Highlights from this issue

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Geoffrey Hughes, *Editor*

A view from abroad

Just as the past is a foreign country where they do things differently, so the definition of what is abroad, where they also do things differently, depends on where you are placing your reference point; one person's abroad is another person's home.

In recent years the *EMJ* has witnessed a slow but steady increase in the numbers of manuscript submissions from outside the UK, most notably the USA, Australia, Turkey, China and other east Asian countries. We are also delighted to see a small but strengthening trickle of submissions from countries where the specialty of emergency medicine is in its nascent or adolescent phases of development. This month several different countries are represented in the EMJ. For those of us working in countries where the specialty is well established and approaching mature middle age, we must remember that we can never stop learning from other colleagues' experiences and practices.

Nigeria

A study from Abuja, the capital of Nigeria, describes the characteristics and capabilities of its 24 emergency departments. The hospitals they were based in ranged in size from 6 to 250 beds; all EDs were open 24 h a day, all saw adults and children and they had a median of 1500 annual attendances; 4% had dedicated CT scanners, 25% had cardiac monitoring and none had negative pressure rooms. The report concludes by asking some pertinent questions about the future of emergency care provision in the whole nation and not just Abuja ***(see page 798)***.

South Africa

This stunningly beautiful country has a tradition of producing clinicians who have considerable experience in managing trauma patients with both blunt and/or penetrating injuries. Despite this long track record the specialty of emergency medicine is new there. How is it going? A paper originating from Cape Town (but authored with collaboration from the USA), reports on the procedural competency of the first 30 graduates from Africa's first emergency registrar training programme. The authors raise some interesting questions about the governance of similar nascent training programmes ***(see page 822)***.

Trinidad and Tobago

For many of us, the dilemma as to whether patients' relatives should be allowed in the resuscitation room during an active resuscitation was resolved many years ago. Mahabir and Sammy, from Trinidad and Tobago, discuss the views of 214 staff who responded to a questionnaire on this topic. The results are interesting; 64% felt that staff performance would be inhibited by the presence of a family member, 71% felt that the resusciation would be prolonged and 72% felt that it would increase staff stress ***(see page 817)***.

End-of-life care (Belgium and France)

The quote on the front of this month's journal says that end-of-life management must be improved in EDs. An analysis of the deaths of 2420 patients who died in 174 French and Belgian EDs discovered that palliative care was given to about half of all patients dying in these EDs. The authors conclude by giving us the aforementioned quote ***(see page 795)***.

How do we make decisions?

It is easy to stereotype the personality traits of the members of the different specialties that make up the medical profession. Many of us will recall the sometimes cruel and sometimes judgemental comments made by one specialty about another. I can clearly recall an eminent plastic surgeon in London telling me (slightly tongue in cheek) that if he ever felt insecure about his suturing expertise he found that a visit to an orthopaedic theatre to watch wound closure always made him feel better. A renowned professor of surgery used to opine that a physician's ward round was similar to a clinical sign for ascites—shifting dullness.

How do emergency physicians make decisions? Are we experiential (fast and intuitive) or are we rational (slower and systematic)? Calder and her colleagues in Canada (where the specialty is mature) attempt to answer this question ***(see page 811)***. Based on a sample size of 434 responses to a questionnaire survey (46.9% response rate) they conclude that overall emergency physicians favour a rational decision making style and that female emergency physicians had higher experiential scores than males. Make of that what you will.

And finally…

We have the usual assortment of short reports, best evidence topic reports and the regular monthly musings of Sophia. As always we hope you enjoy this month's edition of the EMJ.