Does It Really Come With the Job?

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In my second year of residency, a patient choked me.

During this period of my training, I was changing. I was growing confident in not only the bread and butter of an emergency medicine practice but also the tacit knowledge of the management of the regular patients: the ones who came in suicidal, but-not-really-suicidal-who-just-wanted-a-place-to-stay-and-a-tuna-fish-sandwich, or the alcoholics who walked down the hallways naked and yelling profanities. I was learning to shrug my shoulders as I recognized their patterns. I felt that I belonged to an elite tribe of clinicians who had seen it all, and had been baptized by fire into a gruffness that comes with working in an inner-city emergency department (ED).

It is with this mind-set that I returned to my desk to review the resulting labs and imaging of Mr. Butler, whom I had seen earlier. He had come in altered, intoxicated, and was very drowsy but breathing. On record review, he had been to the ED many times with several forms of intoxication and the notes painted a picture similar to his presentation today. The computer highlighted the abnormal results in red: cocaine positive, EtOH well beyond the legal limit, opiates positive. The CAT scan of the head was repeated because he had some abrasions to the forehead showed nothing acute.

He is in the area of the ED where critically ill patients are seen and where rooms are separated only by curtains. He would require frequent reassessments today. I peel back the curtain and the metal rings that suspend the fabric scratch loudly to open—and again to close us in. We are alone in the room together and I see him lying flat in the bed, a tangle of blankets covering him, so tall his ankles hang off the gurney. I see the pathologically slow rise and fall of his chest and become concerned. "Sir, it's Dr. Liroff." I try to shake him awake. "I'm checking up on you." He wakes immediately and turns his head toward me with eyes that are wide and bloodshot. He looks through me with what I interpret to be abject hate.

He sits up slowly; his gnarled hands reach for my neck; his nails are 4 cm long and pointed and tinged black and I feel them dig into my flesh before I can comprehend what's happening.

I'm able to make a garbled sound of panic with the pressure to my larynx. I use all of my weight to step back and free myself from him. The charge nurse throws back the curtain after hearing me and finds me bent over, hands on knees, trying to catch my breath.

She escorts me back to the physician's desk, where I sit and I'm examined by my attending. There's some redness from my assailant's grip that will likely turn into ecchymoses and puncture wounds from his nails. I head to the bathroom to quickly reset my thoughts and to scrub my physical wounds with ChloraPrep, welcoming the sting.

My airway's intact, I joke. Comes with the job, right? *I finish the shift.*

It turned into a story that I would tell at the bar. Exchanging similar tales of assault in the ED with my colleagues, I hear that someone was punched in the face and the cops discouraged her from pressing charges. Another was sexually assaulted by a patient.

We shrug off these experiences as if they don't matter, but the accumulation of traumatic events affects who we are as doctors and can even impact our thoughts and behavior outside of the walls of the ED.

For example, when I am not at work, I spend my time barefoot at a yoga class, listening to Joni Mitchell, or on a hike. I even put spiders outside rather than kill them, so it's out of character for me to start fistfights. While traveling abroad a year later, I surprised myself by doing just that.

Walking along a crowded street in broad daylight, I feel something bump into me from behind. Fight or flight kicks in this time, and my body chooses to fight. I turn on my heels and I throw a hard right hook, surprising myself. I squat and survey the scene: an elderly lady carrying shopping bags is dumbstruck by the attempted assault. Swearing in a foreign tongue, she gesticulates wildly, turns a corner, and walks out of sight.

My reaction startled me. The intensity behind this response had been growing since the last time I had felt threatened.

My outburst finally led me to reflect on my experience in that curtained room in the ED. Small woman. Large man. His hands around my throat.

I can't breathe.

I was terrified.

I write this to start a discussion on how we handle the assault of clinicians in the ED, how we can protect our staff in situations that are rife with emotion, intoxication, and complicated power dynamics.

I don't have the answers to these questions, but one thing is certain: assault *cannot* be part of this job.

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IMAGES IN EMERGENCY MEDICINE

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DIAGNOSIS:

Zoonotic conjunctivitis caused by Chlamydophila felis. *Chlamydophila felis* infection was diagnosed with polymerase chain reaction. The patient was treated with doxycycline 100 mg/day for 30 days, and public authorities were alerted to supervise care of the cats. At follow-up 2 months later, she was asymptomatic.

C felis is a common cause of conjunctivitis in cats, and there is evidence that it may occasionally cause keratoconjunctivitis in human beings.[1] The zoonotic transmission of *C felis* to people occurs through respiratory (nasal and pulmonary) secretions from sick cats and also through fomites.[2,3] The diagnosis of *C felis* infection can be performed by direct methods (culture, polymerase chain reaction, chlamydial antigen tests using enzyme-linked immunosorbent assay, and Giemsa's staining to look for inclusions) and indirect methods (antibody detection using immunofluorescence and enzyme-linked immunosorbent assay techniques).[2,4] *C felis* human conjunctivitis has rarely been described, and this zoonosis may be underreported.[3,4] Unambiguous identification of the causal agent is key to successful management, and rapid identification of *Chlamydia* species by polymerase chain reaction can identify the zoonotic route of infection.

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