

withholding food and drink for six hours is a small price to pay for an increased safety margin.

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- 1 O'Sullivan I, Brooks S, Maryosh J. Is fasting necessary before prilocaine Bier's block? *J Accid Emerg Med* 1996;13:105-7.

The authors reply:

Thank you for the opportunity to respond to the letters from Nandwani *et al* and Stokes and Foster produced in response to our article "Is fasting necessary before prilocaine Bier's block". We believe prilocaine Bier's block to be safe when conducted by experienced operators with appropriate monitoring. The data we collected supported this view. We are aware of the theoretical benefit for the practice of fasting to reduce the risk of airway contamination in the event of fits or faints but our data did not show this to be a significant risk. The reported episodes of equipment failure still without toxicity to the patient provides further support for the safety of the procedure and therefore the redundancy of a fasting period.

We do not support or condone the use of lignocaine, which has a higher toxicity, nor the use of additional sedation, which we agree increases the risk of aspiration and should not be necessary with a properly conducted Bier's block.

Far from "a minor inconvenience", an extended wait for a fasting period causes the patient considerable discomfort and personal inconvenience. Since this is of no proven value, is not officially recommended by the College of Anaesthetists, and is already not practised in many departments without adverse effects, it could be seen at best as an outdated practice and at worst as uncaring defensive medicine.

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GPs in A&E

EDITOR,—Recent research^{1,2} has suggested that general practitioners in A&E departments are cost-effective because they use fewer investigations than senior house officers when treating primary care patients. In a six month retrospective review of our computerised records we looked at the number of *x* rays ordered per doctor in our A&E department. There was no significant difference between the number of *x* rays ordered by the SHOs (6765/17 708 = 38%) compared with GPs (720/1963 = 37%) by χ^2 testing, $P = 0.2$. (SHOs and GPs see the same spectrum of patients in our department.) The greatest number of *x* rays was ordered by a general practitioner (175/407 = 43%) and the least by an SHO (862/2768 = 31%), $P < 0.001$.

While these findings do not measure cost-effectiveness or quality, they are a surprise given the recent research.^{1,2} It is possible that the GP/SHO comparison which favours GPs may not be reproducible in all units. Our findings suggest it would be prudent to audit any substitution of SHOs by GPs to confirm that it is appropriate.

RUTH SPEDDING
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- 1 Dale J, Lang H, Roberts JA, Green J, Glucksman E. Cost effectiveness of treating primary care patients in accident and emergency; a comparison between general practitioners, senior house officers and registrars. *BMJ* 1996;312:1240-4.
- 2 Murphy AW, Bury G, Plunkett P, Gibney D, Smith M, Mullan E, Johnson Z. Randomized controlled trial of general practitioners versus usual medical care in an urban Accident and Emergency department; process outcome and comparative cost. *BMJ* 1996;312:1135-42.

Paramedic care: the case for minimum intervention

EDITOR,—I believe that when it comes to the management of victims of major trauma, we as paramedics may have lost sight of our true role.

Unless there are specific indications to the contrary, our first choice of action should be to "scoop and run" and not to "stay and play". We should not forget that our basic principle is to deliver patients to hospital in no worse a condition than that in which they were found at the scene.

Nancy Caroline, one of the founders of the paramedic services in the USA, stated "a critically injured patient CANNOT be stabilised in the field". This is as true today as it was before the advent of paramedics, yet we seem to have developed a deep seated belief that we must not move our patients until we have performed at least one of the extended skills that we have been taught. I suggest that the time has come for us to reappraise our role. It is not our job to make critically injured patients "better". That is for hospitals to do. Early intervention may well prevent death, but unless it is both appropriate and adequate, the delay so caused is more likely to increase mortality.

There are of course clear instances where paramedic interventions are appropriate: prolonged entrapment; long distances to hospital; any situation in which the patient is likely to die before reaching definitive care.

Nancy Caroline defined the following "critical interventions":

- Airway management
- External haemorrhage control
- Sealing of open wounds to (a) the neck, (b) the chest
- Temporary stabilisation of flail chest

Let us not forget about immediate and continuing cervical spine immobilisation from the moment of the patient contact, and, when needed, assistance to inadequate ventilation.

If we remember that everything that we do takes time, it makes sense that intubation should only be necessary if basic airway management is ineffective. A drip can be set up on the move. Our first choice for cannulation is always the best available vein and it is therefore clear that second or third attempts can only be second or third best. We should ask ourselves "is it in the patient's best interest that I waste precious time hunting for a vein when I could (and should) be heading towards the hospital?" It is irrefutable that internal bleeding from a major vessel may be much more rapid than can be replaced through two peripheral cannulae, even if they are both working perfectly, and any delay at scene in order to gain double venous access may well be to the patient's detriment.

I can almost hear the outcry from my rural colleagues and I freely concede that distance may be a relative contraindication to a "scoop and run" policy, but a patient with severe injuries is already disadvantaged by long journey times and so there is more reason to reduce the time on scene and minimise prehospital

time. There is also a case for selecting, when available, the most appropriate hospital, that is, a trauma centre.

I also believe that "consultant phobia" may be partly to blame. This refers to the fear of criticism by the receiving A&E consultant if a patient is delivered to hospital without every possible paratechnical intervention having been taken. This fear is totally unfounded. A&E consultants' only real concern is that they see an increasing tendency to delay at the scene with struggles to cannulate etc, when there is clearly no hope of "stabilising" the patient without major surgical intervention, which is impossible outside the theatre environment.

In summary, it is my firm belief that we are, on the whole, doing a good job, but when it comes to serious trauma, particularly penetrating trauma of the torso, the best treatment that we have to offer is a heavy right foot on the accelerator pedal and that this should be our treatment of choice, not of last resort.

Let us show that we have the maturity NOT to undertake procedures simply because we have the skills, and to ensure that we act in the patient's best interests at all times.

I am a serving Leading Ambulance Paramedic with 25 years in the ambulance service, most of the time on emergency work. I have been a paramedic for seven years and last year attained advanced life support provider. These are my own thoughts and have nothing to do with my employers, Mersey Regional Ambulance Service NHS Trust.

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VIDEO REVIEW

Advanced Life Support video. *British Heart Foundation, 14 Fitzhardinge Street, London W1H 4DH. A Two Four Production, 1995. (Running time 20 min; £10.)*

This British Heart Foundation video has a running time of some 20 minutes and provides up to date information for all medical, nursing, and paramedical professionals involved in learning or teaching Advanced Life Support techniques according to the current European Resuscitation Council guidelines.

The presenter is Dr Peter Baskett, a well respected founding father of the Life Support programmes in the UK. His style is, as always, clear, concise, and methodical.

The video opens with a simulated cardiac arrest scenario in a physiotherapy gymnasium and there then follows the cascade of recognition of cardiac arrest, call for help, basic life support through to advanced life support, with a welcome final successful outcome.

This video is essentially a "trailer" for Advanced Life Support courses, together with the principles of working together as a well coordinated team whose every member must keep their clinical skills up to scratch through regular training and practice.

The British Heart Foundation has made a sound investment in recruiting the expertise

and enthusiasm of the staff at Frenchay Hospital, Bristol, and Western General Hospital, Western-super-Mare, in the making of this video, whose message is loud and clear that gone are the days when a motley crew would arrive at a cardiac arrest situation full of

adrenergic ardour but devoid of well practiced coordinated clinical skills, with the result that a life potentially saved was all too often lost.

As a former member of that motley crew I am delighted that times have changed and that advanced life support should now be within

the domain of all paramedical, nursing, and medical professionals. This video will be highly effective in promoting that message to the widest possible audience.

I W R ANDERSON
Glasgow

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