Highlights from this issue

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Embarking on a New Year brings to mind the drawing of Father Time with his sickle and hourglass walking off the page followed by Baby New Year, clad in a diaper, and top hat. A quick Google search for this image also reveals some recent modifications – Father time is handing Baby New Year a bottle of scotch or a suit of armour saying You're going to need this, kid.' So, although perhaps a happy accident of our publication schedule, this month's issue features three themes of the season: Geriatrics, Paediatrics, and the demand for emergency care.

Addressing demand first, (a demand by the way, due to the excellent reputation of emergency practitioners worldwide) Leung et al studied the impact of physician navigators on emergency physician (EP) productivity. Navigators are non-medical personnel who minimise physician time spent on non-clinical tasks by finding equipment, placing patients in exam rooms, pulling up medication histories, filtering phone calls, and paging specialists. When working with a navigator, EPs saw an additional patient per hour; despite a rise in patient volume during the study period, turn around time decreased by 10 min. Ready to sign up? Me too! But do read the cautionary commentary by Mercuri and Mondoux o reminding us "there are no silver bullets" to meeting demand. An examination of quality must be part of the equation as we increase productivity. Similar caution extends to the use of scribes. In a qualitative study by Cowan and colleagues, EPs who used scribes reported they reduced stress and improved productivity. They also felt that having scribes in the exam room forced them to explain things out loud which also mproved their communications with patients. Physicians who preferred not to use scribes thought they negatively impact the doctor-patient relationship. However, all physicians agreed that synthesizing the case in the chart, before the end of a visit, allowed the EP to think through their care before discharge, and those using scribes missed this opportunity. Once again, no silver bullets.

The silver tsunami is coming. Are we prepared? In this issue we present two studies of older adults that suggest we are not. The **Editor's Choice** is a cluster randomised trial by May *et al*, involving eight EDs. Patients over 65 with suspected long bone fractures were screened for cognitive decline. At the intervention sites, those that met criteria for cognitive decline underwent evaluation using the Pain Assessment Tool in Advanced Dementia. The results? Disheartening. It took a mean of 82 min for all patients in the study to receive pain medication, with no difference between intervention and control sites, even though the intervention site did perform pain scoring more often. Of note 9% of patients in the control hospitals and 12% in the intervention hospitals did not get *any* analgesia. In the end, the authors found that only 263 patients actually met criteria for cognitive decline and here too, there was no significant difference in time to pain medication I leave you to ponder new solutions for this literally age-old problem.

In a close second for Editor's Choice, Harper et al compared two previously validated risk fall risk screening tools for patients older than 65 presenting to an Australian ED with any complaint and found neither tool was sensitive or specific in predicting falls, with positive predictive values of 0.43 and 0.39. This study demonstrates the importance of setting and population in the predictive value of screening tools, and thus how instituting screening programs in the ED may not always be value-added.

Paediatric EM is a relatively new subspecialty in our field, and the PREDICT research network in Australia and New Zealand note that the wide range of paediatric emergency problems makes it difficult to determine where to direct resources for research. Recently they convened a group of over 100 experts to develop a list of the most important research priorities. In the end, 35 questions were prioritised, including the use of high flow oxygen, treatment of sepsis and asthma, and c-spine imaging. Perhaps reflecting the fact that for so long, kids were just considered "little adults", the list is largely clinical, in comparison to the recent priority-setting in the UK for "adult" EM in which half of the top 10 research questions focused on care delivery.

Illustrating the heterogeneity of paediatric EM are two studies at either end of the spectrum, both in age and setting. For those of us working in the western world, severely ill paediatric patients are thankfully uncommon, but in limited resource settings, some of the sickest patients are those under five. In a study from a large Children's ED in Pakistan, Habib and Kahn report 8% of children were triaged as acuity one, with most under five, and nearly half neonates. Overall 13% of patients died *in the ED*, but death rate was highest in neonates (16.5%) accounting for 63% of all deaths. Many patients were malnourished. Most arrived without an ambulance. This is definitely an area where more resources – and research – are needed.

On the other side of the world, Ahmad et al report the outcomes of a US study using Audio-enhanced Computer-Assisted Self-Interview to ask adolescent and young adult patients (15-21) about sexual history and their willingness to be tested for sexually transmitted infections (STI). Of 800 enrolled (1337 approached) nearly half disclosed risky behaviour. aThe computer program identified 419 who should be tested, even though most of these respondents did not have a chief complaint related to an STI. Its not clear if this method is better than personal interviews, but if there is an app for that, this is the age group to use it, and it may appeal to their reluctance for talking about certain subjects with even well-meaning adults.

Is your patient ready for intubation? Have you seen the fasiculations? Is the chest still moving, the jaw slack? In the **Readers' Choice,** Coccimarro et al compared using waveform capnography with physician gestalt to determine when a patient is sufficiently paralysed. Physicians using waveform capnography had shorter time to intubation and a higher rate of first-pass success. It's a small study (100 patients), so no conclusions about safety can be drawn, and there was no objective measure of adequacy of paralysis which could have contributed to the difference in outcomes. Nevertheless, it is a promising adjunct for RSI. Certainly our readers think so!