Primary survey

doi:10.1136/emj.2010.107144

Simon Carley, *Associate Editor*

Are you a slow, unproductive emergency physician?

Barely a week goes by without someone in my department complaining about the work-rate of Dr X. Work rate is a difficult measure as it's so multifactorial, but on recently discovering the average work rate of some junior doctors to be less than 0.75 patients per hour I was more inclined to listen to some of the complaints. So, the paper by Vukmir is really interesting, looking as it does at efficiency and value in different US facilities, (***see page 916***). Not only does this give us an insight into the performance of US emergency physicians, it also show that experience is valuable (I like to think of that as a trained senior doctor). Those of you who read the Temple report 'Time for Training', will know that there is plenty of evidence and opinion out there to support the increase in the professionalisation and seniority of ED staff. While as emergency physicians we argue most strongly for the quality argument to support this the funders may be more interested in the efficiency arguments. Vukmir's paper is another argument in this area and we should read the findings with interest.

Managing the legless and potentially (h)armless patient

Like most EPs I've never had to perform an amputation in the pre-hospital environment, but for any of us who respond in support of the ambulance service the possibility remains that we may at some point be asked to do it. Keith Porter, who is somewhat of an expert on prehospital matters, gives us an historical, practical and personal review of the subject and gives us insight into what is inevitably a grisly task, (***see page 940***). I was most reassured that the kit required is quite small and light, and most importantly does not require me to fit the surgical registrar in the backpack. Clearly this is something that is eminently achievable by the prehospital care doctor with a bit of planning and forethought.

Hothead

Interest in new techniques, new technologies and new kit is a characteristic that seems to be very common among many of us in emergency care. I am always interested in trying something new or moving healthcare on to the next level, but we must remember that with new successes comes new risks. A salient lesson for this is the case report by Khan *et al* who describe the use of Quickclot for the control of scalp bleeding, (***see page 950***). The patient sustained a large full thickness burn to the head owing to the exothermic nature of the Quickclot reaction. So, with new techniques comes new risks and the lesson must be to exercise caution and care when using technologies with which we have little prior experience.

Lessons from history

There is some more excellent work from the Sheffield Health Services Research Section looking at the impact of the 4-hour target on patient care, (***see page 921***). Over many years the group has challenged, through high quality research, the structure and delivery of emergency care and again they have produced an interesting and timely study. In an analysis of over half a million patient episodes they find interesting trends in the time to clinician, referral rates, investigation rates and short term admissions around the time of the introduction of the 4-hour target and the use of a minor injury unit. While such interventions have been around for some time it is once again an important time to re-evaluate how we organise and deliver our emergency care at a time when time targets are being removed and quality targets are to be implemented. Will the new targets really improve care or just produce new targets to aim for? Perhaps we may learn from the lessons of history and look to studies like this to guide any future re-organisation.

What's going on in triage

It's good to see some more qualitative research in the journal, the nature and complexity of our work may lend itself to this kind of research more often than we think and it is good to see an increasing number of submissions with qualitative methodologies. This month we have an interesting study from an urban ED looking at the complexities, roles and tasks in the triage process, (***see page 931***). An observational study demonstrates that the triage role is seemingly much more diverse, unpredictable and complex than that perceived by some of the bean counters and performance managers that many of us will have come across in the last few years. This once again shoes the adaptability of our nursing colleagues, a measure that is sometimes difficult to reproduce on a spreadsheet.

It's not cool in the ED

Despite a wealth of TV shows depicting emergency physicians as the coolest doctors in the hospital (personal opinion only) it looks as though we are not prepared to bring our post arrest patients to a similar level of 'cool'. How can it be that an intervention that is evidence based, in the guidelines, and which saves lives is not available in the ED? Dr Galloway, I share your frustration, (***see page 948***).