Primary survey: highlights from this issue

doi:10.1136/emermed-2023-213404

Ellen J Weber, *Editor*

Much needed attention is being focused on disparities in healthcare delivery and health status, issues that were highlighted and exacerbated by the Covid pandemic. Emergency medicine has historically acknowledged its disparities in treatment for pain related to age and race but less on the effects of language and culture. This month's Reader's Choice and Global abstract is from Australia, where Chen *et al* compared the management of non-serious back pain given to culturally and linguistically diverse (CALD) populations and non-CALD patients. Despite similar triage codes and diagnoses, CALD patients were more likely to be imaged and admitted, even if an interpreter was used. Pain management also differed: CALD patients were less likely to receive weak opioids, although opioid management n general was equivalent. The increase in admissions and imaging (the latter being discouraged in management of non-serious back pain) suggests a discomfort with the certainty of the diagnosis by physicians, even when an interpreter is involved. The significance of the opioid differences is unclear, but the main point is that systematic differences in care were found which do not appear to be related to severity of condition.

Our editor's choice, by Romeu *et al*, reveals low confidence among prehospital providers in caring for patients with self-harm, citing a lack of sufficient training in this area. Although a small sample, the study likely reflects wider discomfort in both the prehospital and ED setting regarding both self-harm and other psychiatric presentations. As our Decision Editor Aileen McCabe writes in the accompanying editorial, psychiatric emergencies are increasing, and this area should probably take more precedence in our curriculum and in our CPD courses.

Coverage of COVID-19 continues. Even though it is no longer high on our anxiety list, there is much to learn from the pandemic. During the first surge of Covid, EDs worldwide went surprisingly "quiet". This phenomenon has been variously attributed to decreases in injury due to lockdowns, and less illness due to fewer gatherings and wearing of mask as well as fear of getting Covid. However, it may also be evidence for a potential discretionary component in patient decisions to attend the ED. Serendipitously, in 2019 Calastini *et al* had performed a population-based study on ED use and saw the opportunity to learn something from the pandemic by repeating the survey in 2020. Indeed, reluctance to attend the ED was largely due to fear of catching Covid, with people weighing the risk of Covid against their perception of the seriousness of their emergency. More people surveyed during the pandemic who had used the ED said they would have sought an alternative than those attending in 2019. While this may suggest some visits are unnecessary, the discretionary component has a flip side: a number of people with serious sounding complaints did not attend when they likely should have.

Several decision scores were developed during the pandemic to help physicians determine either who had Covid, and also which Covid+patients needed admission. We now have rapid tests, but the need for better prognostication in Covid+patients remains, as we struggle to both preserve hospital resources and admit those who will need intervention. Marincowitz *et al* retrospectively compared several Covid specific and more general risk scores, as well as physician gestalt, for their ability to predict the occurrence of intubation or non-invasive ventilation, death or intensive care unit admission at 30 days from presentation. PRIEST performed better than the other scores, but physicians were more sensitive and specific than all scores. Use of any of the tools would have doubled admissions. You might want to have another look at our prior editorial on the unintended "side effects" of decision rules.

ED patient satisfaction surveys unanimously show that what patients most dislike is waiting. The time is filled with a mixture of anxiety, impatience and boredom. In the language of LEAN engineering, waiting time is usually "muda" – the Japanese term for waste. But it doesn't have to be this way. The authors of this month's Concepts

article suggest how we can use this time to educate our patients, keeping them entertained during the waiting period rather than focusing on time passing. The challenge, I think, is designing just the right tools that are both relevant and engaging.

Take a close look at this month's Sono Case Series on using POCUS to diagnose appendicitis in paediatric patients. Perfecting this skill could really help expedite flow and perhaps avoid unnecessary radiation in these children.

There a number of other interesting studies (eg, on pain, frailty, the HEART score) in this issue but I would like to use the remainder of this Primary Survey to thank two associate editors who this year are stepping out their major editorial roles for good reasons. Simon Carley who has been with the journal for over 15 years has stepped down as Associate Editor to step up to his role as Dean of the Royal College of Emergency Medicine. Caroline Leech, an Associate Editor for 8 years, has received funding to pursue her research interests. We wish them both a successful journey ahead. We remain with a stalwart crew of Associate Editors – Rick Body, Edd Carlton, Mary Dawood and Sarah Edwards, our social media guru. And of course, our devoted and highly talented decision editors. Nevertheless, we are always happy to hear from potential new members of our team.

ORCID iD
Ellen J Weber http://orcid.org/0000-0002-0094-1973