

This month's issue has something for everyone, whether it be paediatric or adult, prehospital or hospital, quantitative or qualitative research. Indeed, the range of material presented is a positive reflection of the diverse nature of emergency medicine practice.

## Systems to manage head injuries

Debate continues at local, regional, national and international levels regarding how to best organise systems in order to provide trauma care. Arguments have tended to focus upon the optimal management of patients with head injuries, particularly considering whether the benefits of receiving expert care at specialised tertiary referral centres more than offsets the potential disadvantages relating to delay to treatment caused by transfer times. Sollid and colleagues report on the organisation of services designed to manage head injuries in the Nordic countries. Referring to the Brain Trauma Foundation guidelines, they challenge some current practice whereby a substantial proportion of operations for acute head trauma are performed at hospitals without specialist neurosurgical expertise (*see page 769*).

## Qualitative research made easy

Many emergency medicine practitioners are comfortable with quantitative research methodology, but consider qualitative research to be a mysterious and confusing area. However, a large number of important areas of emergency medicine cannot be easily investigated by standard quantitative methods, but are amenable to qualitative study. So, if the terms 'ethnography', 'grounded theory' and 'phenomenology' do not slip off the tongue as easily as 'randomised controlled trial', why not read the review article by Cooper, Endacott and Chapman? They provide examples of how qualitative research has been used effectively in Emergency Medicine and make a compelling case for its continuing role (*see page 773*).

## Liverpool Care Pathway

There has been a gradual recognition that Emergency Departments play an important and increasing role in the care of some individuals who are dying. A team from Dundee report on their experience when they introduced a modified Liverpool Care Pathway for the dying patient into one Emergency Department. They describe how this multi-professional document which provides an evidence-based framework for end of life care can have a positive effect on Emergency Department patients (*see page 777*).

## Did not wait to be seen

Gilligan and colleagues report from an Irish teaching hospital Emergency Department on what might be considered to be a traditional problem associated with emergency care: patients not waiting to be seen. They examine in some detail the characteristics of those patients who did not wait. Although many who left the department before being seen were assigned to the lowest triage category, the risk associated with failing to receive assessment and treatment remains undefined. The authors demand that "Emergency care must be accessible care" and use their results to call for improved departmental staffing levels during out of hours periods (*see page 780*).

## Magnesium, asthma, evidence and practice

The constant flow of innovations in the practice of emergency medicine, together with the publication of many new guidelines and protocols and lots of excellent research, makes it quite a challenge to keep up to date. Results of a postal survey undertaken by Jones and Goodacre on the use of magnesium sulphate for acute asthma are therefore impressive, in that the clinical leads in Emergency Medicine appeared to be very aware of what could be argued to be a relatively new treatment. In fact, the results suggest that this treatment may be being used even more extensively than available evidence would seem to support! (*see page 783*)

## Lower the bed please!

It is relatively common to observe individuals of short stature on training courses struggling to deliver effective chest compressions to manikins on a trolley of fixed height when there is no stool available to use. Cho and colleagues from Korea investigated the difficulties in adequately performing chest compressions according to various heights of bed relative to the rescuer. They found significant differences in quality of chest compressions according to the relative positions of the bed with the rescuer's knee and use their results to make recommendations about the optimal performance of cardiopulmonary resuscitation (*see page 807*).

## Prehospital paramedic intravenous cannulation

The insertion of intravenous cannulae in the prehospital setting is a frequently performed procedure, so much so that it is now considered to be 'routine'. However, the performance of intravenous cannulation (in any setting) is not without risks for patients, most notably in the form of pain and infection. Siriwardena and team report upon an educational intervention aimed at improving quality and safety in certain aspects of prehospital intravenous cannulation performed by paramedics. Their paper is a good example of how it is possible to complete meaningful research in the relatively difficult prehospital environment (*see page 831*).

## The not so innocuous clavicle fracture

Emergency practitioners are used to treating isolated fractures of the clavicle and understandably regard them as being relatively self-limiting and minor in nature. Indeed, most clavicle fractures are just that. However, there are exceptions and among the case reports this month, Simon Wright presents a patient with a fractured clavicle with an unusual complication (*see page 840*).