Keeping it simple

Kath O'Connor

Recently I got a lift home with a friend, who is a keen skier. Her kids were in the back seat and her 5-year-old son announced abruptly that he knew every town from Castlemaine to Mount Hotham, and would I like to hear them? I marvelled as he proceeded carefully through the list, starting with Harcourt and ending with Harrietville and Hotham Village. A few times he paused briefly as he assembled the image of the main street of each town in his mind. My friend laughed, 'Do you think we've been to the snow too many times?!'

Memory is a strange and changeable beast. At the age of five, it is a vast empty space and populating it with minutiae can feel like a fun game. As a teenager it is as flexible as a muscle, able to contract and expand at will. As we age, accumulated knowledge gets slowly more slippery and it takes more of an effort to wedge the square peg of new knowledge into increasingly round holes. I have certainly noticed this subtle process in the consulting room. Even though I [hopefully] have many years left to practise. At times, facts I had etched carefully into my grey matter seem to have simply disappeared, or at the very least sit just out of day-to-day reach. Luckily there's usually time for a quick google or glance at notes to fill in a gap. And there are courses where I can bone up on old knowledge and new. However, I am realistic about the fact that the day after the course is when my memory of any take-home messages is the strongest.

Knowledge in medicine grows exponentially.[1] In many areas, more knowledge leads to more complexity in management. There are new drugs, new indications and contraindications for old drugs, new knowledge and new skills to acquire. There are considered decisions to make about applying new evidence versus continuing with established practice. At times it feels impossible to keep up, probably because it is. However, in general practice many decisions can be considered over multiple sessions, with consultation with a colleague or specialist if needed and with patient and doctor learning in tandem about how important new knowledge affects the patient as an individual. And without the general practitioner needing a memory the size of a mainframe.

Unfortunately, this considered approach cannot be applied to some of the emergency situations outlined in the focus articles in this issue of *Australian Family Physician*. In cardiac arrest, immediate action is required. However, resuscitation medicine is an important exception to the rule that more evidence means more complexity. The new Australian Resuscitation Council basic and advanced cardiac life support guidelines are more streamlined, reflecting new knowledge about the central importance of compressions and defibrillation and the way human beings behave in emergency situations. There are less drugs and doses to remember (or read quickly in an emergency situation), and a clearer focus on defibrillating early and maintaining continuity of compressions. Other changes include the early recognition of deterioration before arrest and the importance of postresuscitation care. In this issue of *AFP*, Grantham and Narendranathan[2] provide a concise outline of these changes.

Acute management of anaphylaxis is also streamlined. As Kirkbright and Brown[3] outline in their article, vital elements are intramuscular adrenaline, supine position, airway support and intravenous fluid resuscitation. And an *aide memoire* is available in the form of a wall chart that can be laminated and attached to the practice emergency trolley.

Simplicity in the management of emergencies makes a lot of sense. Emergencies can be stressful, particularly so when they involve a life or death scenario. And Murphy's law dictates that they never happen at the right time or in the right place. Stress affects the way our brains function. On the upslope the adrenaline can sharpen the mind but on the down slope it can make the mind very messy. And when this is combined with a memory that refuses to co-operate, having a simple protocol on hand is very much appreciated.

Also in this issue of *AFP*, Heather Cleland,[4] Director of the burns unit at The Alfred hospital, provides us with a summary of the management of acute thermal burns and a link to more detailed evidence based guidelines available online. And for GPs who are required to interpret emergency imaging, Skinner[5] provides a structured approach to many common scenarios in which imaging is required.

Most GPs manage life threatening emergencies infrequently. Managing them well requires adequate staff training, a well stocked and checked emergency trolley and streamlined protocols. When planning for the unexpected, it helps to keep it simple.

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References

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