

Accessing common sense for clinical decisions

In November 2000, we published an article “Accessing electronic information for clinical decisions” (*Arch Dis Child* 2000;83:373–4) which began:

The setting: It’s early on a Friday evening, and you’re working as registrar in A&E. A 6 year old girl is rushed in as an emergency, complaining of headache; she is febrile with convincing nuchal rigidity. Your colleague performs a lumbar puncture, then you attempt to achieve intravenous access, and by the time the anaesthetic cream has cooked the microbiologist rings from the lab. The CSF contains 50 polymorphs, two red cells, and is “teeming with Gram positive diplococci”.

The question: Before you give an antibiotic though, you wonder about the steroids in meningitis debate. Should this girl get dexamethasone prior to antibiotics? Will it reduce her chance of hearing loss—or just increase her chance of continued infection? You reckon the five minutes it will take to draw up the antibiotic is enough time to try to find some information to help.

In that first article the registrar went on to access a number of databases before concluding that the addition of steroids would be best. One of our readers wondered if the story might not, in the real world, have developed a little differently.

Accessing common sense for clinical decisions—a play

SCENE 1

It is early evening in a busy casualty department. The registrar sits at a computer. A nurse enters the room.

NURSE. Doctor, have you decided what you’re doing with the little girl in cubicle 2? [*she doesn’t wait for a reply*] The LP’s back, its full of bugs and white cells and she still hasn’t got a line, I know you’re waiting for the cream to work and I know you’re trying to decide about the steroids, but don’t you think you should come and have a look at her? I’m not happy about her.

The registrar lifts his head briefly.

REGISTRAR. Actually I’m almost there ... I’ve just got to access one more database and I’ll have the answer.

The nurse looks desperate. She leaves. We see her pick up the phone in the next room.

SCENE 2

A quiet children’s ward. There is a warm glow from the window to the left as the sun sets over the city. The paediatric consultant, recently appointed and now resident on call is sitting by a desk. The phone rings. A young nurse picks up it up but quickly passes it to the consultant.

NURSE. It’s a call for you.

CONSULTANT [*taking the phone, listens*] How long has she been waiting? ... she’s really sick? ... What? ... he said he wanted to wait for the cream to work? ... he’s on the computer ... No, of course I’ll pop down. Give me a minute.

She puts down the phone. With a weary look she leaves the room.

SCENE 3

A busy casualty department. On the bed lies a small child. She is deathly pale. To the left stands a nurse. She is fixing a mask to the child’s face. Tubing runs from the mask to the wall. There are monitors and computer screens and the general feel of high tech medicine.

The consultant walks to the child and picks up her hand. It is cold. She turns to the nurse.

CONSULTANT. I’ll need an intraosseous line. Can you draw up some fluids. [*she doesn’t pause to hear a reply*] What are her sats? Has she had any antibiotics?

The registrar enters, stage right.

REGISTRAR. Before you do that, we haven’t decided about steroids.

CONSULTANT. No, I think getting access is probably more important right now.

[*The registrar looks a little downcast*]

CONSULTANT. Have you spoken to the parents? Do they know how ill she is?

REGISTRAR. We didn’t get time to discuss that ... we didn’t get past treatment options actually.

CONSULTANT. What do you mean?

REGISTRAR. I was working on an informant basis, you know, a sort of partnership model. I discussed the role of steroids and told them to go and think about it over a cup of tea.

CONSULTANT. Oh f... [*very quietly under her breath*] Well what have you actually done with this child?

CONSULTANT. [*handing the nurse a full syringe of blood*] Yes that’s great. Send that to the lab and get me a BM please.

REGISTRAR. Well, the SHO did the LP ... I’m sorry about that one.

CONSULTANT. Sorry?

REGISTRAR. Well, where’s the evidence that an LP significantly alters outcome? I mean, I pretty much knew what was wrong with her when she came in ... It’s an interesting question. I don’t know if anyone’s looked at it properly. I could find out. Do you want me to check the databases ... I know some good ones.

CONSULTANT. [*without looking at him*] It’s pretty busy in the department. You sure you’ve got time.

REGISTRAR. Oh doesn’t take a moment [*disappearing out of the door*].

Enter SHO through same door. She is young. Hair tied in a ponytail.

SHO. Can I help?

CONSULTANT. Yes, thanks ... would you push this through. [*The consultant hands her a syringe*]

SHO. Lovely, its just like APLS. You’re on your own and I’m the dozy but enthusiastic assistant.

CONSULTANT. [*with a tired smile*] Look ... what happened with this girl?

SHO. Well, I saw her and thought she must have meningitis. So, I did the LP. I called the reg but he was really angry and said I’d overstepped the mark and now we were committed to a whole pile of non-evidence based treatment. [*after a few seconds*] He looked pretty upset.

CONSULTANT. What then?

SHO. He went off to tell the parents that the girl was in a bad way. I mean, that obviously she was unwell with little evidence to say what was the best treatment. He said what he usually says ... you know ... bewildering array of

databases ... disappointed the hospital still hasn't subscribed to whatever site on the internet. *[pausing to think]* He takes a lot of time with the parents.

CONSULTANT. Why didn't he just ring me or the A+E consultant?

SHO. Oh no ... he says the modern palm top has made consultants pretty much redundant. You can get everything you want off the computer.

REGISTRAR *[entering the room]* I've got it ... about the steroids I mean ... oh *[looking about]* ... You haven't gone and given the antibiotics have you?

CONSULTANT. Yes.

REGISTRAR. Oh great, that's a completely different question now isn't it ... steroids after antibiotics. No, no, it's okay, I'll sort it out. Don't do anything else till I come back.

Registrar exits, stage left, looking annoyed.

CONSULTANT. Can you phone PICU, let them know she's down here. I'd better go and talk to the parents.

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POSTCARD FROM DOWN UNDER

Fearful children

I smile a lot at children, a professional habit carried over into a character trait. The smile goes something like this: first catching the eye of the child, who is usually watchful and cautious, then a broad smile with lips closed, followed very closely by a widening of the eyes and then perhaps a wiggle of the eyebrows. This is often enough to make a child smile back, although I'm painfully aware that some children will be quite worried by a stranger smiling at them, and some will regard it as a false gesture—nothing more than a professional quirk with no underlying feeling.

When not at work and wandering around the supermarket or down the high street, I often look at children because, for one thing, it is good to see them behaving naturally outside of a hospital setting. When they catch my eye I find myself responding with my professional smile, at which point, if I remember that I'm not at work, I'm suddenly chillingly aware of all the ways that this could be misinterpreted in a frightened, suspicious, and protective world. I am suddenly a strange man smiling at a strange child, with all that this might imply. If the child responds with a smile, then the chill deepens. Have I just unwittingly undermined a lifetime of sensible caution about strangers instilled into this child by caring parents? Have I just inserted the thin end of the wedge into the principle that all strangers are not to be trusted by tricking a child into trusting me with a smile? At work the situation is different, with the parents' presence and participation in the communication labeling me "Not a Stranger". Not known well of course, but to be trusted. Occasionally, in the high street when I forget myself and I—forgive me—smile at a child, the parents see me, and the look that they give me is enough to make me give up smiling at children forever. The fearful suspicion, the rapid appraisal—male, tall, not old, fairly well dressed, doesn't "look" like a pervert—and the eventual conclusion (that I'm probably not a threat at the moment) is soul destroying.

Recently, we have been lucky enough to travel in South East Asia, and more specifically in Thailand, Myanmar (Burma), and Laos. Everything that I have learnt about child protection and about the acts we are attempting to

protect the children from tells me that these children are being hurt here as much as anywhere else in the world, with cultural and social taboos accounting for the relatively low levels of reporting, discussion, and awareness. Perhaps as a result of this, or maybe as a feature of the national character, parents in these countries seem to actively encourage their children to wave to and talk with *falangs* (foreigners). Often, as you approach a group of adults with a child, you'll hear a rapid discussion directed at the child with the word *falang* in it, and then you'll see the child begin to wave, supported and spurred on by the adults in the group. The whole group will be happy and laughing. We walked past a school playground where a group of 5 or 6 year olds were just being let out to play. Shouts of happiness were mingled with cries of "falang!", a cue to run to the fence and laugh and wave and shout at us. Imagine this in our world. An infant school class running to the playground fence to wave at a passing stranger. This would be the cue for a gentle but firm lesson for everyone about the dangers of strangers and talking to them. Maybe the community policeman would be summoned to give a talk or lead a workshop. Notes would be sent to parents.

So what am I saying? Of course, what I am emphatically not saying is that we should teach our children to trust strangers again. It is undeniably a good thing that in our society we have gone some way to removing the taboos and other restrictions that would prevent us from recognising the fact that children are sometimes harmed. But, for want of a better analogy, have we thrown the baby out with the bath water? Is it right that I should feel like a suspected pervert if I smile at a child in the high street, supermarket, or park? Is it right that I worry about the desensitising effect that my smile might have on the carefully hardened, streetwise child?

It is a shame to have to travel halfway around the world to be reminded that a smile from a child is one of the simplest, most uplifting pleasures in a serious and demanding life.

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