Pete Driscoll, Jim Wardope, *Joint Editors*

HOW DO YOU MAKE AN EMERGENCY DEPARTMENT QUIET? HAVE A EPIDEMIC OF A FATAL ILLNESS IN YOUR CITY

Papers in this issue from Australia and the United States are comforting to those of us in the UK who sometimes feel that long waits for hospital admission are a problem of the National Health Service, especially when other health systems are held up as examples of how it could be better. Equally stunning is the experience from Toronto during the severe acute respiratory syndrome (SARS) epidemic. Paradoxically the ED seemed to be quiet. On reflection it is perhaps not such a surprise. Patients are often very astute assessing risks and benefits and if the hospital appears more dangerous than their symptoms, they will seek help from other sources. Equally when a health system focuses all its resources on emergency demand and reduces routine elective work it can cope with most disasters in the short term.

Unfortunately quick fixes do not work in the long term. The papers on this subject make gloomy reading but do spotlight some of the root causes of our problems. The answers will not be simple, quick, or popular but urgent choices need to be made by governments to improve this problem.

See pages 400, 402, 406

EXTENDING NURSING ROLES WITH AN EVIDENCE BASE

Emergency department nurses are performing more clinical roles, and often performing them very well. In this issue we bring together three articles that increase the evidence base for nurse interventions. Emergency care has always been a team effort and the *EMJ* seeks to include research by all parts of the emergency care workforce. The papers on nurse initiated thrombolysis and nitrous oxide analgesia show how patient care can be improved by adding specific nurse led care pathways. The paper on the scope of some of these extra skills indicate that extended roles are widespread. Is it time to consider a common structure to the training and competencies of nurse practitioners?

See pages 410, 414, 418

PATIENTS WHO FALL—WHEN TO REFER FOR FALLS PREVENTION ASSESSMENT

Large numbers of patients come for emergency care every day. Can we identify those who would benefit from preventive care? In an earlier randomised trial, the group from King's College Hospital in London showed that intervention to prevent falls does work. In this issue they point out the factors that increase the risk of subsequent falls, thus hopefully allowing us to target the relatively scarce resource of multidisciplinary assessment and intervention.

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DECISION SUPPORT SYSTEMS

Computer assisted clinical decision support systems are seen as a major plank of the UK government's strategy for modernising the National Health Service. However, such systems for real time use in the emergency department have been in existence for over 30 years, so why have they not become widespread? The paper by Graber and VanScoy in this issue gives part of the answer. The ED doctors' diagnosis was only listed in the computer's "top five" of the differential diagnosis in 32%–36% of patients with relatively straightforward problems. Such computer systems can improve the diagnostic accuracy for specified presenting complaints such as abdominal pain but when it comes to the complex process of diagnosis in unselected patients, the training and experience of the ED clinician seems to be the best technology available. It is also gratifying that the authors had so much faith in the ED diagnosis that they accepted this as the gold standard in the study. We do sometimes get it wrong, but not 60% of the time.

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HOW EVIDENCE BASED IS THE TREATMENT OF ACUTE MEDICAL EMERGENCIES?

Hardern *et al* study the evidence base for emergency medical admissions. Their results could be read in two ways. The evidence based purists would argue that only 59% of treatments had a sound evidence base. Pragmatists would argue that 90% of treatments had a sound research base or were accepted practice. Analysis of this gap would be interesting as it could help identify obviously beneficial treatments that would be unethical to test in a trial. Other treatments that are "accepted practice" might well be suboptimal and at times dangerous. A fertile ground for research ideas.

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EVIDENCE BASED EQUIPMENT REVIEWS

Having the right tools for the job makes patient care much easier. However, there is such a plethora of advice on equipment it can be difficult to decide on the best. The paper on spine boards compared with vacuum mattresses adds to the debate on this subject. However, eventual choice will be guided by a host of factors including robustness, ease of application, and cost. We welcome similar articles and hope these will stimulate debate in the letters section.

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SODIUM BICARBONATE FOR TRICYCLIC ANTIDEPRESSANT (TCA) OVERDOSE

This treatment is often recommended for tricyclic overdose but how effective is this treatment. The paper in this issue describes a large series of symptomatic TCA overdose patients. There was an improvement in a small percentage of the patients treated with sodium bicarbonate. The paper is a good example of how an EMS system might have more experience of a specific treatment than any individual receiving hospital.

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