

My Job: A Courtroom Victim Impact Statement



Amy D. Costigan, MD*

*Corresponding Author. E-mail: amy.costigan@umassmemorial.org.

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I very distinctly remember walking into the room that day. A few moments earlier, we had stopped resuscitative efforts on a young woman in cardiac arrest. Delivering devastating news to people never gets any easier no matter how many countless times I've done it. I paused in the hallway as I always do to collect my words, compose myself, and take a deep breath. The social worker was sitting in the seat to the right of the door and the mother was on the couch straight ahead of me. I had two choices. I could sit in the seat next to the door or I could sit on the couch. I chose the couch. Her daughter had just died, and it only felt right to sit with her.

I looked at her and said the words that I have said so many times before. They pierced through the air and lingered in the dreadful way they always do. Every time those words cross my lips, I am changing someone's life forever. It is without question the most challenging aspect of being an emergency physician. Usually, my words are met with gasps, tears, or pleading. If they reach out for me, it is for a desperate hug or a set of arms to hold them up. This time was different. This time, my words were met with a sudden pain in my left cheek. She had punched me in the face.

We both stood up, and I quickly found myself cornered. She was positioned between me and the exit. She ripped the phone off the wall and moved aggressively toward me, yelling that I "didn't doing anything" to help her daughter. I quickly regretted my choice not to have taken the seat by the door. I looked over at the social worker and saw the hesitation in her eyes as we both realized she would have to leave me alone in the room to get help. She ran out and around the corner and there I was. Alone, trapped, and helpless. All I could think in that moment was that I might get hit again—or worse.

Somehow, I was able to maneuver myself around toward the door. Torn between my instincts as a physician and my fear as a human, I paused in the doorway and attempted to offer my condolences before retreating to the safety of my colleagues. After exiting, I took a couple of minutes to

compose myself and then did what I always have to do after giving bad news: I walked into another patient's room and introduced myself. Only this time I had to do it with shaking hands and a red mark across my cheek.

There is an epidemic of violence against health care workers in this country.

Nearly 74% of workplace assaults occur in the health care setting.¹ Seventy-eight percent of emergency physicians report being targets of workplace violence in the last 12 months.² One hundred percent of emergency department (ED) nurses report being verbally assaulted and 82% reported being physically assaulted in the last year.³

A nurse was stabbed by a patient in the ER at Harrington Hospital, only to have her life saved by her colleagues. An angry family member walked into Brigham and Women's Hospital and killed a cardiac surgeon because he was unhappy with care. In Indiana, an orthopedic surgeon was murdered for refusing to prescribe opioids to a patient.

We have metal detectors in our ED now. Patients hate it. They are angry that they are made to feel that our hospital is unsafe. But it is unsafe. They yell at us, "What kind of place is this?!" Unfortunately, it's the kind of place where nurses get spit on, yelled at, grabbed, and groped. Staff get called every vile name you can imagine. It's the kind of place where 1-to-1 sitters get choked in the middle of the hallway while 88-year-old grandmothers watch as 8 other staff members desperately try to free their colleague.

Physicians get punched in the face for giving bad news.

We are told not to press charges. We are told no one is interested in prosecuting these cases. We are told these cases get dropped so don't bother. We are told the perpetrators shouldn't or couldn't be held responsible for their actions while undergoing medical care or during times of stress. We are told it is part of our job.

That is not my job.

I am a physician. The walls of a hospital should protect me. They should not protect others from being held accountable for their actions.

It is not my job to be assaulted. Just as it is not the job of a judge to be hit by angry or upset or grieving family

members. Just as it is not the job of a defense attorney to get struck by a client when the outcome of a trial was not desired. Just as it is not anyone's job to repeatedly suffer unjust accusations, name-calling, and physical assault.

I do things a little differently now when giving bad news. I never go alone. Sometimes I have security stand around the corner. The door always stays open. I know my exits.

I always choose the seat by the door.

I keep my distance.

Isn't that sad? I keep my distance when communicating some of the most personal and devastating news a family member may ever hear. I keep my distance when the right thing to do is to be near.

As a physician, I think it's really sad.

That is not how I want to do my job. That is not the job I signed up for.

Author affiliations: From the Department of Emergency Medicine, University of Massachusetts Medical School, Worcester, MA.

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IMAGES IN EMERGENCY MEDICINE

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DIAGNOSIS:

Inferior hip dislocation. The radiograph (Figure 1) and CT scan (Figure 2) showed an inferior left hip dislocation, a subgroup of anterior hip dislocations. There were no associated fractures or free bodies in the joint space. Given the reassuring imaging, a closed reduction under procedural sedation was performed in the ED with caudal traction, with internal rotation while downward pressure was applied to the ipsilateral anterior superior iliac spine. After successful reduction, a repeated CT scan (Figure 3) was performed and the patient was given a knee immobilizer and a hip abduction pillow.

Inferior hip dislocations are rare, accounting for less than 10% of all hip dislocations.^{1,2} Because traumatic hip dislocations are often associated with additional injury, a postreduction CT should be performed because it is the image modality of choice to assess for associated fractures or intra-articular pathology.^{1,3} Specifically, postreduction CT allows visualization of femoral head fractures, loose bodies in the joint space, and acetabular fractures.⁴

Author affiliations: From the Department of Emergency Medicine, Vanderbilt University Medical Center, Nashville, TN.

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