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HEAD INJURY MANAGEMENT GUIDELINES

We do not like change, especially when the change is to a pattern of clinical care that has remained essentially the same for 20 years. In this issue we debate the recent guidelines issues by the UK National Institute for Clinical Excellence (NICE). We also publish a series of articles that explain the changes but also examine the practical implications.

Leaman makes a number of points voiced by a number of emergency medicine clinicians and managers. Many hospitals will be struggling with the operational and financial impact of implementation. Swann points out some of the clinical weaknesses of the guidelines.

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However, these guidelines represent a step change in head injury care. They may not be the best possible solution, but NICE recognise this fact and will review the guidance in the near future. Equally NICE must start to acknowledge that emergency health systems are struggling with the pace of change across a number of agendas. When unfunded guideline follows unfunded guideline the message of good care may be lost in the struggle to put these ideals into practice.

The answer is not to abandon NICE but to work with them, suggest how best to manage this often difficult clinical situation. In the meantime, until funds are found and the guidelines perfected the current guidelines should be seen as aspirational rather than the standard of care.

''PAIN TO CALL'' TIME IN ACUTE MYOCARDIAL INFARCTION, CAN IT BE IMPROVED?

As we drive to cut minutes from ''call to needle'' times for thrombolysis in patients with acute myocardial infarct, the time from the onset of symptoms to the call for help (pain to call time) remains a barrier to delivering prompt treatment. Kainth *et al* provide a timely review of the evidence for interventions to reduce pain to call time and find little evidence of effect.

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SAFETY AND COST EFFECTIVENESS OF TELEMEDICINE

Telemedicine has been promoted as a key technology in the modernisation of health services. The hope is that specialist care can be delivered close to the patient's home. One area of use has been the support of emergency nurse practitioners working in minor injury units some distance from emergency departments. However, no randomised trial or formal economic evaluation has ever been published. Benger and coworkers have had the courage and tenacity to fill this evidence vacuum. They report that telemedicine achieves a standard of care equivalent to conventional practice in the care of minor injury. However, telemedicine shows no advantages over routine care provided by general practitioners and is the least cost effective option for both the NHS and for patients and there families. The authors point out that a range of process issues such as increased consultation time may also act as barriers to the widespread adoption of telemedicine.

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THE EUROPEAN WORKING TIME DIRECTIVE (EWTD)

The UK medical profession has been for many years warning of the major problems that implementation of this legislation would bring to the staffing of emergency services. Fortunately shift rotas have always been part of emergency department management and most emergency departments will already have EWTD compliant rotas. However, many inpatient teams may not have this experience and might be struggling with the concept of full shift rotas. In this issue we publish a practical guide to producing such rotas. If you know colleagues who are still struggling point them to the paper and computer program suggested by Todd.

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