LETTERS TO THE EDITOR

Deaths from injury

Sir

Reacting to the article of Anderson *et al.* (*British Medical Journal* (7th May 1988) pp. 1305 and subsequent RCS report), the following 10 points warrant urgent consideration:

- (1) The teaching of the management of trauma to all staff who work in accident and emergency. The standard for this should be the Advanced Trauma Life Support Instructors Programme, to be held at the Royal College of Surgeons in November 1988.
- (2) Reviewing middle and senior accident and emergency staff cover, the prime role of which is the resuscitation of the seriously ill and injured. This emphasizes the need for 24-h middle grade accident and emergency staff cover. Senior House Officers should not work unsupervised. Accident and emergency consultants must work on their shop floors.
- (3) Ensuring there is on the premises 24-h post-FRCS registrar cover. When such staff are on take they should undertake no routine surgery, thereby making themselves available. Consultant surgeons must be involved in the early management of trauma.
- (4) Liaising closely with anaesthetists so that the question of ventilation is considered from the outset.
- (5) Ensuring the life-saving measures of cannulation of major veins, Oricothyroidotomy, and left thoracotomy can be carried out in the accident department by middle and senior grade accident and emergency staff, as well as by duty surgical staff.
- (6) Auditing the management of major trauma using the TRISS methodology of plotting the Revised Trauma Score—a physiological score—against the Injury Severity Score—an anatomical score.
- (7) Addressing the relationship of neurosurgical centres to district general hospitals.
- (8) Questioning whether any suburban accident department seeing less than 50,000 new patients a year should receive major trauma.
- (9) Rotating 'on take' responsibilities between accident departments. In London, for each of the four Thames regions, only one department could be on call for trauma by rotation at night.
- (10) Questioning whether there is sufficient emphasis on trauma in the teaching and examination of trainee surgeons and anaesthetists.

The fact that we suffer less trauma than the USA means we must address our efforts more aggressively to the training, the standardization of procedures, and the on-going supervision of resuscitation and surgery of trauma patients.

There is no catalyst of private practice here to fuel enthusiasm. We must not pretend the problem does not exist—for it does: witness this paper.

Whither the trauma centre? Let the debate range.

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