Clinical Pearls In Emergency Medicine[1]

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The practice of the art of Emergency Medicine is like that of other specialties. It is learned over time, patient by patient. It has often been said of Emergency Medicine "that you are only as good as the next patient" since we don't have patients that we follow year by year. The expert Emergency Physician is one who has many patient encounters and can quickly recognize the ill patient, especially uncommon presentations of illnesses or unexpected problems. The "sixth sense" used to identify serious illness is an acquired skill, one that comes from years of clinical care. It can never be learned by those reticent or reluctant to see patients!

The following list of selected clinical pearls was prepared by Hamilton et al.[1] with some additions by WK. Reviewing them is a worthwhile exercise.

A. The New Rotation in the Emergency Department

1. Respect is earned.
2. Befriend, through a show of respect, your nursing staff.
   (I overheard one nurse tell a new resident once that this could be one of the most enjoyable months of the year or she could assure him that she would make this month pure hell for him; reader take note)

B. Maximizing Patient Satisfaction with Your Care

1. Avoid medical jargon
2. Learn how to tell a patient you don't know what's wrong.
3. Let the patient know that he/she is always welcome to return.
4. Admit an error of judgment or procedure immediately when it occurs. One lie always leads to another, and sooner or later the truth will find you out.

C. Minimize Patient Dissatisfaction

1. One hour feels like three behind the curtain.
2. A companion makes the wait less unbearable.
3. Give the patient an estimate of the time needed to complete the evaluation and try not to underestimate. Significant delays require an honest accounting.
4. If there is a long delay, consider patient comfort in the form of pillows, stretcher, food, etc. Also suggest that those waiting for the patient go for food, etc.
5. Patients don't understand the way we give care and often perceive the process as chaotic. We think that patients understand because it is straightforward in our minds. Explain that first we must do the evaluation in the form of history taking and physical, then we do the appropriate testing (lab and X-rays etc.) and finally we will discuss the results and plan a course of action. If consultants are to be called, explain what needs to be done before calling them. Patients often complain by saying "if they had only called (consultant) two hours ago we would not have had to wait this long!"

D. You are the Patient's Advocate

1. If you must err, err on the side of helping the patient.
2. Respect the patient's need for privacy.
   (It is not always true that the person waiting with the patient in the exam room is family or a close relative. The next door neighbor may have brought the patient to the E.D. and undressing the patient in front of him/her may be embarrassing for everyone)
3. Always consider the "costs" of your interventions both from a financial and discomfort perspective.
4. Don't negotiate any medically important interventions with a patient with an altered sensorium or a child.
5. If a patient is a source of potential harm to himself or others, or cannot take care of himself, he must stay for observation or admission.

6. Physical restraint may be necessary and appropriate to protect the patient or emergency department staff.
7. Do not discharge a now "sobered" patient who has recovered from acute alcoholism without performing a repeat history and physical examination.
8. Anxiety and hysteria are diagnoses of exclusion.

E. Clinical Judgment

1. When the clinical impression does not fit the history,physical examination or laboratory evaluation, STOP! Rethink and expand the differential diagnosis.
2. If the patient can't walk, he can't go home.
3. If the ancillary data (laboratory tests) do not fit the clinical picture, reconfirm the accuracy of the data before making treatment or disposition decisions.
4. If you seriously consider a specific diagnosis when working through a differential diagnosis, then you should rule it out with the appropriate tests.
5. If you don't know what to do- follow instructions. If you still don't know what to do- do nothing, then get someone else to help. Observe the patient carefully for the evolution of the disease process instead of gambling on a marginally indicated therapeutic intervention.
6. Always assume that females of childbearing age (menarche to menopause) may be pregnant, and act accordingly.
7. The patient who returns to the E.D. on an unscheduled basis should always be assumed to be a high risk of serious illness.
8. Abnormal vital signs must be repeated and explained!
9. A patient who won't look at you during the exam is usually either depressed or manipulative. Almost never is such a person shy.
10. Patients usually have one major medical problem for each decade of life after the age of 60.
11. Never completely trust a young child, a geriatric patient, an alcoholic or a drug abuser. That is, corroborate the history and carefully interpret the physical findings in each of these patients.
12. Listen closely to the suggestions of patients and their families about what is wrong and how they should be treated. Often the patient knows what is wrong with him/her long before you do. They may even have been told by another physician!
13. "All crocks die of organic disease."
14. If after the initial history, physical and ancillary tests you don't know what's wrong with the patient, you probably won't figure it out by ordering further tests. You are wasting your time and the patient's money. Get someone else to see the patient.

F. Special Clinical Encounters

1. Since the eye is to see, always record its acuity.
2. Always confirm an Accu-check© with a blood glucose level.
3. Multiple drug allergies often correlate highly with functional or psychogenic complaints.
4. Speak to children in language they can understand.
5. Just because a person is old, don't assume they are hard of hearing. Just because they are old doesn't mean that they have abdicated decision making to their children.
6. Allow at least one parent to stay in the room with a child during your initial exam. Observing the child's interaction with the parent is an important part of the evaluation.
7. Children are rarely hypochondriacs.
8. When you hear hoofbeats, think of horses except when in a Zebra watering hole.

G. Avoid Supporting the Legal Profession

1. If you didn't write it down, you didn't do it.
2. Don't think you are going to win just because you are right.
3. Protect yourself by protecting the patient.
4. A printed form never saved anyone.

5. One of the most hazardous moments in emergency medicine is "signing out" patients to a colleague at the end of a shift. A complete and accurate exchange of information and impressions is necessary.

H. Destroying Your Credibility

1. Subvert the call schedule or be chronically late.
2. Yell at someone.
3. Give an opinion before examining the patient.
4. Treat a number or a disease, not the patient.
5. Miss the lectures without an excuse.
6. Show disrespect for the nurses, clerks or taps.
7. Be reticent to see patients.
8. Be argumentative with faculty, consultants, other residents, or nurses.

I. Your Mental Health

1. Every physician has moments of self doubt.
2. There is always a disposition (no one is left in the E.D. from last year!)
3. If you find yourself becoming frustrated or angry with a patient, step away for a while. Anger and frustration must not be allowed to influence your decision making process.
4. If possible, try to take a brief break(15 minutes) away from the E.D. during each long shift (12 hours).

J. Do's

1. Meet every patient turned over to you at the change of shift- preferably within 15 minutes of shift change.
2. Respond to complaints as quickly as possible to avoid irreparable damage.
3. If there is a squeaky wheel, oil it. You will get no rest until you do, regardless of the cause.
4. Always see and interpret every test yourself. (Goes for X-rays, CTs etc.) Don't rely on someone else to report the results. You are responsible and liable!
5. Have fun during your Emergency Medicine rotation. You will see a lot of patients, do a lot of procedures, and learn a lot of medicine. At the end of the month- you will be a better physician! Really!

K. Don'ts

1. Never say: "There is nothing wrong with you".
2. Don't expect patients to remember verbal instructions or information.
3. Do not try to weasel out of responsibility when you blew it- admit the error, apologize and get on with life (remember Richard Nixon!).

1. (Partially Excerpted, edited and adapted from Emergency Medicine: An Approach to Clinical Problem Solving, Hamilton et al, Sanders 1991)