Primary survey

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This month we publish several articles that give a theme to this edition of the *EMJ*. They include audits, reflections on clinical practice, a patient satisfaction report and recommendations on the future direction of research strategies. We welcome these types of articles and consider them to be just as important and relevant to our readers as papers that report on primary research, evidence-based decision making or provide an opportunity for personal continuing education.

Reflections from the Orient

Shao and his colleagues from Hangzhou describe the history and current state of the speciality of emergency medicine in China. The focus of their paper is on education and training. Comparisons with the equivalent in countries where the speciality is more advanced and mature will be of interest to many readers. To paraphrase Napoleon's famous old cliché, the sleeping giant is waking up; it will surely not be too long before it is shaking (in a positive way with significant contributions) the emergency medicine world. We welcome this development (***see page 573***).

Prehospital emergency research

The 999 EMS Research Forum provides an important timely commentary (with a web link) on research priorities in prehospital emergency research. In so doing, this journal supports their approach and leadership on this important topic. We recommend that this be a useful, perhaps obligatory starting point for future thinking and activity in this area; in particular we believe that those interested in this area of research must take note and work with their top 10 priority topics (***see page 549***).

How good are we at what we do?

The answer to this question has always been important but in our modern world it is without doubt one of the key questions we all face in proving to the public and our governments that we have and continue to have the skills that enable us to continue practising. Three papers this month reflect a trend in medical publishing we are likely to see more of in the future, namely specific clinical practice audits of discrete professional groups or subgroups. Taking ownership of one's own (or one's workplace) area of practice and analysing performance in this way is a marker of a mature or maturing clinical governance framework and is to be applauded. Once the work is done the subsequent disclosure of the results for public display is to be applauded.

Boyle and his colleagues make a definitive statement that is really self-evident, but despite this it has to be said clearly. Their message is plain and simple, namely that emergency physicians should not interpret CT scans for trauma without extra training (***see page 583***).

The second paper, from a team in Australia, reports that undergraduate paramedic students from two Australian universities are inaccurate at interpreting a variety of common lung sounds. The implications for training programmes are further discussed (***see page 580***).

A study from Singapore reports the results of a patient satisfaction survey for patients admitted to an observation medicine unit. Their key recommendation is that doctors and nurses must improve their communication skills, a facet of care that if done well, improves the quality of care given to patients and improves the patient experience (***see page 586***).

Ultrasound and the acute abdomen

Ultrasound scanning, the modern day equivalent of the stethoscope, is now so ubiquitously performed outside the confines of traditional radiological practise, that some readers may ask why we are publishing a paper on its adoption by a non-radiological speciality. Its usage in emergency departments is widespread and has many indications; in addition to established usage for FAST, scanning of the aorta and the pelvis (in early pregnancy), improving success in vascular access and nerve block procedures and excluding lower limb DVT, other uses are slowly being introduced (eg detection of small pneumothoraces and visualising the mid line of the lumbar spine before doing a lumbar puncture). We think the paper from Sweden, that reports its use by surgeons for the assessment of the acute (non-trauma) abdomen in the emergency department will be of interest and is of importance. Emergency physicians are in a unique position as we interact with all other specialities in a hospital. It will surely not be too long before many of us will have the ability to safely and reliably scan the acute (non-trauma) abdomen, including the pelvis, and provide accurate and reliable information for our surgical colleagues as well as for ourselves. As with the introduction of any new procedure, the crucially important dual development is a robust credentialling process to ensure that the patient (and ultimately the practitioner) is protected (***see page 561***)

Tasers and other things

Bozeman and his colleagues from North Carolina provide some interesting information about the cardiac and cardiovascular effects from a Taser conducted electrical weapon or CEW. They noted an increase in pulse rate and a slight increase in systolic blood pressure but nothing else of consequence (***see page 567***).

A team from Bangkok report their findings, in a prospective observational study, on intubation practice in their hospital (***see page 604***); we have a report from the northwest in the UK that highlights the variation in medical training of firefighters across the whole UK (the authors recommend that a national standard be established) (***see page 601***)and we have our usual set of short reports, emergency casebooks, images in emergency medicine, Best Evidence Topic reports, Emergency Medicine Questions (and their answers) finished off with the snapshot reports of Sophia.

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