The Derriford twelve commandments of emergency medicine: a model for good practice in a changing world, or a survival guide for new medical staff

J E Smith, I Higginson, H R Guly, I C Grant, P Belsham, A Hicks, D Alao, D Boon

ABSTRACT
Time is a precious commodity and with more junior doctors coming through our departments for shorter periods of time it has been useful to lay down some ground rules to facilitate their induction. These are presented in the form of the twelve commandments of emergency medicine.

The emergency department (ED) at Derriford Hospital in Plymouth sees approximately 85 000 patients every year. We have doctors of various grades and experience, with (at the time of writing) 41 new junior doctors passing through our department on rotation every year, spending between 4 and 6 months with us. Time for induction is precious and we have found it useful to set out some ground rules for practising emergency medicine. These are given to the junior staff at induction in the form of the twelve commandments of emergency medicine.

Advice has been given in the form of commandments before, notably with regard to emergency radiology and for the North American and Australasian ED. However, the practice of emergency medicine may vary in different countries and we felt a set of commandments relevant to UK practice would be of benefit. We hope they prove useful for other departments facing the task of keeping patients safe, staff happy and a department functioning smoothly.

COMMANDMENT 1: 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 cannot 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 than you would expect, or cannot weight bear when you expect they should, you have probably missed something.

Patients do not 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. Do not forget that there may be a medical reason for the fall that caused the injury.

Patients do not 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 box 1.

COMMANDMENT 2: SEEKING ADVICE
The ED middle grades and consultants are available for advice, but it will help you learn if you have a coherent differential diagnosis and provisional management plan ready. Do not 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 do not know about problems, we cannot 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. Do not accept advice when you think you should be making a referral. If you have asked for advice, record who you have spoken to and what they said.

If you have asked for advice, it is usually wise to follow it; do not canvas opinion 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 3: INVESTIGATIONS
For the 10 commandments of emergency radiology, see Touquet et al.1

With regard to performing blood tests, do not do a battery of investigations in the hope that one of them will be abnormal so you can admit the patient. Do not do a coagulation screen unless it is needed, do not do a D-dimer without doing a pretest probability first, or do a C-reactive protein unless you really think it will change management. Adopt Bayesian thinking and perform a test only when it will alter the pretest probability of a disease. Have a very low threshold of doing a pregnancy test on female patients aged between 12 and 50 years. If you do blood cultures make sure
Box 1 Points to remember

- A normal electrocardiogram does not exclude ischaemic heart disease
- A normal computed tomography scan does not exclude subarachnoid 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 pulmonary embolism
- Just because someone says they are not pregnant does not mean they are not

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 should be a policy for labelling samples from unidentified patients.

COMMANDMENT 4: 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 do not leave them lying around. Complete your notes when you discharge the patient and discharge them on computer at the same time.

Take great care over the words Left and Right, and do not abbreviate them.

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.

You or your consultant may have to write a report, or defend your actions, based on a patient’s clinical notes. If you do not document it, it did not 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 5: PRESCRIBE CORRECTLY

Use UPPER CASE for legible prescriptions. Check doses in the British National Formulary if uncertain. Check for drug interactions and contraindications (especially in pregnancy, renal and hepatic disease). Avoid non-steroidal anti-inflammatory drugs (NSAID) in the elderly, patients with ischaemic heart disease and in patients on warfarin. Prescribe oxygen (in appropriate doses), particularly for chronic obstructive pulmonary disease patients. On the ED record write what you have prescribed, eg, diclofenac 50 mg tds for 5/7, not NSAIDs.

Do not self-prescribe.

COMMANDMENT 6: 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 7: USE THE CLINICAL DECISION UNIT APPROPRIATELY

Many departments now have a clinical decision unit (CDU) with short-stay beds. Remember a CDU is a clinical decision unit, not a clinical indecision unit or a “can’t decide” unit. All patients admitted need to be discussed with a senior ED doctor and need to have appropriate admission and pathway documentation completed. The CDU is not an excuse to avoid referral to inpatient teams, or for inpatient teams to avoid admission. Patients who are unlikely to be discharged within the designated time scale (48 h in our department) are not suitable for the CDU, which usually means that patients with underlying complex medical problems are not suitable.

COMMANDMENT 8: TARGETS

We live in a target-driven world. UK ED 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.

As a result of a national government target, patients should be registered, assessed, treated and either discharged or admitted within 4 h of arrival in the ED. The only exceptions are patients who need to remain longer for clinical reasons. To help achieve this, refer patients as soon as you know it will be necessary and do not wait for the results of investigations if they will not change anything. If you do not know what to do with a patient, seek advice from one of the ED senior medical staff. Do not do tests in the hope of finding something abnormal, do not admit to the CDU to avoid a decision and do not arrange ED clinic 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.

COMMANDMENT 9: 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 a UK ED. If you are a man, either have a shave or have a beard.

Do not go home until your colleague on the next shift has arrived or until told to do so by the senior doctor on duty. Try to work with a full stomach and an empty bladder. Take your breaks but do not get lost during them, particularly at night, and inform someone if you leave the department.

If you are sick let the department know as soon as you know, not just before your shift starts. Let us know when you are likely to be fit to return.

Follow the department procedures for booking leave and swapping shifts. Rosters are uncompromising things and need to be carefully worked out in advance.

COMMANDMENT 10: 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: follow trust policy with regard to infection control (for example, 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 round. 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. Do not 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 consultant.

**COMMANDMENT 11: 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 there to clean up after you. If you would like someone to do something in the resuscitation room or majors area, speak to them in person. If you cannot find a nurse speak to the coordinator.

If you find a piece of equipment that is not 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 replenished. 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.

When 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.

**COMMANDMENT 12: WORK EFFICIENTLY AND DO NOT 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 do not spend too long if it is not your patient and others are waiting. If you have bleeped someone, you can do other things while waiting for a call back. You can see other patients while 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.

**SUMMARY**

Although these commandments may not be applicable to all ED, we hope this paper may be of some use to, or at least strike a familiar note with, the readers of the EMJ. Feel free to borrow them, or modify them, as you see fit.

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**REFERENCES**

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