The survey shows a clear difference in the view between those who have seen thrombolysis in action and those who have not. The author replies that the majority of junior doctors have not seen thrombolysis in action. This should be the message delivered to doctors responsible for managing patients with AMI. I agree with Miss Edhouse that junior doctors should not withhold thrombolysis in AMI without discussion with a senior colleague, and that primary angioplasty and intracoronary stenting may provide alternative strategies for patients in whom thrombolysis is withheld.

Capnography and “major” accident and emergency departments in East Anglia

EDITOR,—This year, Advanced Trauma Life Support (ATLS) courses based on the sixth (1997) edition of the ATLS manual have been held. One major change from the previous edition is the recommendation for capnography (end tidal carbon dioxide monitoring) in intubated patients. Capnography is the “gold standard” for the correct siting of the endotracheal tube in the airway. Such devices have been used in anaesthetic departments for many years, and are recommended by the Association of Anaesthetists in their guidelines for safe practice. Its importance has been emphasised recently in a case before the General Medical Council. The absence of end tidal carbon dioxide monitoring was cited as evidence in support of a claim of negligence again an anaesthetist involved in a perioperative death.

In a telephone survey of 10 “major” accident and emergency (A&E) departments in East Anglia (as described by the British Association of Accident and Emergency Medicine) only five of the 10 units had capnography available, despite all departments (100%) employing at least one ATLS provider at staff grade, registrar, or senior house officer level. In seven of the departments, the A&E consultant was known to be an ATLS course instructor. Six of the 10 hospitals offered an ATLS course in the last year (data from telephone survey and personal communication from the Royal College of Surgeons of England), and six described immediate access to a multidisciplinary “trauma team” (typically with anaesthetic, surgical, and orthopaedic middle grade doctors), with the remaining four able to enlist immediate help from the duty anaesthetist via a pager system.

It appears that since only 50% of major A&E departments in East Anglia have capnography available, half of the departments do not have the recommended equipment to allow ATLS providers and anaesthetists to provide the latest advanced airway care.

It is understood, however, that at least some of the departments contacted are currently considering the acquisition of a capnograph.

Violence in the accident and emergency department: liaison with the police

EDITOR,—In common with colleagues throughout the country, staff in the accident and emergency (A&E) department at Leighton Hospital have become increasingly concerned with the rising levels of violence and verbal abuse and have considered various security measures, including the use of closed circuit television and security staff.

Security staff are extremely expensive and their powers are very restricted.

Relationships with the local police have always been good and they have been aware of the increasing problems of violence. A discussion has resulted in a police base, which was previously sited some two miles from the hospital, being relocated in the grounds of the hospital, immediately adjacent to the A&E department. Consequently, police are immediately available for 126 hours per week (8.00 am to 2.00 am, seven days per week).

This arrangement ensures an immediate police presence in the A&E department for 75% of the time. The hospital has agreed to provide accommodation (a Portakabin), costing £5000 per annum, and car parking facilities. The other expenses are borne by the police, who are obviously able to continue with their normal duties.

Additional benefits of this arrangement include improved relationships with the police (including the coroner’s officer) and the deterrent effect of the obvious police presence.

We believe that this arrangement is unique and provides a superb level of security for minimal financial cost.

BOOK REVIEWS

The Handbook of Medical Care of Catastrophes. By J S P Lumley, J M Ryan, P J Baxter, and N Kirby. (Pp 223; £20.00.) Royal Society of Medicine, 1996. ISBN 1 8535 296 X.

There is a large void within the thought that one could be of value at a catastrophe, and the challenge to be more of a help than a hindrance.