



## Highlights from this issue

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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 age criteria. The gold standard was a CT for those who received one, or 30-day follow-up for those who did not. (Indeed differential verification but scanning everyone would have been unethical and expensive.) The rule performed very well; no patients were missed. But the physicians performed equally well; they too did not miss any patients with significant intracranial injury. However, the physicians scanned fewer patients than the rule suggested. They were equally sensitive but more specific, and saved some of these children unnecessary scans.

Our Expert Practice Review, by Mason and colleagues, demonstrates another unintended consequence of decision rules. This review summarises the evidence on the management of patients taking

warfarin who sustain minor head trauma. Current decision rules do not address this population, as patients on warfarin were excluded from the derivation studies, yet due to a perceived increased risk of bleeding for this group, most guidelines suggest that all of these patients should be scanned. However, observational data from a large UK study suggest that patients on warfarin presenting after minor head trauma with normal mental status do not have an increased risk of bleeding compared with those not on warfarin.

Edward Carlton and I reflect on the roots of these 'side effects' of decision rules and guidance, and the implications of these findings for medical decision-making in general in an accompanying editorial.

Two other studies examine the use of the ED by populations at either end of the age spectrum. A systematic review of parents' reasons for bringing their child to the ED nicely summarises data from a number of prior studies, including some in *EMJ*, showing that the most common reason parents bring their children to the ED is... they think the child is having an *emergency*. Parents also perceive ED staff as having expertise with children. Being unable to get a timely GP appointment is another common reason (which reinforces that they are worried the problem can't wait). Yes, some find it more convenient to attend after hours instead of missing work, and some think it's faster, but these turn out to be less common motivations for bringing a child to the ED.

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  $\geq 4$  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 that 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.