EDITORIAL

The second scientific meeting of the Emergency Medicine Research Society was held at York in June. A major session was devoted solely to the place, if any, of steroids in the treatment of the critically ill. These and other papers from the meeting will be included in a future issue of the Journal. It was a very successful meeting and not only the scientific aspects of emergency medicine were discussed. As at the meeting of the Casualty Surgeons Association in Edinburgh it is clear that specialists in emergency medicine are aware of their wider responsibilities and are no longer solely concerned with trauma. Accident and emergency departments are in fact responsible for a lot of primary care in certain communities. When treating trauma there are usually well-defined referral paths to follow. However, the solutions to many other problems are not so clearly routed. The patient is not aware of the need for illness/need to be categorized in this way and will present to a caring agency expecting expert help. A good example of this is alcohol and its related problems. It has been shown that many attendances at an accident and emergency department are related to alcohol intoxication (Holt *et al.*, 1980). A DHSS research group is now looking into this in more detail and some aspects of this were discussed at York. It may be that an accident and emergency department is a good place to identify the hidden problem drinker. Treatment is the province of other specialities but detection at an early stage may be critical when the outlook for treatment of severe drinking problems is so poor. Some departments are already involved in this work and have shown that screening for alcohol abuse must start in childhood (Robson, 1984). This preventive aspect of emergency work may not be confined to alcoholism. Many of the 10 million patients who pass through accident and emergency departments each year must have hypertension. They probably sit next to a sphygmomanometer and are examined and treated by several people with the skills to use it. However, most people will probably not have their blood pressure taken, unless, of course, they have presented as a consequence of their hypertension.

Many of the social problems that present to an accident and emergency department occur in the elderly. In this issue there are two papers discussing problems of the elderly and the accident and emergency department. The paper by Currie *et al.* was first presented at the CSA meeting in Edinburgh. Social problems, and indeed many others, can often be more effectively dealt with by the appropriate use of a short-stay ward (Dallos & Mouzas, 1981). A general anaesthetic late in the evening for an elderly patient living alone may convert a simple Colles's fracture into a major medical problem. However, full-scale and expensive hospital admission can often be avoided if observation beds in an accident and emergency department are used. Patients with uncomplicated head injury or self-poisoning can be monitored overnight and reviewed the next day. It is imperative that such wards are adequately staffed, for if continuous observation by trained staff cannot be provided then the patient will be safer at home with caring relatives. Some departments improve the efficiency of their wards even more by conducting daily ward rounds involving a social worker and psychiatrist.

The DHSS has tentatively approved extended training for ambulance staff (DA (84)

12). It now accepts that 'extended training in certain resuscitative techniques is likely to be beneficial to patients'. It is up to each Health Authority to decide how to implement such training, if at all. The thrust behind this change of heart by the ministry is a discussion paper from York University (Wright, 1984). The study, commissioned by the DHSS, recognizes endotracheal intubation, defibrillation and infusion as the fundamental elements of extended training. The financial cost of acquiring these skills based on current pay scales and prices was calculated by examining in detail six schemes in the UK. It is clear from the report that most schemes place a great deal of emphasis on intubation and infusion. One scheme thought infusion was in fact more important than any other skill. Yet it was correctly pointed out that inherent in the application of resuscitative skills in the field is the danger of delay. Definitive treatment for major haemorrhage must begin within about 30 minutes if outcome is not to be adversely affected. Infusion will not prevent death if surgery is postponed. In many urban areas definitive surgery is less than 30 minutes away and infusion is therefore of limited value. However, defibrillation must be given less than 10 minutes after the cardiac arrest if there is to be any real chance of survival. Even in urban areas there are few occasions when the time from cardiac arrest to arrival in the accident and emergency department is less than 10 minutes. If the patient is to have any chance of survival then defibrillation must be carried out at the scene. To achieve this within 10 minutes means that all ambulances must carry defibrillators. Defibrillation is the most important skill and must take precedence over intubation and infusion.

The DHSS has recommended that extended training schemes collaborate closely with medical Immediate Care schemes. The British Association for Immediate Care (BASICS) held its annual general meeting in Bristol in July. This organization, which started as a means of delivering expert medical help to victims of road traffic accidents, is widening its horizons. BASICS doctors are looking into the on-site treatment of medical emergencies and cardiac arrest in particular. The provision of skilled medical aid at the scene of an acute emergency involves expert training and the acquisition of difficult skills. In order to supervise and standardize this training and facilitate the acquisition of these skills, BASICS, in conjunction with the Royal College of Surgeons of Edinburgh, is about to institute a diploma in immediate care. This will be for general practitioners who are part of immediate care schemes or work in accident and emergency departments on a sessional basis and for any other medical personnel who are involved in the immediate treatment of emergencies. It will not embrace the wider aspects of the accident and emergency fellowship but is aimed solely at immediate care. It is not a qualification for those who wish to become consultants in accident and emergency medicine, but is another welcome development in emergency care which can only improve standards. The time may not be very far away when the most seriously ill are no longer treated by the least experienced.

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