

## Do's and don'ts of emergency medicine: a primer for residents

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After 23 years of practising emergency medicine at both tertiary care and community hospitals, there are a few things I'd like to share with you. Many pearls have come from working alongside some superb emergency physicians — watching them practise and interact with patients and allied health personnel in the emergency department (ED).

I've learned important lessons from my mistakes, and from the mistakes of colleagues. Sitting in on dozens of morbidity and mortality rounds and being a medicolegal expert on numerous cases has afforded unique opportunities to see the most common and most serious mistakes we make. This list of do's and don'ts contains some of my favourite pearls. It is by no means comprehensive, and is not written in priority of importance. I hope it helps you to become better and safer emergency physicians.

### Lessons learned

#### 1. *Don't ignore abnormal vital signs.*

The child who is tachypneic may have pneumonia, despite the absence of a cough. The patient who becomes hypotensive following a traumatic injury is probably not having just a vasovagal episode. Don't assume anything and don't ignore anything.

#### 2. *Don't take shortcuts on the physical exam.*

It is impossible to pick up a small petechial rash in an infant with a fever unless you undress the child. If you don't take off the underwear of a young male with abdominal pain, you may miss the strangulated inguinal hernia or the testicular torsion. Many zoster eruptions have been missed simply because the skin was not examined under the shirt or dressing gown.

#### 3. *Don't wait for consultants to give antibiotics to sick patients.*

Pneumonia and meningitis are serious diseases that kill. If you think a patient may have meningitis, give antibiotics first and do the lumbar puncture later. If you think an elderly person has pneumonia, give a big dose of an IV antibiotic as soon as possible; it doesn't really matter so much what antibiotic you give, just give something.

#### 4. *Don't be the health care police.*

It is important to be somewhat familiar with the cost of tests that you order and be conscious about appropriate resource utilization. However, if you think a test is appropriate, order it. Don't let your imaging or laboratory colleagues dissuade you from ordering a test you need, just because it's going to inconvenience them.

#### 5. *Don't use "pink ladies" to rule out myocardial infarction.*

The Canadian Medical Protective Association can give you a list of patients with missed myocardial infarction (MI) who were thought to have esophagitis or gastritis simply because they had burning esophageal pain that was relieved by a "pink lady" in the ED. Remember, if you give 10 patients with a confirmed MI some arsenic, 3 will feel better. Relying on a "pink lady" to rule out myocardial ischemia is dangerous practice, and if you do it, you will end up a medicolegal statistic.

#### 6. *Don't be afraid to wake up a consultant.*

Certain things cannot wait until morning. Testicular torsion, ovarian torsion and any other kind of vascular catastrophe are all examples where you need to wake

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up your colleagues, even if they give you flack over the phone, with the usual “Can't it wait until morning?” Your quality of care should be just as good at night as it is during the day.

**7. Do pay special attention to the very young and very old.**

People at the extremes of ages are at high-risk for serious disease, don't manifest the same signs in serious diseases and must be assessed thoroughly and repeatedly. The newborn infant with a fever has meningitis until proven otherwise. The elderly patient with severe abdominal pain has either an ischemic gut or abdominal aneurysm until proven otherwise. The absence of fever or high white blood count in the elderly does not rule out urosepsis.

**8. Do pay special attention to the intoxicated patient.**

Both the history and the physical examination in an intoxicated patient are completely unreliable. Over-investigate these patients and remember that, to rule out subdural hematoma in an intoxicated patient, one CT scan is better than a room full of neurologists.

**9. Do get second opinions / consultations if you have concerns or doubts.**

If a patient is just not fitting a typical pattern, and if you can't get a sense of what's going on — ask someone. You may be tired, not thinking of something or simply haven't considered a particular diagnosis. Don't let your pride get in the way of asking for an opinion from a colleague or a staff physician.

**10. Do treat pain early and aggressively.**

If there is anything that we should do well in the ED, it is to treat pain. This is where we show our empathy and our compassion. Don't forget to do the simple things that relieve pain, such as ice and splinting, and do give opioids intravenously rather than intramuscularly.

**11. Do communicate well with patients.**

More likely than not, your patients are going to remember very little of what you say. Tell them what you're going to do, why you're doing it, and how long the process will take. If they've been waiting a long time for test results, go back and tell them why things are taking so long. Patients just want to be kept informed about the causes of the delays.

**12. Do communicate well with families.**

Families can be a great source of information about the patient's behaviour, especially for patients presenting with headaches or neurological symptoms. The only clue that you're dealing with a brain tumour — even when the neurological exam is completely normal — may be a family member telling you that the patient is “not quite right” or that he's been a bit confused over the past few weeks.

**13. Do treat each other with respect and courtesy.**

I believe there is no more stressful nursing job than ED nursing, and that there is no more stressful medical work than emergency medicine. We need to treat our coworkers with respect and courtesy to help make our workplace as healthy as possible.

**14. Do compliment your coworkers.**

Everyone needs positive feedback. The nurse who triages a patient well, starts an IV quickly, or gives you a good update on an ill patient should be complimented on his or her skills.

**15. Do consider the worst possible disease for every complaint.**

The 50-year-old man with abrupt onset of a severe headache has a subarachnoid bleed — not a migraine — until proven otherwise. The 50-year-old with severe epigastric pain has an infarct until proven otherwise, and the 80-year-old with severe abdominal pain has an ischemic bowel until proven otherwise. Have a wide differential and make sure that your documentation reflects that you considered the most serious of your differential diagnoses.

**16. Do get trauma patients to trauma centres early.**

In trauma cases, don't bother ordering tests that will only be repeated at the trauma centre, or will unnecessarily delay the transfer. Talk to the trauma team leader as early as possible.

**17. Do give blood early in trauma patients.**

As a general rule, no one will fault you for giving blood too early, but plenty of people will fault you for giving blood too late. You need to recognize the subtle signs of shock, and don't be afraid to give either type-specific or O blood.

**18. Do keep patients in the ED if they can't drink or eat.**

Patients who have been assessed and observed for ab-

dominal pain or vomiting should have a trial of fluids in the ED to see if they can keep fluids down. If they can't, don't send them home.

**19. Do order pregnancy tests for women with abdominal pain.**

You don't want to miss an ectopic pregnancy. Order a pregnancy test for all women of child-bearing age who are suffering from abdominal pain or have non-specific complaints of nausea, dizziness and syncope.

**20. Do regional nerve blocks for facial lacerations.**

If you want a good cosmetic outcome on the patient's face, you must avoid infiltrating lidocaine locally and distending the tissues, which can alter the cosmetic results. Learn to do supraorbital, infraorbital and mental nerve blocks.

**21. Do watch a patient walk, if they have any dizziness or CNS symptoms.**

Brain stem and cerebellar infarcts can be subtle. Always watch a patient walk during the final part of

your neurological examination.

**22. Do make sure that patients understand your discharge instructions.**

State your instructions clearly and slowly and, at the end, ask your patients and their families, "Do you have any questions for me?" You don't want your patients going home feeling that they didn't have every opportunity to ask questions.

**23. Do ensure follow-up for every patient.**

Make sure that all the patients you see know what to do if their symptoms persist, return or get worse.

Many of you will have your own list of pearls. If so, please pass them on to physicians more junior than yourselves, so that your knowledge and experience helps shape and mold future generations of great emergency physicians.

**Competing interests:** None declared.

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