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A Good Night Out

By Tim Cunningham

The schizophrenia of a triage pod at a rural level-one trauma center emergency department (ED) mirrors the madness and abuse our system can dole out on the populations we serve. In less than five minutes, the triage nurse must collect a brief history of illness, vital signs, medication and allergy status, determine sick and not sick *and* deescalate a patient's mood so that the suffering person will be able to wait in a waiting area filled to capacity for possibly hours. The determination of sick vs. not sick demands a deeper level of judgment too; the nurse determines how long this patient could wait to be seen before the condition deteriorates, assigning a number to each patient: "1" which indicates dead or dying at the door, up to "5" which asserts a patient can wait for hours, his/her condition won't change—not sick.

As comical as it is stressful, a twelve-hour shift peering through the kaleidoscope of suffering makes me yearn for any indication of honesty. Most of the patients I see come to us vulnerable, scared or angry, arguing—with and without words—why they must be seen by a physician. Yet sometimes a set of vital signs is the only indicator of what is actually occurring in the patient's body, the only truthful snapshot of how sick a person is.

There is little time for sympathy. According to Virginia Woolf, "We can do without it." Her "childish outspokenness in illness" blurting the truth while also blurring its hues often resonates in our eight-foot by eight-foot triage room. This claustrophobic space witnesses furtive outbursts of storytelling, pressed by time and waiting lines. It is like the policymaker standing in front of a congressional hearing trying to fight for what he believes to be just, and when the story is less than half told, the gavel drops, he is shuffled out and the next plaintiff enters.

One Saturday night, I had two such plaintiffs enter this house of rapid judgment. They challenged the role of sympathy, demanded a compassion I failed to offer and stripped bare all "cautious respectability health conceals."

It began with a paramedic walking into the triage room, hurried yet unconcerned: "I've got a twofer for you." Ambulance crews do not usually bring in two patients at once.

"I'll see the sick one…"

Before I could finish my phrase with "first," the paramedic wheels in a tearful woman in her late 20's doubled over, rocking rhythmically with her pain. The paramedic's face is red, jaw clenched; he does not give me any more history beyond "abdominal pain and ankle injury." Then he is gone, leaving the woman in the wheelchair before me.

"What brings you in?"

"My pain!" She resembles a Looney Tunes cartoon character spitting a cocktail of tears and saliva on me with the "P" in pain.

"Where?" I roll my chair away from her.

"Cain't you tell?" Her corrosive southern Virginia accent repels me, "My stomach!"

I lower my voice and take a breath, hoping she may receive some semblance of empathy from the physicians and nurses who will care for her in the back. But in this moment, I suspend sympathy and empathy; I need to know how sick she is.

"I don't know what I did…It jest hit me! I cain't hardly walk. "

"Any chance you could be pregnant?" I wrap the blood pressure cuff around her arm. She chuckles, revealing a moment of lightness inconsistent with the pain she claims.

"Yeah right!" She doubles over again in pain, arms hugging her knees, head in her lap.

"Keep your arm straight, I need to get your blood pressure."

Heart rate: 80, Pulse oximetry: 99%, Respiratory rate: 24, Blood pressure: error

"Hold your arm straight, I need to get your blood pressure." She jumps away from me as I reach to hold her hand and elbow to gently remind her to keep her arm still.

"I cain't, everything hurts too much!"

"On a scale of zero to ten…"

"Twenty," she blurts, "Oh lord, kill me now"

From past experience I've learned that the more protracted a person's response to the pain scale question, the less reliable the description of the pain.

I begin to read her history on the medical record: thirty visits to the emergency department in the last two years; abdominal pain, psychological evaluation, infection, laceration repair, seeking shelter, seeking rehab, abdominal pain…

"Any allergies to medications?"

"Yes! Ibuprophen and morphine, upsets my stomach and I itch."

Blood pressure: 125/82, normal.

She has been in the triage seat for four minutes; I no longer trust her description of pain. What is worse is that my distrust of her complaint has the power to negatively influence her whole visit in the ED if I, in triage stamp her as "narcotic seeking" (even though that is my gut instinct). I am condemning her to a guilty-before-proven-innocent hospital visit. My nursing note is succinct, stating just the facts: The history engraved in her medical record is damning enough.

Because she is complaining of abdominal pain, I am forced, by protocol, to make her a triage level 3, even though I believe she has no severe medical problems. As a 3 she will skip the line in front of all the 4's and 5's who have been waiting for hours. She knows our system well. She will have radiography, blood tests and perhaps sonography done at the expense of the hospital because of her presenting complaint. We will cover our bases and if she gets what she wants, she will leave the hospital with a buzz.

She cries like a spoiled child when I wheel her to the waiting room. Her tantrum behavior when she learns I will not take her immediately back to the treatment area raises the eyebrows of the others sitting in the charnel awaiting attention from an emergency physician.

There is no time for sympathy.

Number two of the twofer limps into the triage room; I gesture for him to sit in a chair. He is sweating and looks pale; he throws a concerning glance over his shoulder towards the moaning woman who I just triaged.

"I'm sorry," he begins.

"For what?"

"My wife, over there. She gits mean when it hurts."

The 5-minute stopwatch is ticking, but I don't see a line behind this man waiting to be triaged and I am trying to make more sense of this woman I just saw.

He explains in a way that sounds scripted, like he has done this before: "She had called the ambulance tonight. We ate supper. Then she called her mother to come over to be with the kids after that."

I put the blood pressure cuff on, assuming I will see nothing but normal vital signs.

"We don't have insurance, no money. After her mom got to our house her stomach started to hurt really bad. Nothin' I could do to make it stop. She took the phone from me and called 9-1-1. When she wants somethin', she gits it."

"You alright in there?" She yells from the waiting room. A security guard approaches her, asking her to keep her voice down. This man's wife is now sitting up in her wheelchair watching television.

Her husband whispers to me: "I didn't think I needed to come."

Vital signs normal.

"I fell a few days ago, was working. Fixing the chicken coop. I tripped over one of my dogs and stepped on a 4 x 4 sideways, like this." He steps awkwardly on the ground with his good foot, showing how his ankle twisted.

"Can I see your foot?"

And as soon as I ask, sock and shoe are off, his calloused foot is hoisted into the air, inches from my face. It looks fine, no swelling, no redness, no compromise in circulation—not sick.

"So when she called the ambulance, she said I should just come in and get it checked out since she was already coming. The kids are taken care of for the night, it's Saturday…we could use some time out."

"What is your pain?"

"Oh, it ain't bad. Maybe eight?"

I make him a level 5; his color has come back into his face now that he has had a chance to state his claim to the story. He is no longer sweating and appears to be much more comfortable after talking with me.

"Is it busy here on Saturday nights? I think all I need is maybe a prescription for some Percocets or somethin', not much. Will it take long?"

"Yes, you'll be here for a while."

He thanks me, shakes my hand and limps back to the waiting room to sit with his wife. I look over at her and she lets out a vociferous groan; her husband forgets about his limp and walks briskly to console her. They sit together and watch TV.

Date night in the emergency department, no roses or bouquets but sympathy in suffering together and the hopes to go home with a new prescription for Percocet. The children are with grandma and this may be their only time together in peace and quiet. The peace is now only broken when I, responsible by law for the health of all the patients waiting to be seen, make eye contact with this woman. When her eyes meet mine, the painful charade ensues; she bends, lurches and begins to cry.

To avoid exposing the others in the waiting room to her childlike outbursts, I limit my contact with the waiting room in general. Security cameras allow me to witness the suffering in the space at a distance.

By this time the waiting patients are stagnate, none have gone back to be seen in the last hour, yet there are no new patients to triage and so I am free to busy myself with the charts. The attending physicians and charge nurse in the back have certainly skimmed the charts of all patients in the waiting room by now, a system of double checking the triage nurse to ensure there are no emergently sick patients I may have mis-triaged. When I have time, I too look more deeply into the patients' charts to make sure I have not missed a pertinent piece of history that would necessitate a more rapid assessment. My first chart review is of my loudest member of the waiting room.

She first came to our facility when she was 24-years-old, gravida 3, para 2. Labor and deliver admitted her for a caesarian birth of her third child. The child had whopping APGAR scores of 10 and 10, but mother did not do so well. Her bowel was nicked during the procedure, which led to a subsequent ICU admission of 20 days, IV antibiotics, central line placement, associated infections, sepsis and even intubation. She was eventually discharged from this first life-changing experience, and then her chart chronicled a deluge of ED and hospital admissions.

Our facility healed her wounds two years ago after a lineage of admissions and readmissions. The fecal matter that contaminated her once fertile core was removed and all ensuing horrors resolved, yet, she is back again for needs that have not been met.

Blame, like sympathy, is useless in protracted medical cases. A chain of events too numerous to quantify have created this woman's suffering. They have concurrently shaped her husband, as well as their relationship, and what they might deem a good night out.

I look up again, scanning the faces of all patients in the waiting room—if someone looks pale or worse, I bring them back in to update their vital signs. My eyes meet those of this couple last; purposefully I watch them a bit longer. I am not sure why, maybe it is that I want her to be more sick, I want to her find some sort of relief. I now want to believe her pain is real, a physiological problem that pharmaceutical intervention can ease. I know it's not, and that her only access now to the medical system that has formed her is a three-digit phone call.

She whimpers again as our eyes meet; she is tired of crying and seems to be enjoying the comfort of having her husband with his arm around her shoulders. She knows I am on to her; she knows how to play this game.

Although Woolf is right—that there is no room for sympathy when pain rears it childish face, blurting out truths and removing the orderliness of health—there remains space for compassion. Despite time limits on nearly all things we do as medical professionals, especially in the ER, there may be methods to express compassion in the small cracks of time, camouflaged windows of opportunity. I have only been an emergency nurse for four years and have much to learn, but believe these opportunities abound. As care providers it is our ethical role to seek them out and do what we can to bring compassion to pain, shedding more light on the uncomfortable "childish outspokenness in illness."

Tim Cunningham is an emergency nurse, clown and doctoral candidate at the Mailman School of Public Health in the Department of Population and Family Health. He has worked in emergency settings internationally and in Virginia, Washington DC and New York. Cunningham also is director of the humanitarian relief group, Clowns Without Borders USA. He is interested in the power of narrative to bridge health, laughter and holistic healing practices. "A Good Night Out" was shortlisted in the 2013 *Intima* Essay contest

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