

## **EMERGENCY MEDICINE APPROACH: STABLE PATIENTS**

1. *The emergency medicine approach focuses on immediately recognizing and treating life-threatening emergencies, followed by definitive H+P, diagnostics, and disposition. Your supervising resident should have already screened for this and assigned you to a “stable” patient.*
  
2. **Vital signs** are an extremely important part of Emergency Medicine. You should:
  - a) *Always check the vital signs of your patient before you proceed with any further history or physical and write them on the chart before you first see the patient. Look at the nurses notes for updates in vital signs as well.*
  - b) *Always document a complete set of vital signs, including respiratory rate, pulse rate, blood pressure, temperature, pulse ox, and pain score*
  - c) *Be aware that axillary temperatures are not an adequate method of core temperature assessment. Therefore do not accept an axillary temperature. Politely request from a nurse that either an oral or rectal temperature be obtained on every patient (unless in extremis).*
  - d) *You must make an attempt to explain any abnormal vital signs. **DO NOT IGNORE ANY ABNORMAL VITAL SIGNS.** Also remember that repeated, *serial vital signs are extremely useful.**
  
3. **Once assigned to a patient, your approach should be:**
  - a) *Write the vital signs and your signature on the chart*
  - b) **HPI**: *Be thorough and *stay focused on the chief complaint.* A useful template is:
    - PQRST (Pain, Quality, Radiation, Severity, Timing)
    - Exacerbating factors
    - Alleviating factors
    - Associated symptoms (ROS based on pertinent positives/negatives)
    - Similar episodes (including prior work-up and treatment)*
  - c) *Take a detailed PMH, PSH, MEDS, ALLERGIES, SH, FH highlighting pertinent positives and negatives.*
  - d) **PE**: *Be thorough unless the above points to a localized extremity complaint, in which case you can focus your exam only on that.*

e) Generate a differential diagnosis based upon your history & physical. Be able to prioritize your differential diagnosis into most-to-least probable, and more importantly most-to-least life-threatening. *Always remember the worst possible case scenario: "think worst first".*

f) Present the above in a concise, coherent fashion to your resident or attending.

g) Diagnostic Tests: After consulting with the resident or attending, determine what diagnostic tests, if any, should be ordered (including EKG, ABG, x-rays, blood tests, urinalysis, etc.). You should be prepared to answer these questions:

1. *Why am I ordering this test?*
2. *What are the test results I anticipate?*
3. *Could this test change the working diagnosis?*
4. *Could this test change my management in the ED?*
5. *Could this test change the management of the patient after he/she has been admitted?*
6. *Could this test change the disposition, e.g., discharge to home vs. admit to medicine vs. admit to surgery?*
7. *What are the alternatives to this test?*
8. *What is the sensitivity and specificity of this test?*
9. *What are possible complications of doing this test?*
10. *What are the costs of this test?*

g) Reformulate your differential diagnosis if necessary, based on results.

h) Discuss your plan, treatment and disposition with your supervising resident

j) Carry out this plan based upon your supervisor's approval and recommendations.

## **EMERGENCY MEDICINE APPROACH: UNSTABLE PATIENTS**

(How to approach cases in C-booth)

1. The traditional paradigm of history, physical and diagnostics, diagnosis, and treatment is:  
**S** Subjective (history)  
**O** Objective (physical and diagnostic tests)  
**A** Assessment  
**P** Plan

This paradigm, though often attenuated in Emergency Medicine, is always present. For example, if a patient arrives severely short of breath and appears cyanotic, the physician will:

- (S) take a minimal, focused history,
- (O) use general appearance as the physical exam and defer tests such as CXR or ABG,
- (A) formulate the assessment as “respiratory failure”, and then
- (P) perform immediate bag-valve mask respiration with O<sub>2</sub> then endotracheal intubation.

2. *The gravity of the above scenario highlights the need to be able to “eyeball the patient” and classify the patient as “sick” or “not sick”; based on this initial impression, the emergency physician may be prompted to order diagnostic tests and initiate treatment prior to obtaining a detailed history and physical, based on limited available information. In general, students are not expected to master this approach (though they will see residents doing this and should one day aspire to master it).*

3. It is often not possible to make an exact diagnosis in the emergency department. The **goals of an emergency physician** are to:

- a. Recognize, Treat and Admit *life-threatening* emergencies
- b. Recognize, Stabilize, and Refer *non-life threatening* emergencies
- c. Make a *disposition decision* (e.g. decide which stable patients require admission)

Note: there is *no goal to make a definitive diagnosis in the ED*; management takes precedence over definitive diagnosis. This contrasts to the dominant paradigm in Internal Medicine. Also, in Emergency Medicine, there is an *emphasis on not missing any life-threatening diagnoses*.

4. As a medical student, you will not be placed in the position of directly treating patients in extremis. However, you should participate as much as possible in a critical patient’s care by performing basic procedures (ABG, NG tube or Foley catheter insertion, etc). You will undoubtedly have a rich educational experience if you also take an active role in mentally anticipating your residents’ decisions and then discussing the case in detail once the patient has been stabilized. With practice, you will be ready to take charge during internship!