LETTERS TO THE EDITOR

We regret that this letter was not published as intended in the July issue:

Nurse practitioners

EDITOR,—We refer to the letter by A M Leaman[1] in the July issue referring to our earlier paper.[2] On the contrary, Mr Leaman, our findings do lead us somewhere–somewhere rather challenging and perhaps a little threatening. The minor injuries unit (MIU) at St Charles' Hospital is managed entirely by our Nursing Directorate and was the first in the country to allow nurse practitioners to request and interpret a limited range of *x* rays independently of doctors. We have shown no statistically significant difference between our nurses' and SHOs' abilities in this. In the age of evidence based medicine we hope others will be encouraged by our results to further develop and depend on their nurses' skills in radiographic interpretation. Clearly a study designed to assess radiographic interpretation is unlikely to address awareness of social circumstances or any of the other factors you mention.

You will appreciate that we cannot agree with your view that only doctors can manage patients with minor injuries. Based on our patient satisfaction surveys, the 9000 patients who choose to receive treatment from the nurse practitioners in our minor injuries unit every year would also find your views puzzling.

If you or any other readers would like to visit the MIU at St Charles' Hospital, please contact the manager, Sheila Proudfoot, on 0181 962 4265.

RAMZI FREIJ
JANE FOTHERGILL
Department of Accident and Emergency Medicine, St Mary's Hospital, Praed Street, London W2 1NY

1 A M Leaman. Nurse practitioners. *J Accid Emerg Med* 1996;13:304.
2 Freij RM, Duffy T, Hackett D, Cunningham D, Fothergill J. Radiographic interpretation by nurse practitioners in a minor injuries unit. *J Accid Emerg Med* 1996;13:41–3.

Regional standards in trauma care

EDITOR,—We would like to comment on the study undertaken by O'Connor and colleagues.[1] This paper illustrates continuing inadequacies in the initial management of multiply injured patients in the United Kingdom. We feel, however, that the message of this study is unclear. The results show that the trauma patients were inadequately assessed and resuscitated on arrival at the referral centre. This is similar to previous published work.[2-4]

A more interesting and important question is why these failures occur. Certain results such as lack of basic "primary survey" *x* rays,[5] intravenous access, and missed pelvic fractures point towards inadequate initial management. Any further interpretation of the data is speculative. Injuries may have become clinically evident during transfer or may have been identified but not documented. Issues such as the time of day, time at initial hospital before transfer, physiological measurements before and after transfer, grade of staff, and resource capabilities of the referring hospital have not been addressed. These data might enable conclusions to be reached on why these inadequacies in trauma management are occurring.

We agree completely that all patients should be fully reassessed by suitably trained senior staff after transfer. The problems in greater need of correction are the inadequate assessment, management, and transfer procedure of the referring hospitals. Trauma management is a continuing pathway of reassessment, resuscitation, and investigation from injury to definitive care wherever that is available. Poor quality care needs to be corrected throughout the "trauma system" rather than in the current fragmented manner. All hospitals should be accountable for their standards of trauma care.

Possible solutions include the development of regional or national trauma accreditation schemes (with hospitals having to be of a certain standard before being allowed to receive, manage, and transfer multiply injured patients). All hospitals' MTOS results should surely be publicly known. Finally as a minimum standard of care all doctors involved in trauma management should be ATLS trained.

A J GRAY
S GOODACRE
G JOHNSON
A MCGOWAN
Accident and Emergency Department, St James's University Hospital, Leeds

1 O'Connor PM, Steele JA, Dearden CH, Rocke LG, Fisher RB. The accident and emergency department as a single portal of entry for the reassessment of all trauma patients transferred to specialist units. *J Accid Emerg Med* 1996;13:9–10.
2 Gentleman D, Jennet B. Audit of transfer of unconscious head-injured patients to a neurosurgical unit. *Lancet* 1990;335:330–4.
3 Lambert SM, Willet K. Transfer of multiply-injured patients for a neurosurgical opinion: a study of the adequacy of the assessment and resuscitation. *Injury* 1993;24:333-6.
4 Hicks IR, Hedley RM, Razis P. Audit of transfer of head-injured patients to a stand-alone neurosurgical unit. *Injury* 1994;25:545–9.
5 *Advanced trauma life support student manual.* Chicago: American College of Surgeons, 1993.

The author replies

The message of our paper was that when patients with major trauma are transferred to a specialist centre it is important that they are initially reassessed in that centre not by specialists but by generalists. We found that, for example, a patient transferred to the neurosurical unit had an undiagnosed ruptured spleen, a patient transferred because of a perforating eye injury also had a Le Fort III facial fracture.

Once a patient reaches a specialist unit such as neurosurgery or orthopaedics it is likely that there will be a delay in the diagnosis undiscovered injuries, or incomplete investigations/treatment, which are outwith that area of specialist interest. We have shown in our paper that this is a sufficiently frequent occurrence to stop patients going straight to specialist units. Instead it is of value if they initially come to the accident and emergency department where they are reassessed by a team of generalists so that important problems in patient care are not overlooked.

We were not seeking in any way to be critical of the care in other hospitals. Patients may have incomplete examination, investigations, diagnoses, or treatment for various reasons, many of which are not due to inadequate management in the first hospital.

We felt that care in our own hospital was not infrequently suboptimal[1-3] and that it was easier and better to try to correct our own inadequacies first.

CHRISTINE H DEARDEN
Accident and Emergency Department, Royal Victoria Hospital, Belfast

1 Dearden CH, Rutherford WHR. The resuscitation of the severely injured in the accident and emergency department—a medical audit. *Injury* 1985;16:249–52.
2 Fisher RB, Dearden CH. Improving the care of pateints with major trauma in the accident and emergnecy department. *BMJ* 1990;300:1560–3.
3 McNicholl BP, Dearden CH. Delays in the care of the critically injured. *Br J Surg* 1992:79:171–3.

Duplication of information

EDITOR,—I read with interest the article by O'Connor *et al* (volume 12/4, page 251) on the unnecessary duplication of events when patients presenting to accident and emergency are clerked by specialty admitting doctors, in addition to accident and emergency senior house officers, without improvement being noted in the numbers of inappropriate admissions or wrong diagnoses.

I agree completely with the principle that it is inappropriate to delay patients who require admission in the A&E department while the repeat clerking is carried out by the specialty senior house officer. My attempts to arrange admission after A&E doctor assessment only have met with a mixed reception in this hospital. While some clinicians welcome the decrease in workload for their junior staff, others have raised objections on medicolegal and continuity of care grounds.

With respect to continuity of care, once the patient has been transferred to a hospital ward, responsibility for care transfers to the specialty team. The specialty team will be unfamiliar with the patient, and if the patient's condition worsens this may delay the appropriate response to the patient's condition. However, if the patient has been clerked in the A&E department by the admitting team, they will already be familiar with the patient's condition and better equipped to deal with the problems presenting on the ward. It may be appropriate for straightforward cases such as fractures to be transferred directly from A&E without prior specialty involvement. However, there could be some risk in admitting the more complex medical or surgical cases without involving the admitting team first–so that they can become familiar with the problem, and not in order to amend or improve the A&E management or diagnosis.

S C BROOKS
Accident & Emergency, Kent and Canterbury Hospital, Ethelbert Road, Canterbury, Kent CT1 3NG