EDITORIAL

April of this year saw the AGM of the Casualty Surgeons Association of the UK. It was held at the Royal College of Surgeons of Edinburgh and is the first time this meeting has been held in the City. The Royal College of Surgeons of Edinburgh is a most appropriate place for such a meeting to take place. Together with the Royal College of Physicians of Edinburgh it has established a Part II Fellowship in Accident and Emergency Medicine and Surgery. This has been an important step in the development of the specialty in this country. It will enable doctors to consider accident and emergency medicine as a specialty at a much earlier stage in their career and provide a framework for training. All of us in the specialty owe these Colleges our thanks. It is important that as the work of accident and emergency departments evolves the problem of how they are to be staffed is resolved. It is unacceptable that when you are most ill you are most likely to be treated by the least experienced working without direct supervision. It is essential that emergency care is given by experts and not learners. If it is important to have consultant cover during weekdays then why is it not equally important out of hours? It may even be more important during these times. One solution already in practice in the USA is to have several consultants in the same department. They elect a chairman to undertake the administrative duties and the remaining consultants work in rotation with adequate time off. This ensures a 24-h consultant presence. Shift work for specialists in emergency medicine is not without problems but they can be overcome (Michaels, 1984).

Mr Tom Hamilton, the President of the Australasian College for Emergency Medicine, was present throughout the week and although the Australasian specialty is younger than the British specialty it seems to be already on a firm footing. Mr Hamilton delivered a lecture on the Developments in Emergency Medicine in Australasia and this will appear in a future issue. The President of the Canadian College of Emergency Medicine, Dr P. L. Lane, delivered a paper on the Care of Trauma and supported the development of trauma centres. In urban areas you may be at more risk from inadequate in-hospital care than you are from inadequate out-of-hospital care if the hospital you are in is not a trauma centre (Trunkey, 1983). The benefits of on-site resuscitation must always be weighed against the dangers of delay in transfer to hospital. However, when the patient is trapped and this may be by limb, by traffic or by time, then resuscitation can be commenced at the scene. The British Association of Immediate Care Schemes (BASICS) is primarily a doctor-based organization committed to the providing of skilled medical aid at the scene of an accident. Everyone feels that immediate care must be beneficial but proving it by controlled trial is extremely difficult. BASICS is about to undertake such a task by comparing morbidity and mortality between those treated at the scene by BASICS doctors and those receiving standard ambulance care alone in the same geographical area. As part of this project they will assess the effects of inherent delay induced by physical entrapment, traffic congestion and sheer distance from the hospital. It may be that each accident and emergency department should identify zones around the hospital where patients will always be trapped by time and where they may be trapped by traffic.

There is an extensive literature on the Sudden Infant Death Syndrome but little of it is concerned with the parent (Kelly & Shannon, 1982). In March this year the Foundation for the Study of Infant Deaths held its AGM for parents in Manchester. These parents who had suffered the death of a small infant were there to learn from each other and question the experts in an attempt to gain greater insight into the condition. The sudden death of a previously healthy child is an intolerable burden for the parents and an extremely difficult one for the accident and emergency department. The parents at the meeting recorded their suggestions for improving the management of this condition and I will outline the suggestions they made for the staff of the accident and emergency department.

Many departments did not issue the fact-sheet which is readily available from the Foundation and which they feel would have been most valuable at the time. There is understandable reluctance on the part of the staff to interfere but people in distress need contact and are not embarrassed by attempts which are made to help them.

The doctors involved were young and inexperienced and often appeared unable to cope. It is not only the technical skills of sophisticated medicine that would improve were senior doctors always present in a department. The human skills gained with age and experience would also be more readily available. The fact that medical and nursing staff were ill-equipped to deal with this condition was clear to many parents and they made a plea for it to be included in their training.

All the parents wished to hold their dead baby and so begin the grieving process. They complained bitterly about the lack of opportunity to do this and the lack of privacy.

If any attempts at resuscitation were made the parents wanted to know what the outlook was and to be repeatedly informed of any developments.

Many parents complained that there were no arrangements made for the baptism of the baby.

When the parents have left the department it is important that the paediatrician, GP and community health staff are notified of the baby's death. If this is not done then extremely painful situations may arise. Many parents received visits from the GP to see their young baby which was by then dead but he had not been informed. Similarly health visitors came to check why the baby had not been vaccinated and so on.

Finally, some parents having surrendered their dead baby to the mortuary were left stranded without any means of getting home.

Reproduced opposite are the guidelines as issued by the Foundation for the Study of Infant Deaths. If you wish to have copies of these or any further information then you can contact the Foundation.

REFERENCES

- Kelly D. H. & Shannon D. C. (1982) Sudden infant death syndrome and near sudden infant death syndrome: a review of the literature 1964–1982. *Pediatric Clinics of North America* 29, 5, 1241–51.
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 Trunkey D. D. (1983) Trauma. *Scientific American* 249, 20–7.

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 Editor