

PRIMARY SURVEY

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HELICOPTERS IN PREHOSPITAL CARE; ONLY IF MORE THAN 45 MINUTES BY ROAD?

Helicopter emergency ambulance services have generated a great deal of controversy in the UK. Much of this has been fuelled by the reports from the Medical Care Research Unit at the University of Sheffield. Their final report to the Department of Health on the costs and benefits of helicopter emergency ambulance services in the UK makes interesting reading and is available on the web (<http://www.shef.ac.uk/uni/academic/R-Z/scharr/mcru/reports.htm>). Recognising the role of helicopters in prehospital care, John Black and colleagues have produced an algorithm to help decide when (and more importantly, when not) to consider primary helicopter retrieval from the scene. A land transfer threshold of 45 minutes may seem a long time but it takes into account the delays incurred at landing sites that are more than just a quick trolley push from the resuscitation room. There is now a need to validate this algorithm in clinical practice.

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BYSTANDER, PARAMEDIC, NURSE, DOCTOR, OR EMERGENCY CARE PRACTITIONER?

As Tim Kilner points out, many of the desirable attributes of ambulance technicians and paramedics do not feature in existing ambulance training curriculums. Development of a clear understanding of these attributes is arguably essential to service and curriculum reform. While efforts are being made to achieve this, the traditional roles of technician and paramedic are being challenged within UK ambulance services much in the same way as the roles of nurses and doctors have been challenged within emergency departments. John Scott and Chris Carney describe a new role in prehospital care: that of the emergency care practitioner (ECP). So where does the evolving ECP fit in? According to the first cohort of ECPs in

East Anglia, it is: "... the space between the general practitioner, the nurse, and the paramedic."

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PROCEDURAL SEDATION WITH KETAMINE: IN AND OUT OF HOSPITAL

Ketamine is used for procedural sedation in many emergency departments across the country. Despite extensive international experience and the fact that laryngeal and pharyngeal protective reflexes are maintained more with ketamine than with any other sedative or anaesthetic agents, fierce debate has continued regarding its use. In the context of paediatric sedation, the basis for the SIGN guideline (subsequently withdrawn) is described by Neil Morton. Steven Green provides strong arguments for the safety of ketamine and Martin Howes has produced a comprehensive review of the evidence. All three authors recommend close audit of the use of ketamine and two excellent examples of audit are included in this edition.

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In prehospital care, ketamine facilitated extrication has an important role. Extrication is the process of physically removing a patient from the wreckage and it represents an extremely difficult and dangerous phase in rescue. There is often a need to control pain, manipulate fractures, and coordinate painful medical and rescue procedures. Ketamine is widely regarded as the agent of choice in the management of trapped patients and one look at Keith Porter's table shows the range of problems faced by the immediate care doctor.

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THE BEGINNING OF THE END OF AD HOC CRITICAL CARE TRANSFERS?

Care during the primary transfer of the critically injured or ill patient from scene to emergency department is an aspect of prehospital care that receives little attention. In contrast, secondary transfer within and between hospitals has received much attention and criticism. Why should the standards of care be any different? Alasdair Gray and colleagues describe the core critical care transfer issues relevant to the emergency department. They argue that the ED is central to the organisation of secondary transfer and can reduce the harm caused by the current ad hoc arrangements in many hospitals.

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EMERGENCY ANAESTHESIA ...OUTSIDE THE ANAESTHETIC ROOM

Cliff Reid and colleagues describe a prospective observational study of rapid sequence intubation outside the anaesthetic room. They provide further supporting evidence that RSI is an emergency intervention that can be safely performed by non-anaesthetists. They argue that "...training programmes for non-anaesthetists should be defined and standardised to optimise the safe and timely securing of the airway in emergency situations rather than debating which specialists should do it." One anxiety expressed by anaesthetists and non-anaesthetists alike is whether or not emergency airway management in the trauma patient may, in the presence of undiagnosed unstable cervical spine injury, cause harm. There has been little evidence to suggest that it does and Harry Patterson presents reassuring data from the Perth Trauma Registry.

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OBVIOUS DEATH?

Should an emergency ambulance be sent to 999 calls where there is "obvious death"? In an effort to answer this apparently straightforward question, Leighton Harvey and Malcolm Woollard found that if the decision is based in current systems, the answer is yes. While most patients were indeed beyond help, 2 of 59 (3.4%) were certainly not. This inappropriate allocation of an "obvious death" code represents a significant risk and emphasises the problems surrounding non-emergency responses.

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