



Editorial

□ THE TEN COMMANDMENTS OF PEDIATRIC EMERGENCY MEDICINE

More than a decade ago, my colleagues in the Department of Emergency Medicine at Vanderbilt University—Keith Wrenn and Corey Slovis—published “The Ten Commandments of Emergency Medicine” in the *Annals of Emergency Medicine* (1). The gist of the editorial was to highlight 10 basic precepts that are at the heart of the practice of Emergency Medicine—“secure the ABCs,” “get a pregnancy test,” and “do not send unstable patients to radiology” were three such examples. With its own nuances unique to caring for acutely ill and injured children, it’s time that Pediatric Emergency Medicine had its own set of 10 commandments. They may not come from the holy mountain, but perhaps some pretty sturdy foothills:

1. CHILDREN ARE NOT SMALL ADULTS

The younger the child, the more unique and special the anatomy and physiology are, compared with adults. The pulmonary dynamics, renal clearance of drugs, and inflammatory response to infection all vary based on age and development. But even a 6-foot, 200-pound 14-year-old, despite having a “routine” fracture, is socially and emotionally not yet an adult. Comprehensive patient-centered medical care requires that these children, too, be cared for by medical professionals who understand and consider their global needs.

2. ILL AND INJURED CHILDREN REGRESS

An older child with a lip laceration may *act* like a 2-year-old when approached with a lidocaine-filled syringe and needle. Lower your expectations and take your time. Preparation—of the patient and the parents, as well as the equipment—is critical to success. This is where a Child Life Specialist becomes invaluable. Many a risky sedation has been avoided with a little TLC and patience.

3. THE “PATIENT” MIGHT BE THE ONE HOLDING THE CHILD

You’ve got more than one customer to satisfy when you enter the room to see a child. Many Emergency Department (ED) visits have as their primary (and often hidden) agenda the parents’ peace of mind. Introduce yourself, project confidence, and treat the parents as your partners in care. Address the parents’ unstated fears; tell them why you think this *isn’t* meningitis, appendicitis, or a heart attack. Children take their cues from their parents, and if you connect with the parents, you’re that much more likely to get an adequate examination of the child. Take Mom’s, Dad’s or the grandparents’ concerns to heart—they know their child better than anyone else in the world.

4. KIDS ARE THE REAL DEAL

With few exceptions, kids do not want to be in the hospital. They’d give anything to be back out there running around with their friends, or playing a game. They bounce back from illness or injury more quickly than we adults do, partly for this reason. Give a child’s complaints the benefit of the doubt. In the majority of cases, their symptoms are real and not factitious.

5. LABORATORY TESTS AND X-RAYS SELDOM BEAT A GOOD HISTORY AND PHYSICAL EXAMINATION

This is true in medical practice in general, but even more so in pediatrics. Children are generally healthy critters with brief medical histories, and so an H & P is more often than not all you need to arrive at a diagnosis. Kids almost never require million-dollar workups or screening tests for rare diseases in the ED. The most valuable diagnostic tools you have at your disposal are your eyes, your ears, and your hands. You’ll learn more from them than a CBC any day. And test-ordering may have inherent risks—witness the recent literature associating malignancies with “routine” radiation exposure from CT scans (2,3).

6. MANY HANDS MAKE LIGHT WORK

Preparation for even the simplest procedures often involves enlisting help. Don't let bravado or strength get in the way of success. Proper (and humane) restraint, calm reassurances, and the presence of Mom or Dad often spell the difference between a successful or traumatic lumbar puncture, i.v. start, or even radiograph. Do it right and you'll only have to do it once.

7. CHECK AND DOUBLE-CHECK. THEN, CHECK AGAIN

Drug doses are a particular stumbling block in the pediatric world. Have someone else check your arithmetic. Decimals are sneaky and will often slide a place or two to the right or left, and it could spell disaster if you proceed without being sure. Double-check the patient's known allergies. And give the medications that you do administer a reasonable chance to work (e.g., benzodiazepines for seizures) before repeating them.

8. CHILDREN FEEL PAIN JUST LIKE YOU DO—TREAT IT

Gone are the days where the belief that children—especially neonates—are insensitive to pain. Many studies document that pain is as real for children as for adults. In the appropriate circumstance, narcotics can safely and effectively relieve abdominal pain or pain from fractures, and gain you improved examinations and quality of X-rays. If you use lidocaine for your lumbar punctures, you can watch your rate of traumatic taps fall.

9. CLOSE THE LOOP

Follow-up care is the cornerstone of pediatric care. Always provide the caregiver(s) of the patient being discharged with clear and understandable instructions on what to look for and when to return. Advise them to touch base with their primary care physician (PCP). Better yet, give the PCP a call and close the loop your-

self. Arranging appropriate follow-up may be one of our most important tasks in the pediatric ED.

10. ABOVE ALL, YOU ARE THE CHILD'S ADVOCATE

Children don't have the capacity to give adequate histories in many instances, and their response to pain or discomfort often precludes localization. They also can't (or won't) tell you when they're being abused. Spend a few extra minutes, watch the child with the parent, consider whether the story fits the pattern of symptoms, and always err on the side of the child by reporting your suspicion, even if the parent is a colleague or hospital benefactor. You may turn out to be the best friend this child ever had.

The Ten Commandments of Pediatric Emergency Medicine are designed to supplement and augment the Ten Commandments of Emergency Medicine, not to replace them. The original commandments still hold. You should still "look for red flags," "assume the worst," and "do unto others as you would your family." But being a little more specific to what we do is a good and caring thing. As we gain more experience and knowledge regarding ill and injured children, we owe it to our littlest patients to make a visit to the ED as pleasant and as excellent as it possibly can be.

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