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Screening for hypertension in the emergency department

I read with interest the paper by Fleming et al concerning screening for hypertension in the emergency department. The important public health issues and current emphasis on screening are well illustrated in this paper. However, there is increasing debate concerning the appropriateness of routine enquiry, as debated in the commentary by Lee. If screening for a condition is warranted it should, at least approximately, fulfil the Wilson criteria. The diagnosis of hypertension fails to meet these criteria in a number of important regards.

Firstly, the endpoint of screening is to establish the diagnosis so that prevention of an adverse endpoint is achieved on a population basis. In this paper only 2.9% of the patients’ general practitioners were directly informed of the diagnosis, and there are no data on the clinical results for these patients. The screening has become an end (to achieve diagnosis), not a means. Secondly, systematic testing of a population for hypertension should be performed on a continuous and total basis, and this paper reveals that this is difficult to achieve. Lastly, the case-finding needs to be economically balanced in relation to diagnosis and treatment and possible total health care expenditure, and this is not discussed.

Although universal screening for hypertension in the emergency department may not be appropriate for the reasons stated above, or desirable for reasons related to service configuration, targeted screening for an essentially asymptomatic disease will fail almost by definition. This is not to say, however, that opportunistic detection in the emergency department is not appropriate.

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doi: 10.1136/emj.2005.03536

References

Simpler thrombolysis decisions in patients with left bundle branch block

I read the article by Reuben and Mann concerning screening for hypertension in the emergency department. The important public health issues and current emphasis on screening are well illustrated in this paper. However, there is increasing debate concerning the appropriateness of routine enquiry, as debated in the commentary by Lee. If screening for a condition is warranted it should, at least approximately, fulfil the Wilson criteria. The diagnosis of hypertension fails to meet these criteria in a number of important regards.

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References
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 indepth 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 train with this level of freedom, 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 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 been achieved through the competition 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 therefore their ability to carry out a similar role, I do not accept the comments in her letter with particular reference to the training and education of paramedics and their ability to carry out a similar role. I have asked the question: With whom should we be compared for the purposes of this type of patient?

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 (ScHARR) 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.

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Reference

Author’s reply: comparison of emerging roles

As the lead author of this paper I was glad to read Mason and Bilby’s letter, which clearly adds 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 interpretivist 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 “room chat” was all about this new role, and 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 vs 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.

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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 discharge 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 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 collisions 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 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 bulk of the funding for these services, arise from the dichotomy that exists in pre-hospital care between geographical regions. However, at an approximate cost of £30 000 per month, an air ambulance is far from a “free” resource that should not be considered as such. Furthermore, the concept of the appropriate training 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.

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Reference
Simpler thrombolysis decisions in patients with left bundle branch block

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