In this context, the continued use of the word 'accident' causes me concern. Sir Francis Bacon wrote 'For men converse by means of language, but words are imposed according to the understanding of the crowd; and there arises from a bad and inapt formation of words a wonderful obstruction to the mind'.

So I believe it is with the inapt word 'accident'. To 'the crowd' the word implies some sort of act of God — that it couldn't be helped. Most dictionaries define it as 'an event occurring by chance', or similarly, and therefore by implication not avoidable. If we are to make progress in the prevention of injuries, be they on the transportation, industrial, domestic or recreational fronts we need to use the language of injuries, not of accidents.

Most injuries sustained in the course of transportation occur in crashes. We respond to train crashes and 'plane crashes with inquiries to determine how they were caused and how a repetition could be avoided. We know very well that most road crashes are not accidental — excessive alcohol, excessive speed, going through red lights and controlled intersections, not indicating, and other road code infringements make up the causes of most.

Patients present with injuries. Only a small proportion could not have been prevented. In the interests of promoting an awareness of this amongst the public, it is time we abandoned the word 'accident'.

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Effects of the Gulf War on accident & emergency attendances

Sir
We recently undertook a retrospective survey to assess the nature of attendances to our Accident & Emergency Department during the period of the Gulf War (17 January to 28 February 1991).

The number of total new patient attendances (over the age of 16) during this period was similar to the number presenting over the same time period in the 2 preceding years (Table 1). Attendances in three specific categories were extracted from within this total: alcohol excess; poisoning/drug overdose; and acute psychiatric problems. In the period encompassing the Gulf War, a marked increase was noted in all three categories of psychopathology. Table 1 documents the 71% increase in attendances for alcohol excess, the 20% increase in poisoning/overdose attendances, and the 27% increase in presentations with acute psychiatric illnesses over the mean of the previous two years.

For the Gulf War, hospital services were alerted and organized to accommodate expected war casualties. No consideration was apparently given to any possible effect the war might have had on the quality or quantity of hospital attendance from the remaining population. The general public were encouraged to use their general practitioners whenever possible and not to utilize hospital services, thus
the numbers of minor injuries dealt with thus might have been expected to drop. Our figures demonstrate that these patients were apparently replaced by a similar number of patients with psychopathology. This group of patients however place a considerably higher demand on hospital services than the minor injuries for which they compensated.

Alcohol excess sufficient to present to an A&E department usually requires an overnight stay, and is often associated with head injury needing regular nursing observation and care. Similarly, patients presenting with poisoning or overdose require management in the department (possibly including gastric lavage), admission for overnight observation and in our unit a review by a psychiatrist the following morning. Any patient presenting with acute psychiatric illness must be screened by the A&E staff, and referred to the psychiatric team, who also need to interview — a time consuming process. The overall demands of an increase in patients with psychopathology are thus: an increase in medical time; an increase in nursing time and procedures; an increased usage of inpatient beds; and increased usage of psychiatric referral and consultation.

Unfortunately, our calculated figures are subject to some confounding factors. Firstly, the classification of patients into the three categories may have varied over the 3 years under study. Secondly, we do not have figures for the following year yet to demonstrate a reversion to previous levels. However, the presented figures are statistically significant in their increase at the 0.05 level for every category measured.

Perhaps of more interest is the fact that previous experience has been that in times of war the incidence of psychopathology has decreased, but usually as measured in populations directly affected by the war. The Gulf War was unusual in its remoteness yet its proximity as presented by the vast media coverage. The health care response was also unusual and widely known, and thus untoward effects of the war on the remote population might not be as unexpected as previous experience would indicate.

With these shortcomings in mind, we still feel we have demonstrated some effect of the Gulf War in the form of increased psychopathology in a remote population. This is a contentious conclusion, and perhaps needs confirmation (or refutation) by studies from other units.

We feel it worth bringing to the attention of your readers to encourage such studies, and discussion of the topic, since if this represents a true state of affairs,
then future planning of health care under war conditions may need to take this factor into account.

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Teaching trauma management

Sir
In reference to the article on teaching trauma management in the accident and emergency department (Williams et al., 1991), we are concerned that it may perpetuate the myth that junior staff can and indeed should continue to manage critically injured patients.

Many studies have shown that preventable trauma deaths can be reduced from 20–30% to less than 5% with appropriate organizational and staffing changes (Cales et al., 1985; Kreis et al., 1986). The management of major trauma presents a complexity of diagnostic and therapeutic decisions, in addition to requiring skill in multiple invasive procedures that cannot reasonably be expected of junior staff.

The ATLS Programme teaches a basic approach to initial trauma care but in no way confers expertise on the participants and is therefore no substitute for management by experienced senior staff. The suggestion that an abbreviated version of ATLS might represent any type of solution to the problem of trauma care by junior doctors is unrealistic.

Major trauma is a disease which demands the immediate presence of trained and experienced senior medical staff. Trauma centres, so favoured in the U.S.A., may not be a practical or economic solution in the U.K. environment with its comparatively low rates of trauma. However, redressing the serious imbalance in the ratio of junior to senior medical staff (10:1) in U.K. accident and emergency departments illustrated by Williams would improve the care of all critical and injured patients, not just those with major trauma, and must therefore represent an essential strategy.

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REFERENCES