Beneath the surface of emergency medicine—The dark sides we seldom talk about

The majority of presentations in the emergency room are far from glamorous, and they are also the most challenging.

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When I tell people that I am an emergency physician, they often think I spend my time dealing with gunshot wounds, stab wounds, major traumas, and other adrenaline-filled life-or-limb emergencies. Reality is far less glamorous. The majority of presentations in the ER are far more mundane. For every crashing patient with a life-threatening emergency where every second matters, I see 10 patients who present with chronic health issues, from a patient who came in to get a second opinion on a rash that had been bothering them for over a year, to a patient asking to get their cholesterol checked, to one with chronic pain or dizziness who decided that enough was enough and wanted an answer *now*.

The mismatch between what bread-and-butter cases in the ER entail and the perception that many people have is perpetuated partly by us, ER physicians. We are more likely to tell medical students, colleagues, and friends and family about the resuscitation or trauma cases than about the people who come in for a prescription refill because they cannot access their family doctor, or those who are struggling to cope with caring for a parent's dementia at home.

The major traumas, the patients in septic shock, and the heart attacks and strokes are also not the most challenging cases; they usually have fairly straightforward treatment algorithms that we have learned in our training. The challenging cases are providing good care to the non-emergencies that arise when patients do not have timely access to their family physicians and outpatient allied health resources like psychotherapy or physiotherapy, and there are limited resources to work up and manage more chronic complaints in the ER. Increasingly, emergency physicians have become the embodiment of Atlas, the god of strength and endurance in Greek mythology, having to hold up the increasing weight of our collapsing health care system on our shoulders.

In addition, we are not infrequently screamed and sworn at by patients in the ER, many of whom feel frustrated and neglected by our overstretched health care system. I often spend hours on a shift advocating for patients with consultants who are reluctant to see a patient who I think needs to be admitted, especially late at night or on the weekend. I sometimes deal with the moral distress of being the only overnight emergency physician on shift and having to choose between providing good and thorough care to the patient in front of me versus going faster but providing suboptimal care so that someone does not die in the waiting room when there are 9-hour wait times and 50 patients to be seen. On very busy shifts, which have become the norm, I sometimes don't have time to go to the bathroom or eat for the whole shift. I ask myself if it is morally acceptable to be taking a quick break to grab a bite when patients have 9-hour wait times. I also remember the many birthdays and social events I've missed due to working six weekends in a row. To add to this, shift work is a class 2 carcinogen, according to the World Health Organization.[1]

These are but some of the not-so-glamorous aspects of working in the ER that many aspiring medical students or residents may not realize. However, despite all this, I feel fortunate to be doing this job, and I thank my lucky stars every day that I have the opportunity to do what I do. It is a privilege to care for patients in their most vulnerable moments, to have the tool kit to manage and make a difference to whoever comes through the door, to be able to solve some of the most interesting mysteries in medicine daily, and to work with a fun and high-functioning team that thrives on the chaos that is the ER. At the end of the day, it is a magical and fulfilling job, and I would not trade it for anything else in the world. ■

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Reference

1. International Agency for Research on Cancer. Night shift work. IARC monographs on the identification of carcinogenic hazards to humans. Vol 124. 2020. Accessed 11 July 2024. https://publications.iarc.fr/593.