PostScript

LETTERS

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Lack of change in trauma care in England and Wales since 1994

We read with interest the article and accompanying editorial by Lecky *et al* in the *Emergency Medicine Journal*.¹ Of note, between 1989 and 1994 there was an increase in the proportion of trauma patients (ISS>15) in whom a consultant was involved in their care: at the same time, trauma related mortality fell. Since then, both the level of documented consultant involvement and the mortality have plateaued. Documented middle grade involvement is unchanged from 1989.

This lack of improvement in the involvement of consultants and middle grades is of concern, and there is great pressure from many sides to increase senior cover on the shop floor. This includes BAEM's 1995 recommendations for increasing the levels of senior staff in A&E departments.² Many of these recommendations were repeated in the Workforce Planning Document from BAEM and FAEM³: one of the main recommendations of this paper is that shop floor consultant cover should be available 12 hours a day, 7 days a week. This is to achieve the objective of allowing all patients to have an experienced clinician (specialist registrar, non-consultant career grade, consultant) either care for them directly, or supervise their care closely. In addition, the recently published NHS Plan made

plain the government's intention to have more consultants involved in patient care.⁴

To investigate the current level of availability and involvement of senior and middle grade doctors in patient care in A&E departments, we undertook a survey of the 12 A&E departments in the South West deanery. These departments see between 24 500 and 85 000 new patients each year, and are staffed by between one and five consultants. We looked at the level of medical staff actually available to see new patients throughout two days in April 2001, and obtained information on all patients presenting on those two days, including triage category and level of seniority of doctor involved in their care.

Nine departments responded. No department provided 12 hour consultant cover. Most had at least 12 hour cover from a middle grade doctor, and three departments provided 24 hour middle grade cover. Consultant cover was poor: at the maximum, only five departments had a consultant on the shop floor at 1200 on Wednesday—other times had lower levels of cover. The level of middle grade and senior cover in these departments was worse at night and at the weekend.

The proportions of patients in each triage category seen by more experienced doctors or with more experienced doctors involved in their care is shown in table 1.

As expected, there is a trend towards senior and middle grade involvement in the more seriously ill patients (although our sample is too small to prove a statistical relation). Sixty five per cent of triage category 1 patients had senior or middle grade involvement, compared with 32% of category 4 and 5. Serious problems occasionally occur in patients triaged to category 4 or 5: in our sample, one patient died and one was admitted to a high dependency unit despite being triaged priority 4.

After comments from some hospitals that not all the senior involvement might have been documented, we undertook a one day audit of our own department, looking at whether the involvement of more senior medical staff is actually recorded in patient's notes. On the day studied, 218 patients were seen, of which 61 (28%) were seen initially by a senior or middle grade doctor. Of the 157 seen initially by a SHO, 39 had a senior or middle grade involved in their care at some stage (either seeing the patient, or giving advice on their care). Thus 100 patients (46%) had senior or middle grade involvement. Unfortunately, of the 39 patients for whom SHOs asked advice, this involvement of the more experienced doctor was only recorded in seven (18%).

While we acknowledge that our study was too small to draw statistical conclusions from, there is recorded experienced staff involved in the care of 36% of patients. In many ways this is better than the impression given in many documents that A&E is still a service provided primarily by SHOs,^{5,6} but it is concerning that the proportion of patients seen solely by a SHO (54%) seems to be little improved despite increasing numbers of consultants and middle grade staff, since the Platt report in 1967, which found that 66% of patients were seen by a SHO only.⁷

We have approached BAEM to raise the possibility of this study being expanded across the country. In the meantime, even if senior and middle grade doctors involved in the care of patients, this involvement may not be getting recorded

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- 1 Lecky FE, Woodford M, Bouamra O, *et al*. Lack of change in trauma care in England and Wales since 1994. *Emerg Med J* 2002;19:520-3
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- 4 Department of Health. The NHS plan. London: Department of Health, 2000.
- 5 Audit Commission. By accident or design. London: Audit Commission, 1996.
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Author's reply

I read the response from Wallis and Guly with interest. From the study they describe it is clearly possible that the level of senior doctor involvement is underestimated on the TARN database because of a failure of notekeeping. However, there is no reason to suspect that failing to record senior doctor involvement would be more prevalent in 2000 than in 1989 therefore there should be no systematic bias in our trends analysis.

More importantly, the failure to record senior doctor involvement may be one reason why there is no significant outcome difference in the patients "seen" by different grades of doctor (according to their notes)—figure 5 of our article.¹

It is probably advisable for all senior doctors to record any involvement they have had with patients—even just the giving of advice—in the notes. As well as satisfying clinical governance requirements this will improve our ability to examine future trends in trauma care.

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Table 1 Proportions of patients in each triage category seen by more experienced doctors*

Triage	Total number of patients	Number (%) of patients		
		Seen initially by experienced doctor	Seen during visit by experienced doctor	With experienced doctor involvement
1	20	2 (10)	13 (65)	13 (65)
2	163	32 (20)	46 (28)	59 (36)
3	502	124 (25)	174 (35)	219 (44)
4 and 5	1304	337 (26)	381 (29)	418 (32)
Total	1989	495 (25)	614 (31)	709 (36)

*Consultant, SpR, or NCCG.

Use of anti-D immunoglobulin in maternal trauma

We read with interest the article by Weinberg that revealed a lack of awareness among accident and emergency (A&E) staff of the risks of rhesus sensitisation as a consequence of threatened miscarriage.¹ Similar findings were reported in previous studies on anti-D immunoglobulin use in A&E.² This problem also exists in cases of maternal trauma in early pregnancy. We conducted a telephone survey of A&E SHOs in the North West region. A clinical scenario was given of a patient of 18 weeks' gestation with closed abdominal trauma due to domestic violence. SHOs were asked regarding their management of this case. Sixty two responses were obtained. The possibility of rhesus alloimmunisation was identified by 19 (31%) doctors. Three of these 19 would request a Kleihauer test while the remainder would check maternal rhesus status. If rhesus negative, nine would give anti-D immunoglobulin in the A&E department. The other nine SHOs would refer the patient to the obstetricians on call for further evaluation. Our survey then prompted the remaining 44 doctors with regard to rhesus incompatibility by bringing to attention previously documented rhesus negativity in the patient's case notes. Equipped with this knowledge, only eight doctors would then give anti-D immunoglobulin in A&E, while 11 would refer the patient for this purpose. Even then, the need for anti-D immunoglobulin was still unrecognised by 25 of 44 (57%) SHOs. Our study is in agreement with the author's findings that guidelines for rhesus prophylaxis are not being followed. In the revised guidelines, unlike threatened abortion at less than 12 weeks' gestation, closed abdominal injury is recognised as a sensitising event in the revised guidelines.³ Without continuing educational initiatives aimed at A&E doctors, these guidelines will continue to be ignored.

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- 3 **Joint Working Group of the British Blood Transfusion Society and the Royal College of Obstetricians and Gynaecologists.** Recommendations for the use of anti-D immunoglobulin for Rh prophylaxis. *Transfus Med* 1999;**9**:93-7.

Tissue adhesive with adhesive strips for wound closure

Mattick *et al* report their comparison of tissue adhesives and adhesive strips and describe them as equally effective "no-needle" alternatives for the closure of suitable paediatric lacerations.¹ Previous reports in the literature include a controlled trial comparing sutures, tape, and octylcyanoacrylate tissue adhesive

for skin closure by Shamiyeh *et al* that showed no significant difference between the methods, but a comment that scars tended to be slightly wider in the non-suture groups.² Quinn *et al* conducted a randomised trial comparing octylcyanoacrylate tissue adhesive and sutures in the management of lacerations, again showing no significant cosmetic difference.³

The use of tissue adhesive and adhesive strips for wound closure is now common place in many emergency departments, though each have their limitations and practical difficulties. I wish to describe a simple technique of the combined use of these two methods for wound closure. An example scenario for this technique is where a wound can be manually held together with little tension but where there is concern that wound edge separation may occur after initial closure.

The wound edges are approximated and then held with one or more adhesive strips. The wound is then reinforced by application of the tissue adhesive between and over (through) the adhesive strips. Alternatively, a wound that will not stay closed initially with adhesive strips alone may be closed by application of tissue adhesive to the underside of one end of an adhesive strip, allowing this to adhere to the skin on one side of the wound, before sticking the other end down in a similar manner holding the wound closed. The wound edges can be reinforced with further strips or tissue adhesive as previously described.

I have found this method, initially seen in Belfast, Northern Ireland, to be extremely useful in securing wound closure efficiently and painlessly, especially in children.

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- 2 **Shamiyeh A, Schrenk P, Stelzer T, et al.** Prospective randomized blind controlled trial comparing sutures, tape, and octylcyanoacrylate tissue adhesive for skin closure after phlebectomy. *Dermatol Surg* 2001;**27**:877-80.
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BOOK REVIEW

Outdoor emergency care: comprehensive pre-hospital care for non urban settings, 4th edn

US National Ski Patrol and the American Academy of Orthopedic Surgeons. (Pp 938; price not stated). Jones and Bartlett, 2003. ISBN 0-7637-1715-0

This is an impressive textbook of 938 pages covering virtually every area that you would want to know about in outdoor emergency care.

It is a manual used as part of the teaching of National Ski Patrol Members in the United States. The book has been produced in co-operation with The American Academy of Orthopedic Surgeons. There has been a huge amount of work put into this book and it is obviously part of an extremely well designed teaching package, which also includes instructor manuals, question test banks, student workshops, instructors CD ROM, and online refresher guide.

The text is well illustrated with appropriately laid out pictures and covers all you would expect to find in a textbook covering emergencies in hazardous outdoor situations particularly ski slopes and mountains. Many are series of illustrations covering practical procedures. There are appropriate introductions on preparation and communication with the emergency services, patient assessment then comprehensive sections on management of trauma by well accepted systems.

The book also covers common medical emergencies, snowboarding and mountain biking injuries, and then undertakes a system by system look at the less life threatening injuries that could be come across in the outdoors. They even cover psychiatric emergencies, drug overdose, use of illicit drugs, and weapons of mass destruction. There are sections on paediatric emergencies and mass casualty management.

While being a wonderful book—and something that any of us who work in the prehospital situation would love to look at and would learn at least something from—I would suggest that there is not a particular audience in this country who would find the book specific for their practice. I feel it is too detailed and comprehensive for ski patrollers and mountain rescue teams in the United Kingdom, much of it is not relevant to ambulance service paramedics and would only be relevant to a small number of doctors working in this field who may well want to have an even greater depth of knowledge of certain specific topics than is covered in this book.

My personal recommendation is that this would be a nice book to borrow from the library and therefore having it in your local medical library where you could have the opportunity to dip into it from time to time would be wonderful. It is also a good book for some to have for reference.

C Laird

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CORRECTION

An error occurred in the Accumulator BET (2003;**20**:372). The title should have read Accumulator BET: atraumatic pleuritic chest pain (not Accumulator BET: a traumatic pleuritic chest pain).