

# PostScript

## LETTERS

### Attitudes to triage of Chinese emergency room patients in a Beijing tertiary hospital

China is the largest developing country in the world. Although most emergency rooms in the mainland do not have an emergency triage system, large urban hospitals are beginning to set them up. However, there has been no media coverage in Beijing to promote public understanding of the emergency triage system. We performed a study to understand patients' attitudes to the triage system, and to compare the patients' expected waiting times with emergency room-allocated waiting times between different triage levels.

The study setting is a tertiary and teaching hospital in Beijing (Peking Union Medical College Hospital, Beijing, China). The emergency room has about 350 visits each day, with most of the visits relating to medical problems. According to the triage criteria, level I and level II patients can be seen by a doctor or cared for by a nurse immediately. Level III and level IV emergency room patients have stable vital signs. However, the condition of level III patients may deteriorate in hours.

A senior emergency room nurse was arranged to perform triage, and a junior nurse gave out questionnaires when the patients were waiting to see a doctor.

In all, 64 level III and 36 level IV emergency room patients were enrolled in the study. All the patients agreed that it is reasonable and necessary to set up a triage system in the emergency room. The median of the waiting time expected by level III patients was 10 min (with 25% and 75% expecting waiting times of 5 and 20 min, respectively). There was a significant difference between the patients' expected waiting time and the emergency room-allocated waiting time of 30 min ( $p=0$ ). The median of the waiting time expected by level IV patients was 10 min (with 25% and 75% expecting waiting times of 10 and 27.5 min, respectively). There was a significant difference between the patients' expected waiting time and the emergency room-allocated waiting time of 120 min ( $p=0$ ). There was no significant difference comparing the patients' expected waiting time of the two groups ( $p=0.449$ , Mann-Whitney U test).

Medical resources in developing countries are limited. Setting up the triage system in emergency rooms can assist in using the medical resources efficiently. Although emergency room patients support the triage system, they do not understand the methods and the criteria used. As a result, patients' attitudes regarding expected waiting time support the necessity of setting up a triage system in emergency rooms. The media should be used to promote public understanding of emergency triage.

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doi: 10.1136/emj.2006.043422

Accepted 27 October 2006

Competing interests: None declared.

### Photokeratitis following the manipulation of aquaria disinfection lamps

UVC radiation (100–280 nm) at the earth's surface is usually encountered during welding or with germicidal lamps. The corneal epithelium absorbs UVC and the main acute clinical effect appears to be photokeratitis, typically appearing within 12 h of exposure.

We report a cluster of six patients (from five independent incidents) presenting with photokeratitis to the same ophthalmic emergency department within a 6 month period, all with bilateral photophobic, gritty and watery eyes. All six men had been exposed to UVC radiation while replacing or cleaning low-pressure mercury vapour lamps of domestic koi fish aquaria within the previous 24 h and had developed symptoms before attendance. Slit lamp examination of all six men revealed corneal punctate epithelial erosions. The six patients were treated with lubricants and discharged with advice to return if the symptoms did not improve.

UVC radiation is used in the destruction of micro-organisms. The lamps generate high dose rates at a wavelength close to the absorption maximum of DNA (~260 nm), producing a germicidal effect.<sup>1</sup> In recent years, outbreaks of photokeratitis or UV burns following exposure to ultraviolet radiation from broken mercury vapour lamps have been reported.<sup>2</sup> These injuries are preventable and in the USA, the Food and Drug Administration (FDA) has prescribed performance standards for lamp operation.<sup>3</sup> Despite these measures, mass photokeratitis and UV burns remain a public health issue. No similar performance standards have been set in the UK on lamp operation, and, although an EU directive does impose a minimum requirement on employers to assess and reduce risks of optical radiation exposure of workers, these regulations apply only in the workplace.<sup>4</sup>

Photokeratitis is an operational hazard when working with germicidal lamps used in aquaria. Exposure in every case was unintentional and was compounded because human eyes cannot detect UVC radiation and because of the time lapse before symptoms appeared. A specific history should be sought in patients presenting with punctate epithelial erosions as they may be unaware of the underlying cause and not volunteer this information.

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doi: 10.1136/emj.2006.044172

Accepted 15 November 2006

Competing interests: None.

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### A guide to reducing citation errors in bibliographies

It is a common experience that by the time one finishes compiling a manuscript and reaches the stage of compiling the bibliography, a sense of fatigue sets in. Generally, people type the bibliography on the computer themselves or seek the help of a professional to do it; this is subsequently corrected by the author. However, even after corrections, errors remain in several references by virtue of errors in quoting authors (including the correct number, order, initials and spelling), article title, journal title (including proper Index Medicus abbreviation), volume number, page number and year.

Potentially more damaging are the errors where the name of one journal is replaced by another. In many instances, references do not conform to the uniform medical reporting system. The number of errors encountered is inversely related to the diligence of the author and the time spent by him/her in correcting the bibliography. The magnitude of the problem can be gauged by the sheer number of articles published on this subject.<sup>1,2</sup>

That the problem still persists is evident from a recent article in *Emergency Medical Journal*, which found an error rate of 19%.<sup>3</sup> We also faced this problem of errors in bibliography in the early part of our career and subsequently devised a strategy to overcome this problem. It is likely that some of you are already using it, and to readers familiar with computers, this will appear very trivial. However, we realised that the majority of our colleagues are unaware of this method, which prompted us to share it with your readers. We believe that postgraduate students in developing countries are likely to be the biggest beneficiaries of this communication.

Pubmed ([www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed](http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?db=PubMed)) is now a standard search engine for medical professionals. After we have

listed our references, we start with the author of first reference and put it in the search window of PubMed, which then lists the indexed publications of that author in chronological order. Searching by the names of more than one author of the particular reference limits the number of search results and makes the job of finding the relevant reference easier. After the reference has been found, it is selected by clicking the small rectangular box next to the reference. Next, we click on the "send to" icon and select the "text" option. This provides the details of the reference in a text format, which can then be saved in a separate document file (we use Microsoft Word software).

This procedure is repeated for all the references and we thus get a compiled bibliography that can then be formatted to any style. If the search for a particular reference yields "no item found", this signifies that there is some mistake in typing the author's name. Under these circumstances, a search can be made using the names of other authors of that reference. Alternatively, index terms from the title of reference can be used. Once the bibliography is complete, we recommend checking it against the original articles to safeguard against any possible errors in PubMed.

This strategy can provide all the indexed publications. However, references from books and non-indexed publications cannot be obtained by this method. We hope that this communication will help postgraduate students and those many authors who publish cases infrequently.

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doi: 10.1136/emj.2006.044206

Accepted 21 November 2006

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## Medico-legal consideration of gastric lavage in acutely intoxicated patients

Gastric lavage is now known to be ineffective, unnecessary or hazardous in some circumstances where it used to be performed as a routine. Adverse effects are more likely to occur when gastric lavage is performed forcefully without the patient's cooperation.<sup>1</sup> There was little clinical evidence in support of gastric lavage improving prognosis in an acutely intoxicated state.<sup>2,3</sup>

In South Korea, there was the case of a patient who ingested organophosphate insecticide in an attempt at suicide and refused lavage. The physician did not perform gastric lavage on the patient and decided to transfer the patient to a higher level medical facility. However, the patient's symptoms worsened and death resulted from organophosphate intoxication. The Supreme Court concluded that the physician was liable for the death of the patient and concluded that, although the patient did not show decreased mental capacity at the hospital in his express refusal and uncooperative attitude, gastric lavage should have been attempted with the use of a physical or chemical restraint.

From the medicolegal aspect, even though a patient attempts suicide, the patient legally has the right to refuse any treatment, and the

physician can respect the patient's refusal. When adverse effects occur as a result of gastric lavage performed forcefully without a patient's consent, if the medical evidence based on the effect of gastric lavage is unclear, the physician can be held liable. However, in this case, as the Korean Supreme Court observed, the physician should have forcefully performed gastric lavage if it was a matter of life or death for the patient. Hence the doctor was held to be negligent in failing to perform an act which he/she had a duty to perform.

As already mentioned, gastric lavage, with or without informed consent, performed negligently and which results in harm could, of course, give rise to a claim in negligence.

In summary, a physician can be held responsible for any damage that occurs as a result of the failure to perform a medical procedure vital to the patient. And he/she also can be sued for death or any clinical deterioration resulting from the lack of treatment or from ineffective treatment.

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doi: 10.1136/emj.2006.034603

Accepted 5 December 2006

Competing interests: None declared.

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