

Virtual Mentor

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Gaps in the Safety Net Metaphor

Jay Baruch, MD

Imagine this. A hospital space dedicated to treating anyone, with anything, at anytime [1]. Fill the space with the sickest patients, medical and surgical emergencies, kids and pregnant women in labor. Intoxicants? Sure. Severe mental illness? Absolutely. Add elderly people unable to care for themselves, homeless men and women who sleep in public view, souls overwhelmed by the circumstances of their lives, and people who can't tell you what's wrong, only that they don't feel right. Now let's limit the number of beds. Pile patients up in the waiting room until they resemble stranded airport passengers during a snowstorm. Long waits, overburdened staff, frightened and possibly sick patients. What twisted mind would dream up a story such as this?

Kurt Vonnegut offered this advice to writers: "Be a sadist. No matter how sweet and innocent your leading characters, make awful things happen to them—in order that the reader may see what they are made of" [2]. But would Vonnegut, master satirist, stress characters in his fiction to the degrees patients and physicians experience in emergency departments (EDs) on a regular basis?

A 2006 IOM report pronounced a developing crisis in emergency care, characterized by overcrowding, ambulance diversion, a scarcity of inpatient beds resulting in the boarding of admitted patients in hallways, unavailability of specialists, and a fragmented EMS system of inconsistent quality [3]. There were 90.3 million ED visits in 1993; 113.9 million in 2003; and 119 million in 2006 [4]. Meanwhile, hospitals are closing; availability of hospital beds, pinched [3]. These challenges are particularly daunting when we remember that this nation's EDs serve as the health care system's "safety net." The safety net metaphor has created perceptions and expectations that are not being met, leading to frustration and dissatisfaction.

Viewing the challenges inherent in emergency medicine through the lens of narrative may help us understand and respond to them. Delivering excellent, efficient and compassionate health care requires both sensitive and sophisticated narrative attention to patients' stories [5]. Sociologist Arthur Frank wrote "One of our most difficult duties as human beings is to listen to the voices of those who suffer." Listening is a hard but fundamentally moral act [6].

The emergency physician's fiduciary responsibility derives from the social function of the ED [7]. A quasi-public space that links the community with the hospital itself, the ED represents the hospital's social conscience and serves as the public

Samaritan, entrusted with certain moral and legal duties that don't apply to physicians in other settings. The Emergency Medical Treatment and Active Labor Act (EMTALA) mandates nondiscriminatory access to emergency medical care for anyone with an emergency medical condition [8]. Essentially, EMTALA promises unconditional rescue.

But the ED is more than a medical space freighted with moral responsibilities. It's a circumstance where narrative arcs converge. Vonnegut's advice for writers, I believe, works as a helpful device for reconceptualizing the ED encounter. Desire drives every compelling story. A character wants something. But obstacles—internal, interpersonal, or vast social or environmental forces—present themselves. How will this character respond to the conflicts? What motivates her actions, shapes her beliefs? Will she get what she wants? Why? Why not? How do other characters respond to her?

Doctors and patients are real-life characters constructing a drama, active agents shaping a story. Whether the emotion and energy in the scene turns positive or negative depends in part upon the degree to which the characters interpret the situation, understand their expectations and appreciate its limits. The doctor-patient relationship isn't a balanced encounter. The knowledge and skills possessed by physicians impart great power. Patients are vulnerable; weakened or thrown off balance by illness or injury, they are now dependent on the ED physician, who is often a stranger.

Patients exert their wills, too. They bring more than their symptoms. Along with expectations that may or may not match the realities of ED care, patients carry worries and fears, backstories and hopes for the future. Most of all, they are driven by the fuel of all drama—necessity. To be an ED physician is to regularly encounter patients facing terrific challenges—lives pebbled with questionable choices or bad luck or socioeconomic conditions beyond their control—all before entering the safety net in crises.

Patients as Characters

The word patient is derived from the Latin *patiens*, which means to suffer. Suffering is a deeply personal matter. Pain doesn't necessarily cause suffering, which has much to do with perception of pain, its meaning, its impact on one's life, and how it colors one's idea of a future [9]. Suffering isn't measured with pain scales.

Many ED patients suffer terribly, but the source of their suffering often falls outside the domain of expertise of emergency physicians. Straightforward medical problems may be complicated by socioeconomic issues, family ordeals, literacy and education impediments, cross cultural divides, to name only a few.

How can considering patients as characters alleviate their suffering? The “character in room three” sounds glib and admittedly disrespectful. But the idea of character might be a richer and more pragmatic way to consider the seemingly infinite range of

challenges. Ethics has the same root as *ethos*, the Greek word for character. Character in Greek drama is a moral concept. Who you are is reflected by what you do. Aristotle said, “Character is that which reveals moral purpose, showing what kind of things a man chooses or avoids” [10, 11]. Vonnegut urges writers to be sadists because true character is revealed through conflict, by the choices we make when the stakes are high.

Consider, for example, the physician and the asthmatic on his third visit to the ED in the past week. The ED physician becomes upset because the patient hasn’t filled the multiple prescriptions, or followed up with the clinic. The patient gets defensive. It’s not his fault the earliest clinic appointment is in two weeks, and all those inhalers critical to his health costs hundreds of dollars without insurance. So the patient improves with treatment, then returns to his apartment building with leaky pipes, wet carpets, cats and cockroaches, and the disinterested landlord.

Chronically inebriated homeless patients are also a common presence in EDs. Numerous attempts at treatment unsuccessful, frequently plagued by untreated mental illness or chronic medical problems, the homeless can present several times in a 24-hour period. They need beds, nursing, and monitoring until they’re sober enough to be discharged, which can be many hours. They can stress the physical and emotional limits of ED staff, but they’re also socially and medically vulnerable, often taken to the ED against their will. I appreciate my chronic inebriates as characters, well-rounded characters, with a past, family, personal interests. It’s important to discover the person behind the alcohol level. Curiosity is the road to empathy.

I’m encouraged by isolated non-ED referral programs where this population may be better served, providing more than a bed and a sandwich, but addiction, medical and social services [12]. So-called “wet house” partnerships between housing authorities and health departments have saved municipalities millions of dollars simply by providing homeless alcoholic high health care utilizers in urban centers a safe place to live [13].

What about the “revolving-door” asthmatic whose apartment is unhealthy? New medical-legal collaboratives flourishing throughout the United States might be able to redress socioeconomic factors that impact medical problems, as well as train physicians and lawyers in this multidimensional approach to care [14, 15].

From Safety Net to a Clean Well-Lighted Place

Metaphor works by “understanding and experiencing one kind of thing in terms of another” [16]. The metaphor of the ED as a safety net works on many levels. It’s visual. It has heroic dimensions. Many physicians and nurses I know were drawn, and find great purpose, in this ideal. But does it make promises that it can’t deliver? Does it stoke expectations that can’t be met? Does this net catch people and break their fall, or simply suspend their descent temporarily?

Is there a metaphor that can satisfy the expectations of those who come to the ED in the way that the safety net metaphor satisfies what society as a whole expects of the ED? Can the narratives of society's ED story and the individual patient's story be more compatible? When working overnight shifts, I'm often reminded of the Ernest Hemingway short story, "A Clean, Well-Lighted Place" [17]. Two waiters, one young and eager to return home to his wife, the other old and lonely, argue about staying to serve another brandy to their only patron, an elderly, deaf man, a "frequent flyer" well known to them who had tried to hang himself, only to be cut down by his niece.

"Each night I am reluctant to close up because there may be someone who needs the café...."

"Hombre, there are bodegas open all night long."

"You do not understand. This is a clean and pleasant café. It is well lighted. The light is very good and also, now, there are shadows of the leaves" [17].

A lighted place provides respite from the darkness, where lonely people can be lonely without being alone. It promises light and dignity.

There are few places in the hospital that respond to a dizzying range of immediate needs with such flexibility and compassion. Whether it fulfills its promise as a safety net and serves nobly as a clean well-lighted place depends upon one's expectations, desires, and relationship to it. But this is certain. I wouldn't want to imagine a society without EDs and the expertise and character of the people who staff them.

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Jay Baruch, MD, is an assistant professor of emergency medicine at the Warren Alpert Medical School at Brown University in Providence, Rhode Island, where he also serves as director of the medical ethics curriculum. He is the author of a collection of short fiction, *Fourteen Stories: Doctors, Patients, and Other Strangers* (Kent State University Press, 2007). His academic interests include pragmatic medical humanities, which he will pursue as a faculty fellow at The Cogut Center for the Humanities at Brown University.

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