Accident and emergency medicine or emergency medicine?

EDITOR,—As trainees in emergency medicine, we welcome Laurence Rocke’s suggestion to re-open the debate on the name of our specialty. We would support the dropping of the clumsy “accident” and “prestige” prefix for the following reasons: it is a mouthful to say; it is redundant since most accidental injuries can be considered emergencies; if not by the physician then at least by the patient; and it carries with it historical connotations of being an orthopaedic subspecialty, reinforcing the attitudes that many other specialists unfortunately continue to hold towards us.

We do not know what the response of the Royal Colleges of Physicians will be to the problem of increased subspecialisation within general (internal) medicine and the lack of acute care physicians,1 but if they secure the right to the name “emergency medicine” we are going to experience a serious identity crisis. Our vision of the future in the specialty is one of increasing intervention (where appropriate) in the emergency department, and of growing credibility as specialists. We acknowledge gratefully the enormous achievements made by our senior colleagues in creating and building accident and emergency medicine into what it is today; as the next generation of consultants we intend to honour their efforts by continuing to raise the prestige of our specialty and to attract the highest calibre trainees. To this end we suggest that bringing ourselves into line with much of the rest of the world by renaming the specialty “emergency medicine” is an important and logical step. This window of opportunity may never be open again—it is important to shape our specialty by design, not by default.

CLIFF REID
BEVERLEY WATTS
JUSTIN NICHOLAS
SUSANNA SLACK
KATHERINE HARTINGTON
MICHAEL HOWELL
ALF OKWONKO
NEIL ROBINSON
GARY L A CUMBERBATCH
HOWARD SIMPSON
ANDY STEARMAN
ELEANOR IVORY
DAVID WAKELEY
HELEN VECHT
SUZANNE BRADY

Wessex Regional Accident and Emergency Trainers’ Association
(Excorrespondence to: Dr Cliff Reid, Specialist Registrar in Accident and Emergency, North Hampshire Hospital, Aldermaston Road, Basingstoke, Hants RG24 9NA)


Use of the Cochrane Library by emergency physicians

EDITOR,—Given that systematic reviews may be considered the best form of evidence (costing £20-70K per review) it is important to establish that this evidence is reaching front-line clinicians. The rapidly expanding Cochrane Library contains a register both of systematic reviews and controlled clinical trials. A postal questionnaire was sent to all trainees and trainers in emergency medicine in the Wessex and South West regions; 50/55 (91%) replied. Twenty four of the 50 had used the Cochrane Library, although use was infrequent; typically it was twice or less during the preceding three months.

The questionnaire provided the conclusions of 14 systematic reviews from the Cochrane Library relevant to emergency medicine, asked the respondents if they knew of each conclusion and, if yes, how they had acquired that knowledge (Cochrane Library, journal club, reading journals, teaching, other).

Of 700 possible responses, 405 responded “yes”, However, in only 10% of these responses was the Cochrane Library the source of that knowledge.

The Cochrane Library is used infrequently by emergency physicians, although much more than reported by other groups.1 In addition it is clear from these results that the awareness of the conclusions of published systematic reviews can be improved. It is essential that the secondary sources of best evidence are disseminated to emergency physicians and a major step forward is likely to be the making of the Cochrane Library available in full on the Internet (http://www.cochrane.co.uk). The undertaking of the Journal of Accident and Emergency Medicine to publish relevant articles in the journal scan, including systematic reviews, from the journal Evidence-Based Medicine is also an important development.

We wish to thank all the emergency medicine trainers and trainees in the Wessex and South West regions for their excellent response to our questionnaire.

G L A CUMBERBATCH
M J CLANCY

Emergency Department, Southampton General Hospital, Tremona Road, Southampton SO9 4XY


1 9NA)


Letters to the editor

The authors reply

If our previous papers give the impression that we place more emphasis on journal scanning than best evidence topic reports (BETs) then appearances are deceptive:1 A large part of the work of the journal club revolves around the conception, planning, searching, and presentation of the BETs mentioned that are the greatest influence on our practice.

Dr Lloyd’s first point regarding the poor yield from an individual doctor “journal scanning” is true. Indeed this has led to the development of secondary publication journals such as Evidence-Based Medicine, and for many specialties this is clearly the way forward. Unfortunately, I do not think emergency medicine is ready to go down this route yet. For example when I tested the first 50 BET topics against the evidence based journals available on CD-ROM I was unable answer any of our questions. The systematic scanning of journals by members of the group selects only those papers worthy of consideration. This same rationale is used by the evidence based medicine publications.

Furthermore his suggestion for a triple jump approach is reasonable and it appears to be a suggestion to improve the BET’s based on the book by Sackett et al.3 In fact these ideas were some of the principal starting points for the journal club. However, experience has tailored our methods to emergency medicine.

We prefer to allow members of the journal club to investigate a topic of their own interest rather than one selected by the group. Invariably members select topics that they have personally seen; this makes the process less of an academic exercise and more clinically relevant for those tackling the BET’s.