Highlights from this issue

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What's the point of ED consultants?

Whilst all EDs are consultant led there is no doubt that for the most part they are not consultant based in that senior doctors are rarely present overnight and during all 'out of hours' periods. Perhaps 'out of hours' is an anachronism for our specialty as the patients still come, and still need help. Traditionally the night and late shifts are not led by consultants, but are there really any advantages to basing a service with consultants on the shop floor overnight? Perhaps it makes little difference? Aruni Sen and colleagues in Wrexham have a service delivery model that does put consultants on overnight and they have clearly shown the advantages of senior presence in the department (***see page 366***). This is really important data that we can use to argue for additional expansion of consultant numbers and I urge you to read this and quote it often.

Zoned out at the front door of the ED

A common suggestion to ED overcrowding in recent years has been the development of rapid assessment areas/zones where early assessment is thought to speed patient journeys and, of course, move departments to achieving their targets. We have instituted similar methods locally and at first glance there seems little to argue with this concept. Interestingly though, we are often told that these are evidence based interventions and that there is overwhelming evidence that they work. If they don't then surely it must be the local clinicians who are to blame…….. I am therefore very grateful to see the systematic review by Bullard *et al* who question the evidence base for rapid assessment and find that the evidence is perhaps not as convincing as it might first appear (***see page 372***). This is essential reading for anyone considering the development or opening of such a unit.

A late result (and it's a draw) on the flu scores of 09/10

The pandemic flu of 2009 seems like a distant memory these days, but I am sure that on reflection most of us will remember the difficulties and anxieties for ED staff at that time. Although the pandemic was much less severe than we feared we do not know when the next pandemic will take place and perhaps now is the time to plan, reflect and prepare. Back in 2009 a number of triage tools were advocated to assess the severity of flu based on little real knowledge of how they would perform. Challen *et al* have put together a prospective study of patients attending EDs in 09/10 that looks at how well the scores performed, and rather worryingly the scores did not do that well (***see page 383***). This does leave the question of what do we use next time we enter a pandemic?

'Fly the patient'

Human factors, non-technical skills….., call them what you will but there is no doubt that people, personality and procedure are factors in almost all medical errors. Our anaesthetic colleagues have appreciated this for many years learning from aviation and training specifically in this area to reduce medical error through human factor training. Emergency medicine, despite being far more complex and prone to problems with non-technical skills lags behind. Bleetman and colleagues give us a brief insight into the models underlying training in human factors and ask us to consider whether this is a core skill for EPs (***see page 389***). I must admit to being a personal convert to this and I agree that this needs to form part of the core skills of emergency physicians. Why? Because I am yet to deal with a medical error that does not involve significant human factors. It is an area that leaves our specialty and our personal registration open to criticism so read on and see if you can recognise similar problems, errors and gaps in your own departments.

PRE-traumatic stress disorder

At a recent conference many delegates were anxious about the impending development of Major Trauma Centres in the UK. We feel the same at local level with all sorts of stories circulating the trust and region. One of our Ophthalmologists was horrified to hear that there would be seven penetrating traumas a week….., until we pointed out that not everything involves the eye! Anyway, there is predictable data out there and we can map the likely workload of the new MTCs. Major Moy *et al* in Middlesborough have done just that and can show that the increase on the MTC in their locality is significant (***see page 404***). While we cannot directly transfer this result to other regions it really does look as though the 1st of April is going to be a significant challenge for our prehospital teams and our MTCs.

An ethnicity difference, but why?

I was interested to read the paper by Wilde and colleagues from Illinois which shows that blacks are less likely to survive prehospital cardiac arrest as compared to whites (***see page 415***). The difference is not only there but really quite large (19.8% vs 26.3%). When adjusted for other factors (eg, age) the difference is perhaps not so great, but still this begs the question of why? They have looked hard to find a reason and it does not appear to be due to differences in interventions by prehospital teams. This is a paper to make us stop and think about what we can do to change this disparity, and an opportunity for us to search for other, as yet unmeasured, reasons for the difference.

Looking east

As the most vibrant economy in the world at the present time it is perhaps not that surprising that the number of papers on emergency care from China is seemingly increasing. This month Xin and Xu from Beijing give us an insight into recent developments around emergency care and research in China (***see page 353***). While there are clearly challenges to conducting research in such a large and rapidly growing country there can be no doubt that the potential for research is enormous. Keep looking East as there is undoubtably more to come from our Chinese colleagues.

Mushrooms of the valley???

Lastly, do check out one of my favourite diagnoses to make in the ED. The Morel-Lavallee lesion is a closed degloving injury that is more common than we think, most commonly seen around the pelvis and knee. Go on, read the paper, make the diagnosis and impress the colleagues.