The Ten Commandments of Emergency Medicine

INTRODUCTION
Emergency physicians approach patients differently than their counterparts in other specialties because of time constraints and because they deal with critically ill patients without the benefit of an ongoing relationship. The potential for error is therefore great. We developed the following ten commandments of emergency medicine to help others avoid these errors. We believe that remembering these commandments could improve patient care, physician-patient relations, and risk management.

SECURE THE ABCs
The emergency physician should initially direct attention to the patentcy of the patient’s airway, the adequacy of the patient’s breathing, and the assurance of cardiovascular stability. Securing the ABCs in every patient every time is essential, whether the patient appears to have trivial complaints or is severely ill.

We have expanded the ABCs to ABC2DEFG. The steps represented by the letters A through E are well understood by emergency physicians. “F” stands for fetal heart tones because the vital signs of a pregnant patient are not complete without listening for fetal heart tones. Likewise, in pregnant patients, the need for rhogam (the first “G”) should always be considered. The second “G” represents the guard rails on the stretchers, which are all too often left down. Even alert patients may roll off a bed; the elderly or confused patient is guaranteed to “go to ground.” Emergency physicians are often the worst offenders when they leave the bedside after examining a patient.

CONSIDER OR GIVE NALOXONE, GLUCOSE, AND THIAMINE
The need for naloxone, glucose, and thiamine (NGT) should be assessed in every patient with altered mental status. A single 2-mg IV dose of naloxone almost never causes toxicity in an adult emergency department patient. Blood glucose should be assessed immediately by an accurate and rapid fingerstick method, or D5W should be administered in the rare event that a fingerstick blood glucose cannot be performed. Rapid IV administration of 100 mg thiamine has been demonstrated to be very safe and should be provided to any cachectic or malnourished patient, including all chronic alcoholics, patients with malabsorption or cancer, and young patients with AIDS or anorexia nervosa.

GET A PREGNANCY TEST
Because the reproductive, contraceptive, and menstrual histories of patients in their child-bearing years are unreliable, it is necessary to consider obtaining a pregnancy test in every patient who has a functioning uterus. It is difficult to treat most complaints of reproductive-age women if their pregnancy status is unknown. Likewise, inappropriately obtaining radiographs in patients who are pregnant can be dangerous. The easiest way to rule out an ectopic pregnancy in the ED is with a pregnancy test.

ASSUME THE WORST
We must always rule out the most serious potential cause of a patient’s symptoms and be certain that adequate attention has been given to the most catastrophic probabilities, even if they are unlikely. Then, and only then, can we ascribe a patient’s complaint to a less severe and more likely possibility.

One of the most insidious serious errors is to diminish the magnitude of the patient’s complaint. Often this happens because there is peer pressure to not admit patients. At other times, a patient’s complaint is downplayed because of a negative attitude toward his “emotional overstatement” of pain. During the initial evaluation, we should take all complaints at face value and not make subjective judgments. It is a bad idea to project our expectations onto our patients.

DO NOT SEND UNSTABLE PATIENTS TO RADIOLOGY
Portable radiographs are not as good as radiographs performed in the radiology department. Radiologists, however, do not treat unstable patients as frequently as do emergency physicians. Their skills may be rusty, and life-saving drugs and equipment may be inaccessible in the radiology department. Unstable patients who must have films in radiology must be accompanied by a person trained to manage their condition should it deteriorate.

LOOK FOR THE COMMON RED FLAGS
Because the ED evaluation of a patient must take place quickly, it is important to keep some recurring “red flags” in mind. First and foremost, there are the four vital signs; all four must always be evaluated, and any abnormal vital sign must be explained in writing. Emergency physicians must be careful in interpreting axillary and oral temperatures that may be misleadingly low. Orthostatic blood pressure and pulse measurements must be considered in any patient at risk for volume depletion or acute blood loss. Orthostatic vital signs, however, are never indicated in a hemodynamically unstable patient.

Second, age, especially extremes of age, should alert the clinician to the presence of potential comorbid conditions. The presence of HIV risk factors is another red flag that signals the need for an aggressive workup. HIV risk factors are present in all socioeconomic levels and ages. Emergency physicians must ask the “em-
harrowing” questions about sexual preference and activity as well as those concerning the use of illicit drugs.

Third, any unscheduled return to the ED for the same complaint is another red flag. The initial problem may have been inappropriately or incorrectly treated, and for patients to be seen again in the chaos of the ED setting gives special significance to the complaint.

Last, there are three questions that must be asked of every ED patient; a negative answer to any one represents a red flag. First, “Have you ever had this complaint before?” If the complaint is new, it clearly requires a different approach diagnostically than if the complaint is chronic. Second, “Can the patient take adequate nutrition by mouth?” and third, “Can the patient walk?” If the patient is unable to provide for himself but could previously, he should not be routinely discharged home.

TRUST NO ONE, BELIEVE NOTHING (NOT EVEN YOURSELF)

Errors are often made when we depend on assumptions. Important decisions must be based on facts, not hearsay or someone else’s perception that is presented as “fact.” A physician’s or nurse’s words are not a substitute for written medical records. An ECG or radiographic report is not a substitute for viewing the tracing or film.

This commandment is also meant to be a caution against blind trust in the expertise or opinions of others. It is always comforting to have the advice of a subspecialist, but emergency physicians must remember that they often know the most about the patient at that time.

It is important to keep an open mind. Many of our worst errors have occurred when we adopted a mindset about the patient and refused to let other opinions or data change our initial perception. Emergency physicians should not be afraid to ask for help or admit uncertainty. Family, friends, nurses, and medical students often provide very cogent observations that can positively alter the course of the patient’s illness. No advice should be rejected out of hand; hubris is a physician’s worst enemy.

Institutional tradition and lore are areas that commonly introduce an element of bias. Institutions tend to become inbred. There is often more than one way to approach a specific complaint, and old traditions die hard. Lore must be validated by the scientific method. Always maintain an element of skepticism about old adages or new trends.

LEARN FROM YOUR MISTAKES

We all make mistakes of varying severity, regardless of our level of experience. The key to dealing appropriately with mistakes is not to deny them but rather to embrace them and learn from them. It is not healthy to dwell on mistakes; it is healthy to use a mistake to become an expert in a particular area. No one is immune to mistakes. As a colleague, it is also incumbent to not be too judgmental. We should learn from each other’s mistakes, not use them to impugn one another.

DO UNTO OTHERS AS YOU WOULD YOUR FAMILY (AND THAT INCLUDES COWORKERS)

When confronted with a difficult decision or an ethical dilemma, we should consider how we would like one of our family members to be treated. Patients are not the enemy. At times they may have habits or behaviors that we do not like, but every patient must be treated within the context of his illness. Unfortunately, the illness may have many comorbid contributors, including psychiatric disease, addiction, family problems, and job stresses. Our lives are molded by stresses. We are here to treat, not to judge.

The “do unto others” commandment also applies to coworkers. Treating colleagues, interns, residents, nurses, aides, emergency medical technicians, and secretaries with respect should be integral to our approach. Treating anyone with disrespect might return to haunt you.

WHEN IN DOUBT, ALWAYS ERR ON THE SIDE OF THE PATIENT

There is no getting away from an element of uncertainty in medicine, particularly in emergency medicine. As physicians, our ultimate goals should be relief of symptoms and optimal patient outcome. When significant uncertainty exists, emergency physicians must be sure that their decisions take into account the potential for a bad outcome. We should always err in a way by which the patient will suffer the least. Decisions to admit or discharge, perform another test, or call a consultant should always be made with the patient’s best interests and safety as the major deciding factors. Our ultimate goals should not be to save money, keep hospital beds open, or protect our peers.

CLOSING THOUGHTS

These ten commandments are an outgrowth of our experience as emergency physicians. As with the original Ten Commandments, no one will be able to observe all of them all the time. There are probably many examples of exceptions and additions to these commandments. Exceptions are fine, as long as they are made with awareness. The number of exceptions any physician makes should relate directly to his level of expertise. We welcome input on what we may have overlooked. It is our belief that keeping some form of these ten commandments in mind will prevent mistakes and improve patient care and satisfaction.

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