some concerns about the study. I was puzzled why the authors chose to compare the ECPs with paramedics. The roles are entirely different—ECPs are equipped with additional skills enabling them to undertake an in-depth evaluation of a patient and treat them accordingly, leaving them at home where appropriate and without referral to another clinician. I am not aware that paramedics are trained to this level, and therefore I cannot understand how a comparison can be made.

Cooper *et al* also commented on the differences in the chief complaints that the ECPs attended, but surely this is the whole point of ECPs? They are specially trained to deal with minor illness and injury and therefore the response should be directed at these patients in order to ensure maximum benefit from the role. This paper would have been more relevant and interesting if the authors had compared the whole patient episode, rather than part of it. This may have allowed some conclusions to be drawn about the potential benefit an ECP might have for the patient in terms of time saved and appropriate clinical decisions made to avoid the emergency department.

S Mason

School of Health and Related Research, University of Sheffield, and Sheffield Teaching Hospitals Trust, Sheffield, UK; s.mason@sheffield.ac.uk

doi: 10.1136/emj.2005.032243

Competing interests: none declared

Reference

- 1 Cooper S, Barrett B, Black S, *et al*. The emerging role of the emergency care practitioner. *Emerg Med J* 2004;21:614–18.

There is a lack of other professionals for emergency care practitioners to be compared with

I too enjoyed the paper by Cooper *et al*,¹ and I was gratified to see that Suzanne Mason had read the paper and responded. My thoughts on the suitability of the comparison between the paramedic and emergency care practitioner (ECP), however, differ from Dr Mason's. While I accept the comments in her letter with particular reference to the training and education of paramedics and thus their ability to carry out a similar role, I have to ask the question: With whom should we be compared for the purposes of this type of paper?

The role of the ECP is relatively new and, in real terms, a role that occupies a unique position in the National Health Service that comparison with any individual group may well be inappropriate. However, the starting point of paramedics is a valid one, not least in terms of the patients seen in the study.

With the forthcoming completion of the School of Health and Related Research (SchHARR) national study on ECPs, I look forward to seeing some further research and evidence on a broader basis. This will help with the future development of the ECP role across the UK.

M J Bilby

East Anglian Ambulance NHS Trust; mark.bilby@eaamb.nhs.uk

doi: 10.1136/emj.2005.032250

Competing interests: none declared

Reference

- 1 Cooper S, Barrett B, Black S, *et al*. The emerging role of the emergency care practitioner. *Emerg Med J* 2004;21:614–18.

Author's reply: comparison of emerging roles

As the lead author of this paper I was glad to read Mason and Bilby's letters, which clearly add to the debate of how we should evaluate new and emerging roles. To clarify our approach, it must be understood that we were collecting data for this study in 2002, examining the role of four of the first emergency care practitioners (ECPs) in UK. We were asking the question: If you change individuals roles (through training and the system of call out) what difference does it make to their practice?

We took a multi-method approach—that is, we used interpretist approaches (interviews and reflective diaries) and a positivist stance in our comparison of ECP and paramedic roles. This was intended as a comparison—the paramedics were not considered as a “control” in any way. We chose to compare roles, as at the time of the study (2002) the “crew room chat” was all about this new role, with some holding the view that an ECP does little more than a good paramedic. In addition, as we mention in the discussion section of our paper, we may also have found that there was no difference—for example, in conveyance rates (paramedics v ECPs), which would have raised questions about the investment in the role.

The scene now has changed and ECPs do appear to be developing a distinct and unique role, so a comparison with paramedics would indeed now be less relevant. In fact, in some current work we are focusing on the role of ECPs in interprofessional collaboration. In our provisional findings the role appears to be diverse, with many potential benefits for the patient.

S J Cooper

University of Plymouth, Plymouth, UK; simon.cooper@plymouth.ac.uk

doi: 10.1136/emj.2005.032268

Competing interests: none declared

Air ambulances—critical care at the roadside?

We recently had the privilege of attending a national Helicopter Emergency Medical Service forum hosted by chief executives of various ambulance service NHS trusts in Harrogate. We listened with interest as several guest speakers extolled the virtues of their “entirely free” resource in helping to improve ORCON standards. This had been achieved through the “freeing-up” of road ambulances by performing non-time-critical transfers via helicopters and by expediting the transfer of seriously injured patients to local hospitals from incident scenes.

During discussion with speakers and other members of the audience we felt somewhat concerned that the general consensus of this group appeared to be that once a paramedic aircrew had rendered treatment and lifted off to transport the casualty to a neighbouring hospital, the patient had received “optimal care”. Various cases were presented as examples of current practice, including a patient with a serious head injury following a fall from cliffs, a patient with polytrauma and limb amputation following collision with a train, and severely injured patients involved in prolonged entrapments. On questioning by a participant in the audience, members of the forum were unable to identify any specific clinical interventions undertaken at the scene that are known to improve patient outcome in the examples that were presented as model cases. It is widely recognised by clinicians involved in the delivery of prehospital, emergency and intensive care medicine that appropriate, early management of seriously injured patients reduces overall patient mortality and morbidity, with a significant reduction in long term potential costs to the NHS.

We are now all aware of emergent conceptual changes to the way prehospital care is being delivered at the roadside in the UK. Competency based training for prehospital care practitioners is now becoming mandatory to ensure consistent delivery of high standard critical care to seriously injured patients at the incident scene. In this rapidly evolving environment it was disappointing to hear very senior ambulance service staff still unwilling to discuss the importance of both the type and the quality of clinical care actually being delivered to some of the patient groups outlined during the forum.

There now appears to be an obvious divide between air ambulances that continue to be used primarily as an expensive transport medium and those that are striving to improve the level of clinical care afforded to patients before their arrival to hospital. The public, who fund the majority of air ambulances, are currently unaware of the dichotomy that exists in pre-hospital care between geographical regions. However, at an approximate cost of £70 000 per month, an air ambulance is far from a “free resource” and should not be considered as such. Furthermore, the concept of the appropriate manning and tasking of these valuable assets being utilised to clinically benefit patients (such as the paramedic/physician partnership initiative) must surely be explored through the employment of clinical governance and regular audit.

Finally, we are concerned that in regions where advanced levels of competency based prehospital medical care are offered to the public through organisations such as BASICS and primary Helicopter Emergency Medical Services, that by denying patients available resources that could be deemed in court to reduce a patient's suffering, improve their outcome, or prevent their death, ambulance services may be liable to a charge of either negligence or, even worse, corporate manslaughter in future years.

S P Le Clerc

Intensive Care Department, James Cook University Hospital, Middlesbrough, Cleveland, UK

S Masud

The Great North Air Ambulance, Durham Tees Valley
Airport, Darlington, County Durham, UK

Correspondence to: S P Le Clerc, Intensive Care
Department, James Cook University Hospital, Marton
Road, Middlesbrough, Cleveland, TS4 3BW, UK;
drsimonleclerc@hotmail.com

doi: 10.1136/emj.2005.030031

Accepted for publication 14 October 2005

Competing interests: both authors are active members
of BASICS and The Great North Air Ambulance.

CORRECTIONS

doi: 10.1136/emj.2005.023754corr1

In the paper titled, Road traffic injuries in the
elderly (*Emerg Med J* 2006;**1**:42–6) the first
authors name has been listed incorrectly. It

should read W Y Lee. The journal apologises
for this error.

doi: 10.1136/emj.2005.012724corr1

In the paper titled, Cervical osteomyelitis
associated with intravenous drug use (*Emerg
Med J* 2006;**2**:e16) there is an error in the
spelling of the third authors name. The
correct author listing should read G Singh,
R R Shetty, M J Ramdass, P G Anilkumar.
The journal apologises for this error.