

There is a subliminal theme to this month's journal content. Many of the papers seem to challenge aspects of accepted clinical dogma. A New Year resolution then; take nothing for granted, the old ways are not always the best ways!

A new idea or simply a new word?

Kilroy starts the ball rolling with a look at the role of competencies in training. The concept seems all pervasive in training circles these days but are we thinking clearly? Does the acquisition of competence equate with professional development? Does either reflect clinical capability? A call for clarity of thought and a revision of the terminology: a return to professionalism with performance and capability (*see page 3*).

Smile, you're on video camera

Spanjersberg and colleagues present the outcomes from a video recording system they used to analyse compliance with guidelines for trauma resuscitation. Some interesting themes appeared from the analysis revealing short cuts and risk taking, definitely opportunities for constructive review and education. It is a Dutch study and there are health system differences but the technology and process are certainly applicable. The research ethics issues were overcome. Perhaps this is worth a revisit as a quality improvement tool? Big Brother could be watching you! (*see page 23*)

Paediatric manipulation

Lloyd and colleagues challenge orthopaedic tradition. For years children with simple fractures that need a manipulation under anaesthesia have been admitted and received a general anaesthetic at some undetermined time in the future. With trauma lists and paediatric anaesthetic

safety limitations, this can be many hours later. Ketamine sedation for suturing in the Emergency Department is now widespread and children are discharged home in a matter of a few hours. Why don't we do the manipulations in the department in the same way? Well ... why not? (*see page 41*)

Special K really is the drug of choice

Yet more Ketamine evidence! A report from the HEMS London team describes over 1000 uses of the drug in the pre-hospital arena with a very limited range of manageable complications. The airway seems to remain safe; RSI skills are not needed as a fall back safety option. Emergence doesn't seem to be a problem but they accept that for this aspect "if it wasn't written down it never happened". I am not sure we can rely on that! (*see page 62*)

What is an acceptable time delay for intervention?

Lloyd and colleagues provide an interesting brief review of their practice in relation to their success rate with reduction of dislocated hip prostheses. There is a clear time benefit to the patient in terms of pain and suffering for early reduction in the emergency department and it is clear that time for general anaesthesia is prolonged. Propofol sedation appear to be a more effective agent than Midazolam for job but the risks and complication rates are not described. Six hours is a long time to be in pain; another case for EM intervention rather than just diagnosing and feeding into the system? We need more information (*see page 39*).

Tending towards the mean

Baskerville *et al* show that whilst the UK moves towards a lower threshold for CT

scanning, our American cousins are realising that the doses of radiation are considerable and recommend that decisions should be informed more by clinical skill than by legal risk and slavish compliance with protocol. They recommend moving towards a higher threshold! With "Actionable Results" and "Emergency Treatable Findings", there is a move for RPA to lead to an ALARA concept. A new language perhaps, certainly an outbreak of new acronyms, but an important message (*see page 15*).

Excess coercive force a can of worms?

Hutson *et al* raise the spectre of evidence of "an excess use of force in the management of detained persons", or Police brutality, appearing in our departments and whether we would either recognise such injuries or report them. This is a very emotive area and are we qualified to define where the threshold for excess lies? At the same time it is potentially a human rights violation so shouldn't we report it? Just how and when would we go about it? If it is real, can we really continue to turn a blind eye? (*see page 20*)

Patients should contribute to textbooks

Guly gives a personal view of an injury and experience of our emergency care system. He raises the interesting question of whether expert patients describing the practical frustrations with our care system should contribute to our standard texts. They say a surgeon should have a major operation to understand their patient's experience, perhaps emergency physicians should ... On reflection, I'll read the next edition of the textbook! (*see page 48*)