A potpourri of news

Geoffrey Hughes

Several items relating to emergency medicine matters have been making the news headlines recently.

PREHOSPITAL TRANSPORT

Prehospital care and transport of patients to definitive care will become a matter of greater significance than it already is if proposed National Health Service reforms of emergency care proceed. There was high profile media coverage of the topic in August, following publication in this journal of a Sheffield study that shows, in certain circumstances, longer travel distances to hospital increase mortality and morbidity.¹

The *Health Service Journal* (HSJ) reports that a charter for air ambulances, adopted by Great North Air Ambulance and the London, Essex and Hertfordshire, and Kent, Surrey and Sussex services, is fuelling debate over the future roles of air and land ambulances.² Four independent air ambulance charities have signed up to a commitment to have "prehospital care doctors" on board, believing they help save lives and reduce the number of costly hospital transfers. The HSJ reports that fewer emergency departments, increased traffic, plus the aim to improve care, will mean a move away from "swoop and scoop" air ambulance services.

It is estimated an on-board doctor costs £300 000 (€445 000, US\$600 000) a year with an annual bill of £7 million (€10.4 million, \$14 million) to fund them on the 23 air ambulance helicopters operating in the UK. All 15 UK air ambulance services operate as charities.

There is a long history of debate about the merits or otherwise of prehospital air transport in the UK, cost effectiveness being the main sticking point. Do you get enough bangs for your bucks? The issue will heat up in the months ahead. Is this a topic for the National Institute for Health and Clinical Excellence to preside over perhaps?

ACUTE STROKE

Acute stroke outcomes improve from the streamlining of specialist services and taking the right patient to the right place at the right time. An honest editorial in the *British Medical Journal*

(BMJ) comments on the UK's poor outcomes for stroke, poor organisational infrastructure and the need for improvement and change.³

In 2006 this journal opined that the College of Emergency Medicine can step up to the plate and take a lead role in responding to the challenge of acute stroke management, making it a top priority on its agenda. There is no time like the present.

PRESCRIBING PROBLEMS

A provocative opinion is published in an August edition of *Pulse* (www.pulsetoday.co.uk), a free newspaper for general practitioners. It publishes an article discussing nurse prescribing, offers some data obtained under Freedom of Information, and also cross references to an editorial in the *BMJ* on the topic.

Hugh McGavock, visiting professor of prescribing science at the University of Ulster and a former member of the Committee on Safety of Medicines, has serious concerns. "Nurses' knowledge of diagnosis is pathetically poor. It takes medical students 5 years to be competent at differential diagnoses. Only a country with not enough doctors would go down this cheapy line." He identifies particular concerns over nurses' use of amiodarone, digoxin, antibiotics, antivirals, calcium channel blockers and angiotensin converting enzyme inhibitors.

It is fair to say that McGavock cannot be accused of sitting on the fence. Readers may also have their own views on some doctors' use of the same drugs.

COST OF STAFF VACANCIES

At some stage in their career most doctors will have worked as a locum and many nurses as an agency nurse. It helps maintain flexibility when studying for exams or domestic circumstances change, earns an income between substantive posts, and allows time out from the rat race. It used to be, and indeed still is, that accident and emergency (A&E) departments are only kept functioning by a steady stream of locum doctors and agency nurses.

Anecdotal known to be expensive, the true cost is uncertain. Locum and agency pay is generally higher than that of a

salaried post but there are fewer, if any, benefits such as superannuation, annual leave and sick pay. From the management perspective they help maintain a service, either long term or short term, but at what cost?

Independent analysts compared the cost of employing doctors through commercial agencies with NHS Professionals, the in-house agency used by more than 60 health trusts.³ It found a locum from NHS Professionals' bank of doctors costs on average £2.40 (€3.55, \$4.80) an hour more than one employed by a medical recruitment agency signed up to the national framework agreement. It works out at £4500 (€6650, \$9000) a year more but the cost difference could spiral to £10 000 (€14 800, \$20 000) should NHS Professionals increase charges to tackle debts. The report also found commercial agencies had higher success rates for filling doctor vacancies and shifts, on average scoring a 61% "fill rate" in 2006-07 while NHS Professionals achieved 35%.

There is no detail about which grades the pricing refers to, nor comparison of agency versus bank nurses, an industrial area that also needs transparent and robust financial scrutiny.

MEDICINE AT THE SHARP END

The journal of the Royal College of Physicians of London, *Clinical Medicine*, publishes two papers of interest to our practice. In a section headlined "medicine at the sharp end" (yes, there are several epithets one can add) a respiratory physician from Birmingham describes how his unit manages their emergency admission workload.⁴ Telling points arise when he writes about the pressure for medical specialties to dissociate themselves from emergency medicine [sic] and also the extreme unease among junior staff about the way their training programmes are advancing.

A London hospital describes how processes from A&E [sic] to their Medical Admissions Unit and onwards to a base ward were streamlined.⁵ They briefly comment on the impact of the 4 h target on their workload but mainly highlight the changes they made to their weekend work patterns, coupled with better access to investigations, specialist teams and pharmacy. They do not comment on any impact these changes had for A&E.

Emerg Med J 2007;24:746-747.
doi: 10.1136/emj.2007.053835

Correspondence to: G Hughes, The Emergency Department, Royal Adelaide Hospital, North Terrace, Adelaide 5000, Australia; cchdhh@yahoo.com

Accepted 30 August 2007

Competing interests: None declared

REFERENCES

- 1 Nicholl J, West J, Goodacre S, *et al.* The relationship between distance to hospital and patient mortality in emergencies: an observational study. *Emerg Med J* 2007;**24**:665–8.
- 2 Stephenson J. Airborne medics save lives claim helicopter charities. <http://www.hsj.co.uk>, 17 August 2007;13, 19.
- 3 Markus H. Improving the outcome of stroke. *BMJ* 2007;**335**:359–60.
- 4 Miller MR. Respiratory services in the context of emergency medicine. *Clin Med* 2007;**7**:325–7.
- 5 Epstein M, Barmania N, Robin J, *et al.* Reforming the acute phase of the inpatient journey. *Clin Med* 2007;**7**:343–7.

IMAGES IN EMERGENCY MEDICINE

Calcaneal fracture with ipsilateral bi-malleolar and fourth and fifth metatarsal fractures

R Ahmad, S Shobaki, S M Y Ahmed

Figure 1 Radiographs showing calcaneal, ankle and metatarsal fractures.

Calcaneal fracture is the most common fractured tarsal bone. The mechanism of injury is axial loading in which the talus is driven into the calcaneus, or a twisting injury. Over

20% of these patients suffer associated injuries of the spine, pelvis or hip.

A 39-year-old man presented to the emergency department with a history of chip board sheets falling onto his

lower leg. The heel was flattened with bruising of the sole. Radiographs of the ankle revealed an intra-articular fracture of the calcaneus with a bi-malleolar fracture of the same foot. Radiographs of the foot taken afterwards revealed fractures of the fourth and fifth metatarsals (fig 1).

This is a very rare combination of foot and ankle injury and we stress the need to inspect and palpate other areas at high risk for fracture, such as the medial, lateral and posterior malleoli, as well as the base of the fifth metatarsal. We also reiterate the significance of Ottawa decision rules for requesting ankle and midfoot radiographs.¹

Emerg Med J 2007;**24**:747.

doi: 10.1136/emj.2006.044537

Authors' affiliations

R Ahmad, S Shobaki, S M Y Ahmed,
Department of Orthopaedics, Weston General
Hospital, Weston-Super-Mare, UK

Correspondence to: Mr R Ahmad, 18 Oakwood,
Coxhoe, Durham, DH6 4SQ, UK; riazhazi@
yahoo.co.uk

Accepted 27 November 2006

Competing interests: none declared

REFERENCE

- 1 Pigman EC, Klug RK, Sanford S, *et al.* Evaluation of the Ottawa clinical decision rules for the use of radiography in acute ankle and midfoot injuries in the emergency department: an independent site assessment. *Ann Emerg Med* 1994;**24**:41–5.