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EDITORIAL

The First International Conference on Emergency Medicine held in London in April was, unreservedly, a great success. Specialists in emergency medicine from all over the world gathered to share their knowledge and problems, and it seems that the movement is generally both uniform and similarly directed. Many scientific papers were presented but, in keeping with modern trends, a delegate was likely to only hear a quarter of those presented. Simultaneous sessions do allow a large number of papers to be read and, therefore, guarantee a larger delegation from abroad. However, it can be like choosing a meal from a menu: you always end up feeling that everyone else has chosen something better than you. Even worse, perhaps, the choice is too good and you feel you want to sample everything. Some even try this and, as though flicking through channels on a TV set, they manage to follow the storyline of everything but know nothing of the details.

The most valuable part of any conference has always been the unstructured meetings and informal gatherings. It is here that people can pick each others' brains and genuine learning takes place. The discussion sessions of this conference were a clear attempt to give space to this phenomenon and gently guide the participants to some conclusions. The attempt proved to be the highlight of the event for many. The topics of the plenary sessions were dissected and examined, and we all learned from the experience of others. The US experience, in particular, can teach us that out-of-hospital trauma is a different entity to out-of-hospital cardiac arrest. On-site resuscitation for cardiac arrest has an enormous pay-off in lives saved, whereas it may critically increase the delay in moving an injured patient to definitive surgery. The major advances in trauma care are still to be made in the organisation of in-hospital services. It is not good enough that the 'on-call' trauma surgeon has other duties and the operating theatre is not solely dedicated to trauma. It is the time from injury to definitive surgery that largely determines outcome. The patient must be rapidly transported to the centre where this surgery can be performed by someone experienced enough to do it.

This organisation of emergency services is a nettle the UK has still to grasp. Having pioneered the concept with the Birmingham Accident Hospital, no further development has occurred. If surgeons are to be adequately trained and more sophisticated services made available, then the laws of efficiency and effectiveness dictate that some centralization of trauma services must occur.

Specialists in emergency medicine have their own nettle to grasp in concert with this concept. Continuous senior cover for emergency departments on a 'live-in' basis was accepted as a good thing at the conference. This means working 'shifts' with appropriate compensation in terms of time off. It may also mean taking your turn in the major centre to receive the major trauma now diverted from your own department. The 'consultant' concept for some specialties is clearly appropriate but emergency work demands both skill and experience, and instant access to both. Perhaps we should move away from the concept of being 'on-call' and accept that we are either 'on-duty' or 'off-duty'.

The paper in this issue by Champion *et al.*, although specifically about one emergency procedure, quite clearly illustrates the degree to which a trauma service can be developed. Unfortunately for many emergency departments (and patients), any debate about emergency-bay thoracotomy slides into pathos as night after night the junior doctors in the emergency room play the games of 'hunt the surgeon' and 'find a theatre'.

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