Primary Survey

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In this edition, the international status of the journal is obvious with papers from around the globe. Europe, Australasia and North America are frequently present, even the Koreans have begun to appear. The Iranians are new and very welcome!

Designing the system

In this edition there is a challenge to think about what we are trying to do in our Emergency Departments. Higginson suggests that, in providing a service, we need to consider our consumer base. I would not have put the airline operation *Ryanair* and The Cleveland Clinic as together as exemplars of a concept but the case for taking such a patient point of view is well made (***See page 3***).

Following on, there are two papers highlighting the potential effect of political drivers on our system. Thompson *et al* describe the change to one Emergency Department's attendance following the change in Primary Care Out-of-Hours care provision at the end of 2004. Whilst there is a careful summary of all the confounding factors that might account for the change, that there is a change in the number of medically sick in the out-of-hours period as a result is compelling (***See page 22***). Jones *et al* show how a change in patient management, by early and prescriptive blood testing based on presenting complaint, to help meet the 4 hour performance target in the English system, created a problem. A positive D-dimer test is only one part of the assessment for pulmonary embolism but, for those with limited clinical experience, a positive test can be difficult to put in context and result in unnecessary admission, investigation and patient anxiety (***See page 43***).

Point of Care Testing

Whilst on the subject of testing, there feels to be a general push to testing at the bedside. As with all developments, there are both strong and weak examples. We have Elkharrat showing that a simple test for tetanus immunity would potentially allow us to be more focussed in our provision of tetanus immunoglobulin and toxoid. How often can our patients actually remember their immune status? (***See page 36***) On the other hand, Biggs *et al* in a very timely paper, show that some bedside testing must be treated with caution. During the early stages of the spread of the pandemic H1N1 (Swine) influenza, containment was attempted and diagnosis was based on formal laboratory confirmation. This typically took 24 hours to report and, certainly based on my own experience, only 50% of suspected cases were ultimately truly positive. This paper shows how an intuitively helpful rapid bedside test would not necessarily be a positive contribution (***See page 5***).

Debunking Myths?

Child protection is a critical responsibility for us all but here, two established "principles" come under scrutiny. Leaman *et al* raise the possibility that an increased frequency of attendance to an ED may not be an indicator of potential abuse (***See page 26***). Kidd *et al* suggest that the typical abuse injury of an oral frenulum tear is often genuinely the result of an accidental mechanism. Identifying abuse is difficult; the importance of having true vigilance and proper safeguarding systems and procedures in place could not be better highlighted (***See page 52***).

New ways of learning

Moharari *et al* describe an attempt to analyse the educational benefit of an Emergency Department "Morning Report". Many of us are familiar with "Board Rounds" and the opportunistic teaching potential that this presents, but to have regular formal sessions and make the effort to assess their value is new (***See page 32***).

With shift patterns and a 24/7 departmental working culture, keeping everybody "in the loop" and feeling that they can contribute is ever more difficult. Reid *et al* describe a very simple and free system that has worked for them. Most people are familiar with on-line user groups, but how many have made full use of the power of the internet like this? (***See page 50***).

The potential power of virtual learning is illustrated by Rickman *et al* who describe a multifaceted educational initiative to improve knowledge and inform the choice of local anaesthetics in their ED. They show what can be achieved but also that people have different learning styles and that a blended approach is necessary to achieve maximum effect (***See page 17***).

At a more practical level, Yang *et al* present a study comparing the value of various simulation models for teaching endotracheal intubation. There is a balance to be struck between the psychomotor skill training and exposure to reality. Simulation is becoming ever more prevalent, but there appears to be no substitute for experience of "real life" (***See page 13***).

Don't always throw away the old in favour of the new?

Harrison presents a case series of three patients with a sudden life-threatening asthmatic episode who were successfully resuscitated by external chest compression and argues that this procedure, often based upon the old style methods of artificial respiration, should be included in the training of first responders. In this evidence-based era, anecdote is not evidence. Having said this, the description and logic are rather compelling! Controversial? See what you think (***See page 59***).