

# PostScript

## LETTER

### Monitoring junior doctors after a major incident

The major incident that occurred in the capital on July 7 2005 put many junior doctors on the front line, seeing badly injured and traumatised patients. Exposure to such horrific sights will make many health care workers vulnerable to post traumatic stress disorder (PTSD).<sup>1</sup>

Following the major incident, occupational health staff sent relevant line managers information alerting them to the symptoms of PTSD. In accordance with current recommendations, formal counselling was not routinely offered to staff immediately after the event.<sup>2</sup> Evidence shows that it is not necessary for specific intervention until four to six weeks after the incident, when individuals have exhausted their normal coping mechanisms. It is difficult to achieve 'watchful waiting' in such a fluid environment as accident & emergency. In particular, four weeks after this major incident, the majority of the junior doctors moved on to other posts.

Four weeks after the event, we carried out a departmental survey based upon Chris Brewin's Trauma Screening Questionnaire, in order to identify those more likely to be suffering from PTSD.<sup>3</sup> The results showed that although no junior doctors were experiencing enough symptoms to suggest a greater risk of developing PTSD, only 50% knew where to access counselling despite detailed information available on the hospital's intranet service.

We recommend that a senior staff member is responsible for informally following up junior doctors involved in a major incident. This should be four to six weeks after the event, potentially by postal questionnaire and should identify any on going problems. Posters advertising counselling should be clearly visible in communal staff areas and ultimately, every accident & emergency department should have a follow up plan for remote monitoring of staff that were involved. This should be the final chapter of the major incident plan for any department.

**J Blythe**

Department of Accident & Emergency Medicine, Royal Free Hospital, London, UK

**K Whitwell**

Department of Accident & Emergency Medicine, Royal Free Hospital, London, UK

Correspondence to: Dr Kerrie Whitwell, Accident & Emergency Department, Royal Free Hospital, Pond Street, Hampstead, London NW3 2QG; kerrie.whitwell@royalfree.nhs.uk

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## Reference

- 1 Grieger TA, Fullerton CS, Ursano RJ, *et al*. Acute stress disorder, alcohol use and perception of safety among hospital staff after sniper attacks. *Psychiatr Serv*, 2003 Oct, **54**(10):1383-7.
- 2 Rose S, Bisson J, Churchill R, *et al*. Psychological debriefing for preventing post traumatic stress disorder (PTSD) (Review). *The Cochrane Database of Systematic Reviews* 2002, Issue 2. Art No. : CD000560, DOI:10.1002/14651858.
- 3 Brewin C, Rose S, Andrews B, *et al*. Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry* 2002;**181**:158-162.

## BOOK REVIEW

### The high altitude medical handbook

A J Pollard, D R Murdoch. Oxford: Third Edition, £23.50 (paperback). ISBN 1-85775-849-8.

If imitation is the best form of flattery, then the authors of *The High Altitude Medicine Handbook* should consider themselves flattered indeed. The "mini micro" bootleg version of the first edition of the handbook, published in India, and widely available in bookshops in Kathmandu, has perhaps sold more copies to those departing on high altitude treks than the original. This illicit version was my first copy of the handbook and it lived in my back pocket when I was working as a medical officer on expedition in a remote corner of eastern Nepal. At high altitude, when cold, fatigue, and hypoxia muddled my brain, it was my constant reference text and bible.

I was therefore delighted to be asked to review the third edition, which was published in 2003 to coincide with the 50th anniversary of the first ascent to the summit of Mount Everest and the 25th anniversary of the first ascent without oxygen.

The handbook is not, nor does it set out to be, a definitive text on altitude medicine. There is therefore little on the physics of hypobaric hypoxia or the underlying pathophysiology of acute mountain sickness. Instead, it achieves exactly what it sets out

to do: it is a clear, concise, commonsense guide to the management of all aspects of medical problems at high altitude. There are not only the expected chapters on high altitude illness, first aid and travel related illnesses, but also sections on children, ethics, culture, environmental and medicolegal concerns. All chapters are extensively referenced so readers can easily refer back to original literature. This third edition has been thoroughly revised to reflect the rapid increase in knowledge in the 5 years since the last edition.

The foreword by Sir Edmund Hillary reflects that both Andrew Pollard and David Murdoch are experienced mountaineers, Andrew Pollard having reached 8600 metres on the south col of Mount Everest in 1994. They are both experts in high altitude and expedition medicine and have a breadth of experience in managing medical conditions in some of the world's most challenging environments. David Murdoch worked for 2 years in the Everest Region, first at the Himalayan Rescue Organisation's first aid post at Pheriche, then at Kunde hospital. This makes the handbook occasionally controversial, always authoritative, and full of practical advice on how to overcome the technical challenges of practising medicine in such difficult conditions.

This is a valuable guide to have with you on expedition or any high altitude trek, but also includes valuable pre-departure planning information such as an appendix on what to include in a typical high altitude medicine kit list. Although the handbook is primarily aimed at medical practitioners, its straightforward text makes it accessible to lay travellers and can be highly recommended to anyone considering travelling to high altitude.

**F Bellis**

Competing interests: A Pollard (book author) and F Bellis (reviewer) are both members of Medex, a medical mountaineering and expedition club

## CORRECTION

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In the paper titled, Ketamine for paediatric sedation/analgesia in the emergency department (*Emerg Med J* 2004;**21**:275-80) reference 67 was incorrectly cited. The correct citation is; Chudnofsky CR, Weber JE, Stoyanoff PJ, *et al*. A combination of midazolam and ketamine for procedural sedation and analgesia in adult emergency department patients. *Acad Emerg Med* 2000;**7**:228-35.