that general practice patients are able to defer their requirements for primary care services until they can receive these from a GP. Is this a common experience in other countries?

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The assistance of the NSW Department of Health in providing these data is gratefully acknowledged.


Pain management

EDITOR,—I read with interest the paper by Kelly et al1 that outlined some change strategies for a pain protocol implementation. It was unfortunate that the journal did not include a copy of the tritratned IV narcotic policy for readers to assess separately. Novel approaches to improving pain management are always welcome and the author clearly illustrates the failure in emergency department 10 years ago to provide adequate analgesia. It is interesting to note that despite the stated successful implementation of the policy, 10% (5 of 50 who received narcotic analgesia in 1997) of patients still had at least one dose of analgesia intramuscularly.

Many of the changes described in this paper are based on subjective assessment rather than any more robust analyses. The rationale for using a nursing led process seems to have been justified because “it was felt” that they would provide more formal review and assessment, rather than any evidence that the emergency department doctors were unable to do so. In addition the conclusions that there has been a change in pain management practice between the time periods was attributed to the “example of senior staff” and that the policy is now “everyday practice” with no supporting evidence.

The author has used a χ² test to illustrate that over time the outcome of the process has changed—that is, more patients now receive intravenous rather than intramuscular narcotic analgesia. As there is no temporally related control group the obvious bias of temporality has been ignored. It may well be that clinical practice has changed in the study emergency department and other departments over time, this secular trend is not necessarily related to the implementation of a local pain policy. Thus, the author’s conclusion that a “major and sustained change to analgesia ordering” is attributable to the described process approach lacks validity.

Bias in the matching of subjects has not been fully resolved. While the author states that the two groups are comparable for age and sex no supportive data are provided. The author states that the reason only one patient had a fracture of the tibia in 1993 and 21 in 1997 is attributable to chance”. Simple analysis of difference of proportions would show that the probability of such an event occurring is very unlikely (p<0.0001, standard normal deviate −6.03). Although a χ² test on table 1 supports the author (p=0.0001, df =3, χ²=20.88) for no difference in the overall fracture type, between the study periods.

The author has described some important aspects of departmental change management in relation to analgesia policy. However, the author has failed to prove that the implementation of such a policy has influenced the outcome of this process.

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Author’s reply

EDITOR,—I thank Dr Leman for his thoughtful letter but am disappointed that he seems to have missed the important message of this paper—that pain management can be improved by innovative process change.

Dr Leman makes several points that I will answer in turn. The process of developing a pain management protocol was a group exercised by the EDIS (Emergency department) team to take an honest look at our work practices and environment. It was the team’s assessment that, in our ED, members of the nursing staff had more regular contact with patients as part of scheduled observation that forms part of the nursing process. Doctors, on the other hand, had less regular contact and were often occupied with other duties. While it would have been possible to have doctors perform the review and augmentation role, it would have meant a major change in work practice and thus was less likely to be successful. The issue is not one of who performs which steps in the pain management process, rather than all steps are performed consistently in a way that fits well with established work practices. Different departments may well adopt different strategies to achieve this end.

The question of a control group for comparison was carefully considered at the time the process change was being developed. We had considered investigating time to analgesia between groups treated by the protocol and one that was not, but this was considered unethical in light of our knowledge that previous practices were ineffective. I agree that there may well have been gradual change in analgesia practice between the time periods studied, however the magnitude of change shown in this study is large and is as impressive for patients treated for other painful conditions, such as renal colic.

The question of bias in the matching of subjects is well made. The study aimed to compare two groups with long bone fractures and it was this larger group rather than specific fracture subgroups that was sampled, giving a reasonable match for overall fracture type between the periods as Dr Leman agrees. Only on subgroup analysis was the mismatch for tibial fracture identified—a chance finding appropriately acknowledged.

That some patients were treated outside the protocol is almost inevitable! For this fracture group the rate of non-compliance (that is, giving intramuscular analgesia) was 5% of patients (5% of those receiving analgesia) in 1993 and 21% in 1997. This rate is low compared with other studies that have investigated adherence to protocols in acute medicine.”

My aim in reporting the Western Hospital experience in developing a new process for managing pain was to demonstrate that a commitment to improving patient care, an open and honest appraisal of the barriers and a flexible approach to solutions can result in
Open chest cardiac compression

EDITOR,—I really wonder about the value of Dr Calinas-Correia’s article on thoracotomy and internal cardiac massage for non-shockable arrested patients. It seems to me that the study only proved the futility of attempting resuscitation this way on these patients. Thoracotomy and internal cardiac massage have a place in the moribund patient with a tamponade and/or penetrating heart wound but this is gung-ho in anystole. The ALS algorithm of early BLS and early ALS must remain the mainstay of attempts to salvage these patients with their universally poor prognosis.

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BOOK REVIEWS

Textbook of adult emergency medicine.


This is a new major textbook of emergency medicine first published in 2000. The contributors read like a “Who’s who” of emergency medicine in Australasia—with a few contributions from North America and UK.

The book is primarily aimed at the emergency medicine trainee—although the wide authorship has allowed the text to become a “snap shot” of current Australasian emergency medicine practice.

The editorial board has adopted a consensussy style and approach to the mater.


Neurology is not generally perceived as one of the more glamorous medical specialties. This textbook has an upbeat approach. In the preface, the author borrows the now ubiquitous “golden hour” concept for acute neurology.

The text is said to be “brief to facilitate reading” and “intended to reflect the train of thought and action in the emergency department”. Compared with the average neurological textbook it may be brief but it would not be recognised as such by most emergency physicians.

The book is divided into two sections. The first covers conditions affecting the neuroaxis and the second, neurological disorders attributable to specific causes. Detailed descriptions of a number of neurological conditions and their aetiology are provided. The usual neurological emergencies are included, for example, status epilepticus and aneurysmal subarachnoid haemorrhage. In addition rather less obvious emergencies such as acute obstructive hydrocephalus and acute white matter disease are also discussed. The chapter on altered consciousness and coma contains an exhaustive list of the major causes of coma, some of these conditions are unlikely to present as a differential diagnosis formulated in the emergency department. However, the detail contained within the sections on examination of the patient in coma and the assessment of patients with acute intracranial masses re-
minded me of a number of long forgotten clinical signs. In many chapters there is a brief but detailed and informative review of anatomy and pathophysiology.

Many of the investigations, for example, EEG, SPECT suggested in other chapters might be problematic to arrange in the average emergency department. “I want a SPECT stat”.

In parts the clinical practice described does not follow current UK practice (or even standard clinical practice of 10 years ago). For example, it is implied that the administration of antibiotics in bacterial meningitis be delayed until CT/MRI and lumbar puncture have been performed.

The book is unlikely to be used “acutely” on a daily or weekly basis. I suspect this book is akin to an interview suit, something to be referred to on a daily or weekly basis. I suspect this book is not currently used in the emergency department. “I want a SPECT stat”.

In this second edition David Currie, a Scottish neurosurgeon, has been joined by two anesthesiologists to provide a handy guide for the management of patients with head injuries aimed at those involved in junior doctors working in the emergency room and ward setting. A welcome addition is the excellent chapter on the disturbed patient, which will be appreciated by nurses on wards that are often under staffed. Advice with which most A&E specialists would agree includes “observation should ideally be undertaken on a neurosurgery ward”.

There could be more detail on the practical issues of how the “frontline” staff can safely and efficiently sort out difficult patients with complex problems. When they arrive in A&E, patients rarely have “isolated head injury” stamped on their forehead yet I believe this is the way neurosurgeons would like to receive them. The management of potential alcohol withdrawal deserves more than a mention.

I am concerned about the use of a contraction of the 15 point GCS score to a total of 14—this could create confusion in clinical discussions if the score is used without clarifying the denominator, for example, GCS < 8 instead of GCS < 14. This is a decision for intubation and ventilation. The importance of describing the levels of the three responses and avoiding numbers should be emphasised.

It is good that ATLS principles are espoused and there is an expanded chapter on cervical spine injuries but the inappropriate term “traction” is still used rather than “in line immobilisation”. Scalp “lacerations” should be differentiated from “incised wounds”—an important clue to the likely mechanism. Some typographical errors and mislabelling are retained and, in my copy, the clarity of some photographs has deteriorated compared with first edition.

Possibly because of the timing of this edition, it excludes the guidelines for the initial management of head injuries by the Society of British Neurological Surgeons (1998), which, for example, recommend computed tomography within four hours for GCS 15 patients with skull fracture.

This book about a common A&E presentation is written mainly for A&E staff by non-A&E specialists. To justify its title there needs to be a greater focus on what really happens in the emergency room everyday and an up to date view of what we should be doing in the future.

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ABSTRACT

The following was omitted from the abstracts published in the November 2000 issue of the journal for the Millennium Scientific Meeting hosted by the Faculty of Accident and Emergency Medicine.

Minor injury services—the present state

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Introduction—There are no studies describing the present systems of care in minor injury units. BAEM has recently issued a position statement but it is not known how many units adhere to this.

Methods—Postal questionnaire to all minor injury services in the UK.

Results—There was a 65% response rate. Units described themselves as minor injury services (32%), injury and illness services (24%). Eight per cent receive all local 999 ambulances but 24% receive none. The distance from the A&E department was under 10 miles for 9% of units. Only half are open 24 hours per day although most are open seven days a week. GPs are the main provider (49%); with ENP the main provider in 27%. Only 15% had doctors permanently based in the unit and 50% had nurses permanently based in the department. Only 4% of nurses rotated with A&E. Over half did not have staff with ALS on duty at all times. They had high review rates.

Conclusions—Structure and staffing are highly variable. Most do not conform to BAEM guidelines. Optimal configuration is not known. More A&E input may be beneficial.

Full report available at www.emerg-uk.com on reports page.

Funding—Department of Health A&E Modernisation Programme.

NOTICE

1st Kuopio Conference.

“E-Health”—The use of information technology and telematics in emergency management and education

23–25 August 2001, Kuopio, Finland Further details: Conference Secretariat, University of Kuopio, Department of Health Policy and Management, PO Box 1627 FIN-70211 Kuopio, Finland (tel: + 358 17 163 631, fax: + 358 17 162 999, e-mail: aapo.immonen@uku.fi).