We begin this primary in an unusual way, by pointing you to this month’s View from Here. There are a number of published and quite poignant accounts by physicians of what it’s like to put on that backless hospital gown and become a patient. The story in this issue is different—it is an account of an emergency physician finding himself ‘on the other side of the curtain’ as his wife is treated for an emergency. This is not a story that criticises or praises our care, but rather one that reveals the emotions of those whose lives can be irreversibly changed by the outcome of their loved ones. Above all, it’s a reminder that we have a duty to our patients and also to their families, to provide information, reassurance (when appropriate) and empathy.

After you’ve read this, we’d suggest you move on to two related papers that demonstrate the fact that the art of medicine is alive, well and as essential as ever. In the Editor’s Choice, Babl et al validated the Nexus II guidelines for head injury in children, modifying it by removing the unintended consequence of decision rules. Prior studies have shown that most elderly patients who attend the ED in fact do have an emergency and often need admission. But could these emergencies have been prevented? Croft et al use a novel approach to understand the missed opportunities in the system for elderly patients to avoid an ED visit. Looking at data from Hospital Episode Statistics for 18 departments, they found a high admission rate (34.3% to 40.9% across facilities) for elderly patients. Moreover, they determined that over a third of these admissions were for potentially avoidable conditions. Although the proportion of short-stay admissions was lower than in younger persons (28.3% vs 51.9%), avoidable conditions were associated with 42% of short-stay admissions in the elderly. While it’s clear that many elderly adult patients require ED visits and admission, this study suggests that there may be opportunities to avoid some of these attendances, while improving overall care of this population.

Oligoanalgesia in the ED is a well-documented problem, but now Kant and colleagues from Australia have conducted an intriguing study that asks Analgesia in the emergency department: why is it not delivered? In this prospective study, the authors determined if patients with a triage pain score ≥4 received pain medications; if they had not, the nurse caring for the patient was asked to choose one or more reasons from a list after the patient left the ED. Two days later, the investigators called the patients asking whether their pain was treated, reason for not receiving pain medications and satisfaction with pain treatment. Overall satisfaction with pain treatment was higher in those administered medications, whether or not they were aware they had received any. Over one-quarter of patients did not receive analgesia, and of these, (only) 17.5% agreed with nursing the medication was refused. Perhaps the most interesting finding is that, among patients who did not receive pain medication, satisfaction with pain treatment was similar whether they refused medications or did not get it for other reasons.