

## EDITOR'S CHOICE

## Competence in a crisis

Trish Groves *deputy editor, BMJ*

This summer Bruce Keogh, medical director of the NHS, told the *Daily Mail* newspaper about a new mandatory shadowing scheme for medical students to help them practise more safely as doctors. “The intention is to end the so-called killing season,” admitted Sir Bruce. “This is good news for patients—we recognise the change-over period in August puts patients at risk” (<http://bit.ly/SAsYp8>). Informal shadowing has been encouraged for years in many countries. But it’s now compulsory for final year students in England to spend four days shadowing their predecessor in their impending foundation post, a policy supported by a successful pilot study in Bristol (<http://bit.ly/ODjNyn>).

Newly qualified doctors need all the help they can get, and that’s why the *BMJ* started an intermittent series of “how to do it” articles called Competent Novice (<http://bit.ly/TNjrZP>). The latest contribution is by intensivists Paul Frost and Matt Wise, on early management of the acutely ill inpatient (doi:10.1136/bmj.e5677). Using case scenarios and reviewing scores that alert staff to abrupt deterioration, Frost and Wise explain how to approach the challenge calmly and systematically. The system of national early warning scores (NEWS) that’s being rolled out across the NHS may be a big help: its scorecard rates variations in six routine clinical observations made by nurses and sets a threshold for calling the ward doctor. The authors acknowledge, however, that lack of undergraduate training in acute care may hamper doctors’ judgment. They warn that “nurses may use their clinical acumen to alert junior doctors to patients who they suspect are developing acute illness, even though the routine physiological observations are normal . . . we recommend that junior doctors heed these requests as they are often well grounded.”

Pulse, blood pressure, and respiratory rate can be normal even in a critically injured patient. Tim Harris and colleagues point out that no single factor can accurately identify all patients who need early fluid resuscitation after severe trauma, and that the doctor’s experience and clinical knowledge may be as accurate as diagnostic tools (doi:10.1136/bmj.e5752). Evidence has changed the initial management of these patients: reliance on injury severity scores and high volume fluid resuscitation has now given way to the prosaically named damage control resuscitation. This means using intravenous fluids sparingly to a level of “permissive hypovolaemia,” avoiding crystalloids and colloids in the sickest patients, giving blood if need be, and getting the patient to the operating theatre or intensive care quickly. For patients who seem to be bleeding, giving tranexamic acid intravenously within three hours of injury reduces mortality.

That evidence on tranexamic acid comes from the CRASH-2 trial, the authors of which have just published a secondary analysis of the trial’s data (*BMJ* 2012;345:e5839). Ian Roberts and colleagues developed and validated a prediction model to identify patients with life threatening traumatic bleeding and then used the CRASH-2 dataset to see if the effect of tranexamic acid on mortality and thrombosis varied according to baseline risk of death. It didn’t vary much, so the authors suggest that this cheap drug can be given safely to a wide range of patients with traumatic bleeding and should no longer be restricted to the most severe cases.

Follow Trish Groves at [twitter.com/trished](https://twitter.com/trished)

Cite this as: *BMJ* 2012;345:e6153

© BMJ Publishing Group Ltd 2012