# Primary survey

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Steve Goodacre, *Editor*

## Keeping the customer satisfied

The main, and slightly uncomfortable, conclusion from the study of patient satisfaction undertaken by Walsh and Knott seems to be that the longer patients are in our emergency department the less satisfied they are. Perhaps that is inevitable. Suffering a medical emergency is no sensible person's idea of a good time, so our role is to ensure that it is as quick and painless as possible. In this respect the study offers some helpful pointers. Noise levels, trolley comfort and food quality were rated as being important by patients but associated with lower levels of satisfaction. Maybe it's a sign of age (or a cheap stethoscope) that I feel very sympathetic about the noise issue (***see page 821***).

## Are emergency nurse practitioners quicker than doctors?

If shorter length of stay improves satisfaction then the study by Considine, Kropman and Stergiou suggests than patients managed by emergency nurse practitioners are likely to be more satisfied that those managed by doctors. Median emergency department length of stay for non-admitted patients was 1.7 h for those seen by emergency nurse practitioners, compared to medians ranging from 2.1 to 2.7 for various grade of doctor. Is this evidence that experienced nursing staff are more efficient than their medical colleagues, or is there a confounding factor? There seem to be some strong opinions about this on the medical internet discussions. Thoughtful comments are welcome though the EMJ rapid responses (***see page 838***).

## Intensive care for asthma

Endotracheal intubation for children with severe asthma must be one of the most nerve-wracking procedures anyone can perform. Recognition of failing medical treatment and willingness to intubate can be life-saving, but the procedure itself is high-risk and challenging. This is shown in the data presented by Deho and colleagues who report that 36 out of 51 children intubated for acute asthma experienced one or more complication during intubation or the early phase of mechanical ventilation. These included 27 cases of hypotension and 20 cases of severe bronchospasm (***see page 834***).

## Diagnosis and management of syncope

Syncope is a common presentation to the emergency department with a variety of causes relevant to different specialities. Tattersall and Reed studied 540 patients admitted to hospital after an episode of syncope and found that a diagnosis was made in 33 (85%) of the 39 patients admitted to cardiology compared to 239 (61%) of the 392 patients admitted to general or acute medicine. There was also greater use diagnostic testing for those admitted under cardiology. This could suggest that the emergency department was doing its job properly in getting the right patients to the right speciality. Cardiac causes of syncope, such as arrhythmia and severe aortic stenosis, are more likely to benefit from treatment and thus require more detailed investigation and definite diagnosis (***see page 870***).

## Do patients know how much paracetamol they can take?

Wood and colleagues undertook a survey of 910 emergency department patients to test their knowledge of whether various over-the-counter medications included paracetamol and what the maximum daily dose of paracetamol was. Rather worryingly, only 54% of the 853 respondents knew the correct maximum daily dose, although more reassuringly most of the wrong answers were lower than the maximum. Nevertheless, 5% of respondents stated doses higher than the maximum recommended. This is worth bearing in mind whenever we recommend paracetamol (***see page 829***).

## Who are the repeat attenders?

A study from Singapore by Paul and colleagues examined the characteristics associated with patients who made five or more attendances at the emergency department over the course of a year. The characteristics that independently predicted repeat attendance suggest that, in Singapore at least, repeat attendance is a problem for the elderly population. It would be interesting to know if these findings were reproduced in other countries (***see page 843***).

## Ottawa knee rules in Iran

Ottawa rules have been developed for several complaints and tested in many settings. Jalili and Gharebaghi tested the Ottawa knee rule in Iran and reported sensitivity of 95% and specificity of 44% for fracture. The one missed injury was a tibial plateau fracture that was treated conservatively (***see page 849***).

## Which supraglottic airway device is quickest to insert

Seconds count in prehospital airway management, so the time differences reported by Castle and colleagues are not trivial. They compared the time taken by 36 paramedic students to place an Igel, a laryngeal mask airway and a laryngeal tube airway in a manikin. The Igel came in fastest with a mean time of 12 s, with the laryngeal tube airway coming in at 22 s and the laryngeal mask airway at 34 s. The students obviously preferred speed with 63% backing the Igel and stating ease of use and speed of insertion as the primary reasons. The next step will be to move evaluation from manikins to humans (***see page 860***).

## Return of the giant hogweed

Some people (or perhaps just me) will not be able to read the words 'giant hogweed' without thinking of a song by Genesis (Peter Gabriel era). Two 11-year olds from Manchester will have equally painful associations after developing hytophotodermatits from contact with giant hogweed on the banks of a local river. Fortunately their lesions healed with appropriate treatment, although we are warned that photosensitivity may last for months. The scars from exposure to progressive rock last much longer (***see page 883***).

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SUPPLEMENT

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# The life of a police surgeon

The term police surgeon, often brandished by many older police officers, has been replaced by Forensic Medical Examiner (FME) or Forensic Medical Officers (Northern Ireland). The FME is in a rather unusual position as he/she has a dual role: to the detainee/patient and assisting the criminal justice system in delivering a fair trial.[1] Most FMEs are self-employed which provides for independence and this aspect is highly regarded by the judiciary.

## SO WHO ARE THEY AND WHAT DO THEY DO?

FMEs are doctors who are called to attend custody suites in police stations, sexual assault centres or UK Borders Agency (UKBA) custody suites.[2–4] The main work involves examining detainees, victims of assaults and police officers to record and treat injuries, to administer medication, to declare a detainee fit for interview, fit for detention, fit for charging or to take forensic samples. There is a current drive by many police forces to reduce cost and replace doctors with paramedics or nurses. So the nature of the work is changing, with FMEs providing more advisory services and covering larger areas.

The Police and Criminal Evidence Act (PACE) 1984 obliges custody officers to call a healthcare professional where detainees suffer from any medical or psychiatric illness, medication is required and/or injuries may be present.[5]

Many detainees are under the influence of drugs and/or alcohol and the role of the FME is to ensure that the detention is safe and the interview is carried out when the detainee is 'fit'—that is, not withdrawing or under the influence. There have been famous cases of convictions based on false confessions—for example, Carole Richardson, one of the 'Guildford four', who was convicted of an IRA bombing substantially on the basis of a statement made after having been given a sedative for drug withdrawal.[6, 7] Drug addicts undergoing severe drug withdrawals have an impaired capacity to make rational decisions and increased suggestibility.[8, 9] It is often a delicate balance between avoiding a withdrawal or managing a patient in an intoxicated state.

The case mix is varied and can be rather similar to emergency medicine, consisting of drug addicts and alcoholics who commit crimes to sustain their habits, drunks, minor injuries, patients brought in under section 136 of the Mental Health Act, suspected terrorists, drug dealers, gun dealers, alleged murder or assault suspects, victims and alleged perpetrators of domestic violence, sexual assaults assailants, blood for drug or drink driving, drink or drug driving assessment and scenes of death. FMEs may be called upon to take intimate samples—for example, penile or vaginal swabs from sexual assault assailants or victims. Scenes of death can be particularly unpleasant, especially in the summer when bodies have been decomposing for a while. An FME will spend a lot of time travelling and will be basically working on his own. He tends to practice more defensive medicine, being close to the interface between medicine and law. The consequences of a death in custody have a wide ranging impact, not only on the family and relatives with an estimated investigatory costs of £1 million, but also on police officers who may be suspended for 2 years while the Independent Police Complaints Commission investigates.[10] The Coroner's Inquest may produce an adverse finding and civil and/or criminal negligence suits may result.

## COURT PRESENTATION

An FME will at some stage be preparing professional (and if suitably qualified expert) statements. A good statement will reduce the need to attend court, bearing in mind the process of giving evidence in court always fills one with trepidation.

## QUALIFICATIONS

A 5 day foundation course will provide you with a basic knowledge of the custodial environment, legal aspects, management of drug addicts and alcohol dependent persons, forensic sampling, statement writing and court training.[11] A detailed police check, including signing the Official Secrets Act, a driving licence and Medical Defence Organisation cover are other requirements.

## THE FACULTY OF FORENSIC AND LEGAL MEDICINE (FFLM)

The FFLM of the Royal College of Physicians of London was formed in 2006 and there is now a membership examination for entry. The specialty covers doctors working in three related disciplines: forensic medical practitioners (forensic physicians, forensic pathologists, sexual assault examiners, and child physical and sexual assault examiners), medicolegal advisers and medically qualified coroners.[12] The Faculty are working towards achieving specialty status apart from providing educational and training pathways.

This examination is divided into part 1 (knowledge test) and part 2 (written examination) and the part 2 clinical/practical examination. Part 2 is divided into three subspecialties of either/and/or medicolegal advisor, general forensic medicine and sexual offence medicine.

There are other external diplomas such as the Diploma in the Forensic and Clinical Aspects of Sexual Assault, the Diploma Course in Forensic Medical Sciences from the Society of Apothecaries of London, LLM/MA and the Postgraduate Diploma in Forensic and Legal Medicine (University of Central Lancashire).[13, 14]

## FINANCIAL REIMBURSEMENT

You will usually be employed on a self-employed contractual basis (to ensure your independence in court) paid on a sessional rate (varying from £35 to £70). Court attendances and statement (£38) are usually paid separately. Once established with suitable qualifications, expert reports can also bring financial rewards with the caveat of remaining within one's area of expertise, as highlighted in the recent case involving Professor Sir Roy Meadows.

## ORGANISATIONS AND CPD EVENTS

Membership of the Faculty of Forensic and Legal Medicine is recommended.[12] The Clinical, Legal And Forensic section of the Royal Society of Medicine, British Academy of Forensic Science[15] and the Medicolegal Society[16] all hold excellent CPD meetings.

## SUMMARY

London has a thriving criminal scene and provides for a very interesting mix of cases. This job has given me an insight into another world and made me more aware of medical jurisprudence. I have examined celebrities, doctors, murderers, paedophiles and even terrorists. I have become much more streetwise and am even recognised by all the local criminals and prostitutes. The police are very successful in catching most criminals. However, the criminal justice system makes convictions difficult, and rightly so, to prevent miscarriages of justice.

The main difference from hospital work is the importance of recording the lack of injuries to defend or refute any allegation. An FME will also see a lot of mental health cases, especially as acutely psychotic section 136 patients are usually brought to police stations. Drug induced psychosis, borderline personality and arsonists are other common cases. I have never been injured by a detainee although the risk of personal injury is potentially high.

Detainees are often more polite than patients in the emergency department as FMEs are the only impartial people they may meet apart from their solicitors. Police officers are generally great to work with, courteous and will go out of their way to be of assistance. Not too many doctors can say that they have seen the inside of a custody cell, prison, Scotland Yard or the Old Bailey. This job would certainly suit those in emergency medicine as they possess a lot of the required competences. I would recommend that you contact the Faculty to arrange a meeting or to shadow an FME.

**Dr Meng Aw-Yong**

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## FASSGEM CONFERENCE 2010, BELFAST

16–19 November 2010

The Forum for Associate Specialist and Staff Grade Doctors in Emergency Medicine (FASSGEM) has a few places left for its upcoming conference. Highlights include USS workshops and talks; Haematology; Sepsis; Pre-Hospital Care; Bomb and blast injuries; and Expedition medicine. Contact Sophie Graber (sophtigra@mac.com) or see www.collemergencymed.ac.uk/FASSGEM for further details.

# Pres Blog

Just back from the excellent Birmingham Conference. This was a great success with around 600 delegates—a CEM record—and excellent presentations throughout the programme, including the plenaries, papers and posters. The opportunity to hold a conference on the theme of learning from each other with colleagues from military emergency medicine and the Association of Paediatric Emergency Medicine was hugely rewarding. The eponymous lectures were particular highlights, with this year's David Williams Lecture being given by Tony Redmond describing his previous and sadly ongoing work in areas of humanitarian crisis resulting both from conflict and natural disaster. The impact of the work led by Tony and his team was truly humbling. This year's Alison Gourdie lecture was given by Dr Doug Murray from Edinburgh whose visit to centres of excellence for toxicology in New York and Toronto provided some very interesting indications of future approaches to the poisoned patient. Sincere thanks and many congratulations to those who led on the organisation of this conference—Fiona Lecky and Chris Walsh from CEM, Tim Hodgetts, Rob Rusell and Brian Phillips from the military, and Kath Berry from APEM.

At the conference dinner it was a privilege to be able to present the CEM Honorary Fellowship to Professor Peter Cameron, President of IFEM, and to welcome the President of the American College of Emergency Physicians, Dr Angela Gardner. Gautam Bodiwala was presented with a CEM medal to mark his retirement as President of IFEM and to celebrate his immense achievements in this international role. Jonathan Marrow was presented with a CEM medal and gift in thanks for his superb contribution to the development of the specialty and the College. In return, I was delighted to accept the excellent picture of the Emergency Department at Derriford Hospital (see *EMJ Supplement* passim) on the understanding that we now need a new CEM HQ with a suitable wall on which to hang same.

Dr Ed Glucksman receives the thanks of the College of Emergency Medicine for his vision and clarity on behalf of the specialty.

Both at the dinner and AGM, the immense contribution of Ed Glucksman was applauded, as Ed demits office as Vice President. Prolonged standing ovations occurred on each occasion. Also at the AGM, Ruth Brown demitted office as Registrar to become a College Vice President. Ruth's outstanding work as Registrar, particularly during the merger, was warmly acknowledged. Cliff Mann from Taunton has now succeeded Ruth as Registrar of the College.

Also at the AGM it was a pleasure to introduce the new Chief Executive for CEM, Gordon Miles, who joined us from the General Dental Council. A fuller bio will appear on these pages shortly and we look forward to Gordon joining us—there is much to do!

No College conference would be complete without the misleadingly titled fun run. This year a high speed circuit of the Birmingham canal path was the reward for having an excellent time at the previous evening's drinks reception. Again, a world record turnout (not all under military orders), including your current correspondent and previous President, both ran well but generously allowed others to take the medal positions.

Just a reminder of the next CPD fest being held in Southampton on 29–31 March 2011. Details on the website. This years' spring CPD event sold out so early booking is strongly advised.

Back in the real world, the two key issues are the 4 hour standard replacement, details of which should be known by the time this Pres Blog appears, and the middle grade crisis. As you will know, CEM has been working hard to address the issues which are fuelling this situation, including reduction in trainee numbers and Home Office imposed visa regulations. Similarly, CEM has supported and facilitated initiatives to recruit middle grade doctors from overseas. Progress has been frustratingly slow and the recent suggestion of an overnight closure of an emergency department in South London has

crystallised the issues. It is likely that direction from the government will be required to unlock the various activities contributing to the middle grade shortage and CEM will continue to press this matter as an issue of immediate urgency.

Further news will be posted on the College website—the 2010 update of which was launched at the Conference. Thanks to Ruth Brown, Phil Macmillan and the website team. Your feedback on aspects which could be made even better would be welcome of course.

**John Heyworth**

# Learning from each other at Birmingham

At times the College of Emergency Medicine has been described as a college in its infancy; if that simile is to be applied to conferences too, then in Birmingham this September the College underwent one almighty growth spurt....

Hosted by the Defence Medical Services at the International Convention Centre this was a conference on a scale not previously seen by our fledgling college; 650 international delegates shared a busy 3 days in grand style in the second city, over 70 sponsors took part in an impressive trade exhibition in the ICC's main hall, 250 posters were presented and over 100 speakers took to their feet on topics across the spectrum, from military damage control resuscitation to lean management theories in the biscuit business.

The theme of the conference was 'learning from each other' and Colonel Tim Hodgetts, Emeritus Defence Professor of Emergency Medicine, and his organising committee with Fiona Lecky from CEM, gathered together a galaxy of big names and 'high rankers' from the military and civilian worlds to share lessons learnt in recent military conflict and up to date concepts in civilian emergency care. Some non-attendees have complained that the conference was 'a bit too military' but the hunger for 'learning from each other' was borne out by the huge number of delegates attending the military themed plenary sessions and the fact that the combat helicopter, 'care under fire', and other military simulator sessions were fully booked within the first hour of registration. Seeing a civilian colleague with glasses askew, helmet 'wonky' and drenched in sweat as a Scottish Sergeant Major barked orders at him was worth the registration fee alone.

Workshops covering ultrasound, simulation, major incident response and practical resuscitation skills were well attended and well received but a word of warning for any future organising committees: put your 'difficult airway symposium' in a large room or risk disappointment! APEM ran a parallel track for 2 days and, as always, there was an enthusiastic response to these sessions from CEM members who grasped the opportunity to share ideas with our paediatric colleagues.

Highlights from the plenary sessions included Colonel Ian Greaves talking pragmatically about which lessons from contemporary military operations could realistically be transferred to the NHS and Professor Lee Wallis from Cape Town talking on medical support to the 2010 World Cup; who knew that vuvuzelas were potentially so versatile a medical device? Anyone wanting copies of his Dutch supporters' images can contact us by email.... The afternoon of day 1 saw six quick fire presentations on trauma resuscitation from an esteemed military panel which introduced the concepts of 'right-turn resuscitation' and thromboelastography to an enthusiastic civilian audience. The David Williams lecture this year was by Professor Tony Redmond who enthralled a packed house with his moving account of the development of organised humanitarian medical aid from the UK through natural disasters such as the Armenian and Iranian earthquakes, war torn areas (Bosnia, Kosovo, Sierra Leone) and sites of immense and untold human suffering, including Lockerbie, and Haiti at the start of 2010. While Redmond's was a journey of apparently selfless 'lessons learned' in the logistics of delivering high quality care to areas with no infrastructure, for the conference audience the harrowing imagery conjured from his tales combined with the overwhelming humility with which the story of the evolution of the Humanitarian and Conflict Response Institute was delivered left many a delegate moved nearly to tears.

Of course, one of the main objectives of any delegate is to network and catch up with faces from the past, and the ICC proved a successful location for this, the enormous main hall providing plenty of space for a chat. Most delegates on day 1 stayed on for a performance of military music and a free flowing cocktail party while the regimental dinner on day 2 again broke records with 250 guests sharing a formal dinner without the regimental rules—that is, you were allowed to go to the toilet! The President will no doubt be pleased to have found nearly 40 friends to run with at 06:30 on a drizzly Brummie morning; so many 'fun runners' turned out that two routes were offered. It's amazing what you can get people to do with an order....

Overall the Birmingham conference was a great success: 'learning from each other' was achieved on many levels by a hugely diverse audience from the international emergency medicine community. Thanks are due to the very many people who gave up time to make it a success, and in particular Brian Phillips, the full time conference organiser (it really was that big...) who did much to make the ambitious plans of the organising committee come to fruition. At one point on day 1 he was heard to mutter that "this thing's bigger than Ben Hur", and he might well have been right. Over to you Newcastle Gateshead....

**Ian Gurney, Annette Rickard**