

Dignity and Safety



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My marriage is in crisis. I am still unsure how a relationship that began with such optimism and genuine love unraveled into its current fragile, tenuous state. The decline was a gradual one, with a series of small compromises leading to an untenable position. One morning, our marriage imploded into violence. Even as I attempted to repair the damage and mend our relationship on my own, I continued to allow myself to be verbally and emotionally abused by my spouse. With my self-esteem compromised and shattered, I stopped trusting my own judgment.

How could I have been so wrong about someone? Why did I allow someone to treat me so badly? I mulled over such questions for several weeks, turning them over and over again in my mind. While my childhood was far from perfect, I certainly was not raised to accept such mistreatment or contempt. Where on earth did I go wrong?

After many months of rumination, a realization came quietly one afternoon: **Because I'm treated so poorly at work, the mistreatment I received from my spouse didn't seem as bad by comparison. My tolerance for abuse has grown to the point that I don't know what it's like to be treated well in other areas of my life.**

Professionally, I've been in some incredibly tough positions, even by emergency medicine standards. In addition to medical school, an emergency medicine residency, and board certification, I've served my community, as well as my country. I have also held (and continue to serve in) positions of leadership that require additional responsibilities such as maintaining positive patient satisfaction scores and engaging in measures to mollify irate patients. These positions have also involved being screamed at by patients and families and being subjected to physical attacks. If I fail in even the smallest, inconsequential way, I'm confronted with disciplinary action by the administration even if I personally did nothing wrong.

My experiences at work have been fraught with self-deprecating messages: I am never right. I am always wrong. There are no consequences if someone yells at me

or physically attacks me. I still must care for them and mollify them. My physical safety and dignity are unimportant. My needs don't matter.

It's important that I clarify that my managers aren't mean. I work for a very kind and thoughtful administration. However, the needle has slowly shifted, and it seems no one has stopped to consider or evaluate how abusive or condoning of abuse we have become as an organization or a system.

Consider the disturbing resemblance between the cycle of domestic violence and our approach to patient satisfaction: First, there is no external objective evaluation of patients' behavior. We expect unstable and unpredictable lashing out. We try to stop it because we know it's painful, but we also know it is irrational to expect otherwise and eventually we succumb and bear the brunt of patient outbursts. Second, we are always to blame. We repeatedly hear that we could have done something to prevent the situation. *You should have smiled more. You shouldn't have crossed your arms. You should have said that sentence differently. You should have dressed nicer or cleaned the house better....* Oh, wait... We're still talking about patient care. Finally, instead of external voices supporting us to help realign our internal barometers shattered by self-doubt and blame, our colleagues and leadership continually tell us that we could have prevented our own abuse if we had just done something differently. As if that weren't bad enough, annual written evaluations remind us of our failings.

Some time ago, a patient's family member, who was much larger than I am, yelled at me in front of a waiting room full of patients. I tried to make the family member happy but quickly realized that I was not going to be successful. As I attempted to leave, the family member continued to yell and aggressively stepped into my personal space. I apologized and exited the room thinking that everything would be OK. There were administrative colleagues with me who also witnessed how scary and degrading that was. Surely the hospital leadership had seen what had happened and had witnessed that I had been physically threatened. However, rather than being empathetic and supportive,

my administrative colleagues immediately went to the C suite to express their disapproval of how I responded to being verbally abused and physically threatened.

The hospital administration quickly contacted my group who, in turn, promptly disciplined me based on the hospital's input rather than asking for my account of what had happened. I cried as I shared with them what this individual said to me, how much larger this person was compared to me, and how threatening the use of body language was. It didn't matter. It was still my fault.

I should have handled that better. I should have done something different to de-escalate the situation. I should have worked out more and lost another 10 pounds. Oh, wait...am I talking about my marriage or my job?

This whole event reflected painful aspects of my own marriage: my feelings don't matter, my needs don't matter, my physical and emotional health don't matter...and everything was my fault.

What are we doing? How have we allowed things to get this far? Why are physicians killing themselves at such an alarming rate? Why is my work environment, which happens to be the best job I've ever had, so persistently awful that it made my abusive marriage seem like an acceptable situation? This is jarring and disturbing. Even worse, I am in this juggernaut, and my one small voice cannot possibly stem the tide that is drowning us as a profession.

I am sure that I am not the only physician who is going through this painful cycle of abuse at work and, sadly enough, at home. Perhaps we really can have a serious and necessary conversation about this at some point and enact changes in our community. We must stop abusing one another, and we must insist on personal safety and dignity for ourselves and for our colleagues. I, for one, will continue to fight for us all to have a safe and dignified work place.

IMAGES IN EMERGENCY MEDICINE

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DIAGNOSIS:

Distal esophageal rupture with mediastinitis. Esophageal rupture is rare but has significant morbidity and a mortality rate of greater than 15%,¹ and should be considered as part of the differential diagnosis in patients presenting with severe epigastric, chest, or back pain. Thoracic radiograph results are nonspecific. Findings include free mediastinal, intraperitoneal, or subcutaneous air but are rarely diagnostic.² Contrast esophagram or CT scan with water-soluble oral contrast should be performed for definitive diagnosis and to determine whether emergency surgery is indicated. Initial management including resuscitation, antibiotics, and surgical evaluation must occur promptly because the mortality rate doubles if treatment is delayed greater than 24 hours.³

The patient was taken urgently to the operating room, where a 7-cm spiral tear and a 4-cm esophageal mass were found just proximal to the gastroesophageal junction. The mass was thought to be the precipitant of the tear. Purulence and food matter consistent with black beans were noted in the mediastinum. The mass was resected and the esophagus was repaired. The patient was discharged home on postoperative day 12.

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REFERENCES

1. Ali JT, Rice RD, David EA, et al. Perforated Esophageal Intervention Focus (PERF) study: a multi-center examination of contemporary treatment. *Dis Esophagus*. 2017;30:1-8.
2. Pate JW, Walker WA, Cole FH Jr, et al. Spontaneous rupture of the esophagus: a 30-year experience. *Ann Thorac Surg*. 1989;47:689-692.
3. Brinster CJ, Singhal S, Lee L, et al. 2004. Evolving options in the management of esophageal perforation. *Ann Thorac Surg*. 2004;77:1475-1483.