What to do about psychological distress in emergency department senior house officers?

The article by McPherson et al. raises some interesting questions concerning disproportionately high levels of psychological distress among emergency department senior house officers (SHOs). The combination of shift work, a challenging working environment, and new acquired decision latitude may explain the findings.

We did have some reservations about the article. We are unfamiliar with the general health questionnaire (GHQ) and brief COPE questionnaire. A more detailed description and explanation of terms would have been valuable. We felt that SHOs on nights should have been included to reduce sample bias. Confining the study to units based in district general hospitals raises questions regarding generalisation. It would have been interesting to know the degree of shift floor senior cover in the units studied, and to examine whether this influenced distress levels.

How can we apply this useful work to our own practice? If we acknowledge the core finding, and accept that there is a problem among our junior colleagues, we then need to ask whether intervention is required. SHOs are required to have regular contact with a consultant supervisor, but there is potential tension between the roles of supervision and support. Formal mentoring schemes offer an alternative, but their value in the emergency department has been questioned. It may be that the best way to support SHOs is to be aware of their potential vulnerability to psychological distress, and to encourage a team based and pastoral atmosphere within our departments. This will permit doctors recognising a need for support to seek it out for themselves, from people who they feel are appropriate for the problem in hand. This is the approach we have, in the past, taken within our own unit. However, as a response to this article we will incorporate a session on stress management into our SHO teaching, in conjunction with administration of the GHQ and brief COPE... once we find out more about them.
Contact lenses can compromise the corneal epithelium and act as pathogenic vectors, facilitating the development of bacterial keratitis. Most corneal abrasions heal quickly when treated with topical antibiotics, which act as lubricants and antimicrobial agents. However, in contact lens wearers there may be rapid progression to corneal scarring or even perforation.

Two patients with contact lens related corneal abrasions, who were initially treated with topical fusidic acid or chloramphenicol, have presented with corneal stromal abscesses. The abscesses developed 12 hours and three days respectively after diagnosis of simple corneal abrasion. Visual acuity was perception of light and hand movements. Both required admission for intensive topical fortified gentamicin and gutaec cephalosporin.

Pseudomonas aeruginosa and proteus were grown, which were resistant to chloramphenicol and fusidic acid. Best corrected visual acuity was 2/60. Resolution of the infections; one patient has proceeded to corneal grafting. After 15 years of study in resistance in bacterial isolates from corneal scrapings found that 30.4% of isolates were resistant to chloramphenicol (54% of Gram negative organisms), with a significant increase in resistance during this period. Once microbial keratitis is established, a combination of topical fortified aminoglycoside and cephalosporin or fluoroquinolone is indicated; no trend for increasing resistance to these antibiotics was observed in the aforementioned study.

Contact lenses are the most important risk factor for the development of bacterial keratitis. In the emergency department, a history of contact lens wear should be sought, with urgent review of worsening abrasions. We advise that all contact lens related red eyes should be referred to the ophthalmology department, as clinical signs may initially be subtle and corneal scraping may be warranted. Time to commencement of guttae oloxacine with the first sign of infection, may greatly reduce the chance of poor outcome.

Contributors
Sharron Quinn treated the second patient, reviewed the literature and wrote the paper. Jeffrey Kwartz treated both patients and contributed to the discussion of core ideas. He was the supervisor and is the guarantor.

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References
The limitations of the medium are inherent to all books that profess to teach radiology: particularly in an A5 format large radiographs are reduced to small pictures in which the detail is lost. This may be one of the reasons why the section on head computed tomography is so effective: the pictures are about the same size as the original films. For me, however, there is no substitute for handling and examining the real thing. Until digital radiology finally arrives in the south west of England, that is.

Sudden death and the myth of CPR

Most emergency physicians will sometimes recognise a feeling of futility during cardio-pulmonary resuscitation (CPR)—the algorithm is followed despite the fact that most of those present know the attempt is doomed to failure, or frankly inappropriate.

Stefan Timmermans is a Belgian healthcare sociologist who spent time in American emergency departments observing the rituals surrounding CPR. His book questions the notion of CPR for all, and the over-optimistic programme of surveillance out of hospital cardiac arrest that is portrayed in the media, and by some medical authorities. The book describes the attitudes and feelings of doctors, nurses, and paramedics, their definitions of good and bad resuscitation attempts, and the way in which they feel constrained by guidelines and lawyers.

The chapters are wide ranging and include the evolution of resuscitation techniques, death awareness, and what constitutes a “good” death, as well as discussion on advance directives and the presence of relatives during resuscitation attempts. The author divides resuscitation attempts into four distinct cases or trajectories, which should be familiar to all practising emergency physicians: the legal death trajectory, where resuscitation is performed mainly as a legal matter; the elite death trajectory where the victim is presumed to have high social viability and receives aggressive resuscitation irrespective of clinical viability (for example, the young); the temporary stabilisation trajectory, in which the patient is resuscitated despite the fact that the short term prognosis is poor; and the stabilisation trajectory, in which prompt resuscitation leads to a better outcome.

The book is written from a sociologist’s perspective, and therefore does not aim to provide answers—just observations. Yet despite the North American setting, it raises questions that are highly applicable to UK practice, and this book should be required reading for all ALS providers.

Handbook of paediatric emergency medicine

Knowledge is a process of piling up facts; wisdom lies in their simplification. Martin Luther King, Jr (1929–1968)
Upwards of two million children will attend accident and emergency departments in the United Kingdom every year. Many thousands more will attend general practice for advice or treatment after acute illness or injury. Large numbers of practitioners in many different specialties therefore need to be prepared to deal with children with a variety of urgent and emergency conditions. As an old Chinese proverb states “Small children do not pretend to be sick”. The problem is that the vast majority of children have minor to moderate illness, much of which is self limiting. Indeed many of the injured children require little more than symptomatic relief and general supportive care.

The problem therefore is identifying the wheat from the chaff. In other words, how does one identify the critically ill child, or the child who is brewing something serious? Age and experience help. Certainly knowledge is useful. More often the wisdom of Solomon is required. There is no doubt that experience brings greater wisdom, and with it ability to deal with children effectively. I suppose that is really what I like about this book. The authors have brought their collective experience and wisdom, gathered over the years (I am not brave enough to state how many, but I know it is considerable!) to produce an extremely readable text that is well laid out and well presented. The salient features are highlighted in boxes and the use of diagrams is good. I personally would have liked to have seen more radiographs and clinical pictures, but then again this may not be the purpose of a handbook. This may best be left to a colour atlas, or better still actual clinical practice. Computed tomograms of the head are poorly incorporated. It would be churlish to let these overlooked points round off each chapter, and the recommended further reading is appropriate and proportionate.

A number of the cases bear upon emergency care and many are set in the resuscitation room. The importance of securing the ABCs is emphasised before discussion of theoretical concepts, not always the case in books of this sort. This reflects the interests of the authors, many of whom are active in education at the interface between intensive care and emergency medicine. Relevant cases include burns, trauma, and overdose, but pyrexia is included uncomfortably in the chapter on status epilepticus. The chapters are up to date; the roles of inhaled nitric oxide and prostacyclin in ARDS are set out.

And there is a review of the evidence on non invasive ventilation in COPD. Activated protein C is (to this reviewer at least) a very new treatment in septic shock, and its brief mention is testimony to the book’s contemporariness. The Swan Ganz catheter is placed in its correct context, alongside alternatives including the pulse induced continuous cardiac output monitor. I was also pleased to see the role of corticosteroids set out in accordance with current thinking on the treatment of sepsis.

This reviewer has an aversion to diagrammatic representation of pulmonary physiology, lung capacities, closing volumes, and zones of perfusion. The authors avoid such esoteric concepts, and there is no assumption of knowledge of molecular biology in the chapter on sepsis and multiple organ failure. Cardiac care is the major omission from what is otherwise a reasonably broad based content.

Trainees in intensive care medicine from all parent specialties will find this a useful and accessible resource. It sets out to present a consensus approach to common clinical problems, and is not a comprehensive textbook. For any specialist registrar about to start a secondment in the ICU this little book would be a good investment.

Core cases in critical care

In 230 pages and a few monochrome illustrations this paperback covers the top 20 critical care cases that a doctor must be aware of in every intensive care unit. The authorship is a reassuring collection of UK intensivists, a who’s who? of the Intensive Care Society. I liked the standardised format; case histories and clinical questions are followed by discussion of the main issues with reference to pathophysiology, treatment options, and outcome. A panel of key learning points rounds off each chapter, and the recommended further reading is appropriate and proportionate.