12 Commandments of Emergency Medicine

What follows has unashamedly been adapted from an article by Smith, Higginson, Daly et al and published in the EMJ in 2008. The authors have given me their permission to pass it on to Nelson ED house surgeons.

Commandment 1: Turning up to work

You are a professional. Be on the shop floor when your shift is due to start, dressed and ready for action, not coming through the door needing a shower after your cycle ride to work. Dress in the way that patients expect doctors to dress, and wear sensible shoes. Shorts, bare midriffs, and miniskirts are not appropriate attire in the ED. If you are male, either have a shave or have a beard. Scrubs are appropriate and are available in the ED. Don’t take them home with you.

Don’t go home until your colleague on the next shift has arrived or until told to do so by the senior doctor on duty. Work with a full tank and an empty bladder. Take your breaks but don’t get lost during them. Don’t leave the department at night without informing the nurse in charge.

If you are sick let the house surgeon coordinator (weekdays) or ED senior (weekends) know as soon as you know, not just before your shift starts. Let us know when you are likely to be fit to return.

All roster changes need to go through the house surgeon coordinator.

Commandment 2: Treat patients as you would like to be treated yourself

Wear your name badge and introduce yourself, being polite to all patients and relatives (despite occasional provocation). Avoid transmitting infection: have bare arms below the elbow and wash your hands before and after every patient contact.

You need to learn to assess patients rapidly without taking short cuts, and if you can genuinely say that you have treated every patient to the best of your ability, you will sleep with an easy conscience. However, do not take risks with patients’ lives. They may only have a 2% chance of a myocardial infarction but would you be prepared to take that degree of risk if you were the patient?

Do not ration pain relief; there is plenty to go around. If treatment needs starting, go ahead and start it. Arrange suitable patient admission or discharge, and appropriate follow up. Consider where a patient lives before asking them to return for review.

Ensure that patients understand the advice you give them, documenting the advice you have given, and give written advice when available. Warn patients about possible complications from either their injury or treatment. Don’t let your professional standards slip for those who have sustained an injury as a result of inebriation or as a result of engaging in illegal activities. Even if a patient has attended inappropriately, point out the error of their ways politely.
If you make a mistake, apologise (and mean it). If you make a big mistake, speak to the duty SMO.

**Commandment 3: Treat other members of staff as you would like to be treated yourself**

If you treat a colleague, they must be booked in and treated in exactly the same way as any other patient.

Dispose of all sharps in the yellow bins; do not cause a needlestick injury to another member of staff. Clean up after you have finished, as the nurses are not your handmaidens (or whatever is the male equivalent). If you would like someone to do something in the resuscitation room or observation area, speak to them in person. If you can’t find a nurse speak to the coordinator.

If you find a piece of equipment that isn’t working, report it so that it can be fixed or replaced. If you use the last spatula or speculum, report it so that supplies can be topped up. Keep the department tidy; if you see rubbish on the floor, pick it up and throw it in a bin. If there is blood on the floor or trolley, report it so it can be cleaned up appropriately.

Where relevant, keep the nurse in charge informed with regard to your patients, for example if you have referred them, or if they are sick and need urgent treatment.

When answering the telephone don’t just say “hello”. State your location and then your name e.g. “Emergency Department, Dr…… speaking”.

**Commandment 4: Work efficiently, and don’t be afraid to multitask**

See patients in the correct order; do not cherry-pick. If there is something interesting in the resuscitation room, go and learn, but don’t hang around if it isn’t your patient. If you have paged someone, you can do other things whilst waiting for a call back. You can see other patients whilst waiting for x-rays.

You should be able to see at least three minor patients per hour. Social chat is fine, but not when the department is busy and patients have been waiting hours to see you.

**Commandment 5: Some patients are there to fool you**

You need to be cautious when seeing certain groups of patients, as many before you have made (at times, fatal) errors. Be particularly vigilant when seeing elderly patients with abdominal pain, loin pain (you think renal colic, they may have an abdominal aortic aneurysm), acute confusion or collapse, and atypical chest pain. Beware of patients you diagnose with constipation, especially if they are elderly (see above). Remember the intoxicated patient with a head injury sometimes has a significant intracranial problem. Patients who can’t communicate because of language or other difficulties need special attention.

Beware those patients who look sicker than you expect, as they usually are. If a patient is in more pain that you would expect, or can’t weight bear when you expect they should, you have probably missed something.

Patients don’t always have a single injury, and remember to examine the joint above and below an injury. When examining limbs, compare left with right but
beware the bilateral injury. Don’t forget that there may be a medical reason for the fall that caused the injury.

Patients don’t read textbooks. Atypical presentations are common and it is common to see rare things in an ED. Have an enquiring mind, or you will miss occult pathology such as child abuse, elder abuse, and artefactual disease. Some other important reminders are listed in Table 1.

Table 1: points to remember

- A normal ECG does not exclude ischaemic heart disease
- A normal CT does not exclude sub-arachnoid haemorrhage
- A normal X-ray does not exclude a fracture in a patient in whom you have high clinical suspicion
- The presence of chest wall tenderness does not exclude myocardial infarction nor PE
- Just because someone says they are not pregnant doesn’t mean they aren’t

Commandment 6: Seeking advice

The ED SMO’s are available for advice, but it will help you learn if you have a coherent differential diagnosis and provisional management plan ready. Don’t seek advice without first seeing the patient, as the advice is likely to be: “see the patient”. Notify the senior doctor about any problems, both clinical and administrative. If we don’t know about problems, we can’t solve them. Seek advice from the senior ED staff before you refer to other teams, and when you phone other teams, always be polite, even if provoked. It is possible to be both polite and assertive. When you phone other teams, be clear whether you are asking for advice, or making a referral. Don’t accept advice when you think you should be making a referral. If you have asked advice, record who you have spoken to and what they said. If you have asked for advice, it is usually wise to follow it; don’t cruise until you get the advice you think you wanted in the first place. If you are offered advice without asking for it, there is usually a reason. If an experienced medical or nursing colleague advises you to do something, think VERY carefully before ignoring that advice.

Commandment 7: Investigations

For the ten commandments of emergency radiology, see Touquet et al., 1995 (1).

With regard to performing blood tests, don’t do a battery of investigations in the hope that one of them will be abnormal so you can admit the patient. Don’t do a coagulation screen unless it is needed, don’t do a D-dimer without doing a pre-test probability first, or do a CRP unless you really think it will change management. Adopt Bayesian thinking and perform a test only when it will alter the pre-test probability of a disease. If you don’t know what Bayesian
thinking is, ask. Have a very low threshold of doing a pregnancy test on female patients aged between 12 and 50. If you do blood cultures make sure you take enough blood, and if you ask for an investigation, it is your responsibility to check the result.
Take care when taking blood (especially for cross-matching). Check the patient’s identity from their wrist band. There is a policy for labelling samples from unidentified patients.

**Commandment 8: Paperwork and documentation**

Write legibly, printing the date, the time, your name and your designation every time you write in the notes. Keep your notes in the proper place, and don’t leave them lying around. Ensure an electronic discharge is typed and “finalised” for all discharged patients and print out a copy for the notes. When you write to the patient’s GP, ensure that you include all relevant information such as what you have prescribed. Write concise and focussed notes; patients with sprained ankles do not need a three page clerking, but complex patients in the majors area may do.
Take great care over the words “Left” and “Right” and do not abbreviate them.

You or your SMO may have to write a report, or defend your actions, based on a patient’s clinical notes. If you don’t document it, it didn’t happen.
Remember to document what was said during telephone calls. For patients who allege they have been assaulted, remember that you may have to prepare a police report based on your notes.

**Commandment 9: Prescribe properly**

Use UPPER CASE for legible prescriptions. Check doses in MIMS if uncertain. Check for drug interactions and contraindications (especially in pregnancy, renal and hepatic disease). Avoid non-steroidal anti-inflammatory drugs (NSAIDs) in the elderly, in patients with ischaemic heart disease, and in patients on warfarin. Prescribe oxygen (in appropriate doses), particularly in COPD patients. On the ED record write what you have prescribed, e.g. diclofenac 50mg tds for 5/7, not “NSAIDs”.
Do not self prescribe.

**Commandment 10: Seeing children**

When seeing children, always document who attends with the child, what their relationship is with the child, and who gives the history. If they present with an injury, carefully document how the injury is said to have happened, and who witnessed it. Always consider child abuse, and if you suspect it, seek senior advice. Use caution when prescribing for children, and prescribe the dose according to weight. Do not do the calculations in your head – write them down.

**Commandment 11: Referrals**
When writing an x-ray form put adequate clinical information on it. We have the benefit of knowing the history and performing an examination, our radiology colleagues do not. Help them to help you by succinctly stating what happened and appropriate exam findings.
Discuss patients with an SMO before sending them to an outpatient clinic. We have defined pathways for patients with DVT and corneal foreign body (and soon cellulitis) that see these patients managed in the community after their initial ED visit.

**Commandment 12: Targets**

We live in a target-driven world. Emergency Departments have national and local targets to meet, not only administratively, but also clinically. These targets often relate to clinical standards and best practice, such as giving pain relief to patients in pain. It is your responsibility to help us achieve the targets that relate to Emergency Medicine while working in the ED. Do not sit back and look at the Category 2 chart in the box. Pick it up and see the patient – the 5 minutes you spend writing another patients notes may be the difference in failing to meet the 10 minute timeframe we have to see that patient. Don’t do tests in the hope of finding something abnormal, and don’t arrange ED follow up to avoid making a diagnosis.

Patients should be assessed for pain, and given pain relief if necessary, on arrival in the ED. If this has been omitted when you see the patient then rectify it as soon as possible. Give antibiotics as soon as possible to septic patients – if in doubt then discuss with the SMO.

**References**


