Darren Walter, *Associate editor*

PEER REVIEW – INSIGHT INTO THE DARK ART

Writing a paper for a journal can mean a lot of dedication and hard work only to find that all goes quiet as the journal asks your ''peers'' to review your work. The reports can, on occasion, be less than enthusiastic! Who are these people? Where do they come from? What do they know!?!

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ESCAPEING SAFE PRACTICE?

The multi-centre UK Chest Pain Unit trial, ESCAPE, has finished its data collection and the analysis is starting to come through. CPUs can turn patients around rapidly and make decisions quickly and safely using standardised protocols and exercise treadmill testing for low-risk patients. They work … but how do they match up to conventional care? We need to wait for the next instalment!

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TIMI – WATCH OUT CHAPS!

Risk stratification for acute coronary syndrome is a tricky business. Differences in clinical presentation and the significance of risk factors between the genders raise the question of whether stratification models are both equal and effective between the sexes. The news is not good chaps.

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EMERGENCY MEDICINE DOCTORS AND THAT TUBE

As our speciality comes properly of age and with the development of the College of Emergency Medicine curriculum, trainees are being challenged to demonstrate competencies in areas that have traditionally been the domain of other specialities. Ultrasound has led the way, but the issue of RSI and emergency department airway management has been a topic producing a great deal of heated debate and opinion in the literature over the years. The authors of this paper show that while there has been some development of emergency medicine leadership in emergency airway management, there is still a long way to go. This is an area of urgent challenge if we are going to evolve further and deliver the necessary training and experience to our trainees.

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FORGETTING THE FIRST RULE OF EMERGENCY CARE?

Look after your own safety first! Ask any clinician to describe the personal protective equipment that should be worn to minimise the risk of occupationally acquired infection and there is likely to be a range of answers. Observe real practice and few of us comply with the guidance issued, but this is usually our choice; employers provide and we choose not to use.

We are all familiar with mandatory training to address needs regarded as essential to the running of a system and aimed at dealing with the ''reasonably foreseeable''. In this worrying paper, a healthcare system clearly has some work to do to minimise the risk to its staff and raise awareness about the importance of infection control. An occupationally acquired infection similar to those described is a low frequency but high impact event for both the employee and the system in which they work.

Resources may be scarce, but not all system changes cost money. Neglecting the issue of staff safety is a dangerous course. Rather than being complacent, how confident can we be that our departments will meet their obligations to protect staff? Our colleagues may be putting themselves at risk in the name of patient care. Are we meeting our duty of care to them?

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GADGETS AND TOYS

The Spanish have a wide experience in the use of a novel piece of intubating equipment but it is only now travelling north to UK shores. This case report is a gadget story but it illustrates a sequence of prehospital airway management issues and challenges prehospital providers to think how they might have managed the case within their scope of practice. ''Toys'' are an important part of prehospital emergency medicine and this device may have potential. The challenge has been made, can we determine if it has a place in our kit bags?

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FIERCE AGREEMENT

Planning for controversy and stimulating debate is good editorial practice for a journal. Prehospital emergency medicine has a very weak evidence base and, as the letters here show, there is a fierce agreement that the issue of doctors versus paramedics at scene is riddled with confounding factors and anecdotes in both directions are available in abundance. We all agree on the problem, can we come together and create the critical mass of evidence to provide an answer to the issue?

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PostScript

LETTER

Substance use among those attending an accident and emergency department

We read with interest the letter from Patton *et al* on ''Substance use among patients attending an accident and emergency department''.[1] We have cross-sectional survey data from 2488 patients who attended one of eight accident and emergency departments in Wales. Individuals aged 18–40 years were sent a questionnaire after attending, following an injury at work, a road traffic accident, sports or home injury, or for a non-trauma reason, in the previous 6 months.

Levels of heavy alcohol and illicit drug use were similar to those reported by Patton *et al*[1]: 33% reported drinking more than the sensible weekly limit (14 and 21 units per week for women and men, respectively); 23% reported drug use in the previous year, and 14% in the previous month. There were also univariate associations between reporting three or more injuries requiring medical attention in the previous year and both recent drug and heavy alcohol use (previous month drug use: odds ratio (OR) 1.78, 95% confidence interval (CI) 1.21 to 2.62; previous year drug use: OR 1.64, 95% CI 1.16 to 2.30; alcohol: OR 1.53, 95% CI 1.11 to 2.10). Injuries have multiple aetiologies, and further analyses of this[2] and a community based dataset,[3] controlling for other potential confounding influences, suggest independent associations between drug use and non-work related injuries, particularly among those with higher levels of other injury risk factors.

We therefore concur with Patton *et al*'s recommendation of a brief screening of accident and emergency department attendees.[1] However, since our data also suggest associations between drug use and minor injuries,[2 3] screening those attending the general practitioner and/or practice nurse following a more minor injury might also be appropriate.

Emma Wadsworth, Andy Smith
Centre for Occupational & Health Psychology, Cardiff University, Cardiff, UK

Correspondence to: Dr Emma Wadsworth, Centre for Occupational & Health Psychology, Cardiff University, 63 Park Place, Cardiff CF10 3AS, UK; wadsworthej@cardiff.ac.uk

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References

1 **Patton R**, Smythe W, Kelsall H, *et al*. Substance use among patients attending an accident and emergency department. *Emerg Med J* 2007;**24**:146.
2 **Smith AP**, Wadsworth EJK, Moss SC, *et al*. *The scale and impact of drug use by workers*. London: HSE Books, Health and Safety Executive Research Report 192, 2004.
3 **Wadsworth EJK**, Moss SC, Simpson SA, *et al*. A community based investigation of the association between cannabis use, injuries and accidents. *J Psychopharm* 2006;**20**:1, 5–13.

CORRECTIONS

Walter D. Primary Survey. *Emerg Med J* 2007;**24**:453.

In the July issue, the Primary Survey item headed ''Gadgets and Toys'' refers to the article on page 509 (not 504).

doi: 10.1136/emj.2007.048082corr1

Dibble CP, McHague C. Rapid sequence intubations by emergency doctors: we can but are we? *Emerg Med J* 2007;**24**:480–1.

The journal apologises for an error that has occurred within this paper. The email of the corresponding author should be dibble1@mac.com.

doi: 10.1136/emj.2007.047878corr1

May G, Bartram T. The use of intrapleural anaesthetic to reduce the pain of chest drain insertion. *Emerg Med J* 2007;**24**:300–1.

This Best Evidence Topic Report contained some typographical errors. The dose of local anaesthetic in table 4 (Patient Group column) should be 0.5% bupivacaine with adrenaline (not 0.5% adrenaline). In the Comment(s) section of the text, the suggested repeat doses of local anaesthetic should be given at 8, not 4, hourly intervals.