dissatisfaction. We can say we practise "emergency health care".

Organisations, such as colleges and faculties will be those of "emergency physicians", for example the "Faculty of Emergency Physicians" and later the "Royal College of Emergency Physicians".

Now we have all the labels.

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1 Rocke LG. Accident and emergency medicine or emergency medicine? *J Accid Emerg Med* 1999;16:74.

2 Concise Oxford dictionary. 7th Ed. Oxford: Clarendon/Oxford University Press, 1982.

Accident and emergency medicine—the next 25 years

EDITOR,—I greatly enjoyed reading Mr Binchy's intelligent and thought provoking "personal view".¹ He describes six very credible causes for increasing accident and emergency workloads but omits one important factor which, simply put, is social failure.

Various researchers have endeavoured to explain the steady rise in hospital admissions, but it is clear that no single factor is solely responsible. In 1996 Stephen Kendrick published a detailed study of the trends in hospital admission in Scotland between 1981 and 1994.² Contrary to many expectations he was unable to attribute the steady rise to an aging population, increased readmission rates, or increased morbidity. Instead it was apparent that emergency admission to hospital occurred when the family, social services, and general practitioner were no longer able to help. This means that marginal changes within informal, community, or primary care will have a disproportionate effect on the demand for emergency admission.

Most doctors working in acute medicine are well aware of the effect that increasing social fragmentation is having upon admissions. As informal care networks deteriorate and the expectations of relatives change we find ourselves admitting more and more patients who would previously have been cared for at home. At the other end of the spectrum, discharges are delayed by problems in establishing effective social care, and within my own city at least one hospital trust is paying for temporary nursing home provision while further discharge arrangements are being put in place.

Unfortunately, identifying this problem is rather easier than solving it. "Hospital at home" schemes have shown some promise,³ but there is doubt as to their overall cost effectiveness.⁴ Certainly they would need to be very widely adopted to have any real impact on our daily working lives.

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1 Binchy J. Accident and emergency medicine—the next 25 years. *J Accid Emerg Med* 1999;16:48–54.

2 Kendrick S. The pattern of increase in emergency hospital admissions in Scotland. *Health Bull (Edinb)* 1996;54:169–83.

3 Shepperd S, Harwood D, Jenkinson C, et al. Randomised controlled trial comparing hospital at home care with inpatient hospital care. I: three month follow-up of health outcomes. *BMJ* 1998;316:1786–91.

4 Shepperd S, Harwood D, Gray A, et al. Randomised controlled trial comparing hospital at home care with inpatient hospital care. II: cost minimisation analysis. *BMJ* 1998;316:1791–6.

The PEP transducer

EDITOR,—Dodds *et al* illustrate a way of measuring the respiratory rate by means of a simple mask mounted transducer.¹ The importance of respiratory rate monitoring has been emphasised by the authors and the need for a disposable mask mounted sensor is clear. We surveyed 300 consultants in respiratory and accident and emergency medicine throughout the UK and found a 85% interest in such a device. On the issue of cost, 60% would purchase the device if less than 50 pence, with half of these willing to pay less than 20 pence. The clear message is that the sensor needs to be very cheap!

We have developed a sensor (the "respirometer") that has all the qualities of the pyroelectric polymer (PEP) sensor except self exciting, but with the advantage of being visual to the eye, with a digital sensor option. The visual nature of the device will help respiratory rate

recording in the pre-hospital setting in fully clothed patients. Our sensor has the important property of being able to differentiate between a cough and a breath by measuring inspiratory effort and we suspect the PEP sensor is unable to do this.

The sensor has been validated in the respiratory laboratory using volunteers, a variety of masks, oxygen flow rates, and breathing patterns and produced excellent correlation with capnography and plethysmography (accurate to within two breaths in 97%). A clinical study of 40 patients with a variety of masks and oxygen flow rates found an accuracy of 98% again within two breaths.

With a sensor for less than 20 pence and an accuracy of 98% we have developed a very useful tool for pre-hospital care assessment of respiration that can be incorporated into the continuing resuscitative care in the hospital setting.

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1 Dodds D, Purdy J, Moulton C. The PEP transducer: a new way of measuring respiratory rate in the non-intubated patient. *J Accid Emerg Med* 1999;16:26–8.

Protocols for deep vein thrombosis

EDITOR,—O'Shaughnessy *et al* rightly draw attention to the benefit of an outpatient based protocol for deep vein thrombosis (DVT) in terms of both economy and patient satisfaction.¹ However the original work on which light reflection rheography (LRR) is based demonstrated a false negative rate of 3% to 8%.² Between 22 and 59 patients in this study are therefore likely to have been inappropriately discharged. While no patient represented, the study would have been more robust had follow up (six months with no ill effects) been complete.

In addition the protocol does not consider any evaluation of pre-test probability for which a validated prediction guide now exists.³ For patients with high or moderate pre-test probability and a negative LRR (or duplex ultrasound) further testing is recommended. The SimpliRed D-dimer assay has a negative predictive value of 97%, may be performed at the bedside, and is a worthwhile adjunct in selected patients in this setting.

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1 O'Shaughnessy DF, Tovey C, Miller AL, et al. Out-patient management of deep vein thrombosis. *J Accid Emerg Med* 1998;15:292–3.

2 Thomas PRS, Butler CM, Bowman J, et al. Light reflection rheography: an effective non-invasive technique for screening patients with suspected deep venous thrombosis. *Br J Surg* 1991;78:207–9.

3 Anand SS, Wells PS, Hunt D, et al. Does this patient have deep vein thrombosis? *JAMA* 1998;279:1094–9.

The authors reply

We thank Dr Lloyd for his interest in our paper on the outpatient treatment of DVT. As he points out there is a small false negative rate for LRR. However in the original paper published in 1991 and a subsequent unpublished study we found that these patients only had very minor calf thromboses unlikely to lead to significant pulmonary embolus. Indeed in some of these cases there was dispute