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My No Good, Very Bad Night in the Emergency Department

You're gonna need a bigger boat.

—Amity Island Police Chief Martin Brody in Jaws

Friday Night in the Emergency Department

August 15, 2003, Billings, Montana

We begin in illness and injury. On this hot Friday evening, patients swamp the emergency department in the regional trauma center where I work. In the late summer heat, the night is just starting and has already flooded us with a raft of patients, and it promises to keep building. The waiting room overflows with more people. I have worked hundreds of nights like these in the previous decade plus, and I know the pattern. The quiet heat and the coming sunset belie the more ominous certainty of my shift ahead. People would get sick, some dramatically so. People would die. No one had gone about their day thinking these things would happen, but we know. In the emergency department, we check our equipment and ready ourselves with certainty.

As I cross the threshold of the automatic double doors into the department to begin my shift, I know it's busy even without scanning the electronic register we call "the board," a remnant of the days when

we used to list each patient and their chief complaints in bright dry erase marker on a big whiteboard before privacy concerns made it obsolete. I can hear the beeping of monitors, the shift in cadence of nurses' feet, and a low kind of ER buzz. The source is hard to pinpoint, like the low but incessant sound of unseen insect wings. To a casual observer, the department seems quiet, orderly, bright with fluorescent light. We like it that way—who wants to work in, let alone be sick in, a chaos of noise and motion?

The full cornucopia of unexpected disaster and discomfort bubbles out of the streets and homes and open spaces of life in America and flows into every room in our emergency department: automobile trauma, diabetes, cardiovascular disease, emphysema, diverticulitis, stroke, assault, cervical cancer, migraines, lacerations, domestic abuse, and opioids. The terms are medical and numbingly antiseptic, but the reality is stark: as the people of my town enjoy the warm summer evening, they are also crashing, dying, bleeding, fighting, and writhing in droves. While they go about their daily lives, they are part of a large, oddly silent tsunami of ill health that washes over the entire population.

No one is catastrophically ill at the moment, so I ease into my shift, getting labs and X-rays started on a few patients while I mentally accept that we will be working behind for a few hours. No one on the team likes working from behind. We prefer to stay ahead of the wave, seeing people as they come in. It is safer that way, and psychically easier for us. When the wave breaks over us, when we get behind, delays pile up and surprises happen, and surprises mean a higher chance of bad things for patients. Some nights, despite our best efforts, especially hot ones on summer weekends, the wave breaks, and we are playing catch-up. Tonight is one of those nights. The department has been behind since the afternoon, and it will be several more hours before we can get on top of the wave again.

The patients are varied, which is normal for us. The ER is the funnel for anything that can go wrong anywhere, at any time, for anybody. I see an obese patient whose knees hurt, a woman with vaginal bleeding,

a middle-aged man with chest pain, a mom with back pain who can't lie down comfortably, an 80-year-old man with bad lungs. Nothing out of the ordinary, except I see all those people in the first 15 minutes, because twice that many wait unseen after that. I use my "30 seconds to meaningful rapport" to inspect and connect with each person I see. My trained eye scans breathing dynamics, skin color, tone of voice. I see eyes and facial expressions, plumb for fear or hidden motivations, search for the best way to settle every person who meets me for the first time in this place that is their bad detour and my daily work. My hands find theirs, and I rest them on shoulders and knees.

I step out of an older man's room into the low hum and look right, then left. I am impressed and grateful for what I see in the team of nurses, techs, registration clerks, and my emergency physician colleague seeing patients alongside me. Several years before, we weren't so much a seamless round-the-clock clinical team as a collection of technically proficient individuals. We couldn't elevate our game in the face of unrelenting pace. We didn't work that well together, and we weren't able to mesh the technical craft of our job with the human presence of connecting to each and every person who was ill, whatever their circumstances.

Eight years later, almost everything is different. More people come to us for care, and the metrics that define "good department" are positive: patient satisfaction and staff engagement have rebounded to high numbers from low ones, safety and quality metrics are strong, and the department sustains itself financially. Nurses are on a waiting list to get a position in the ED from other places in the hospital. Patients come by foot and ambulance, airplane and helicopter. Thank you notes dot the bulletin board in our break room, some with pictures of healed patients on vacations or hikes in the nearby Beartooth Mountains. Nurses, techs, and physicians work hard to help each other across the shift: quiet high-fives, thank-yous, and smiles pepper our interactions.

This night, we are at the top of our game. The patients are getting attentive and skilled care, and the team works fluidly without stress

under the pressure of pace and pathology, moving fast without hurrying. We flex and bend to the needs of each patient and the staccato flow of the pace. As an emergency physician, I am at the peak of my craft. Well-trained and supported by capable nurses and skilled physicians alike, taught by thousands of patients, I am in the sweet-spot overlap of state-of-the-art training and sufficient experience, eight years out of a leading residency in my specialty of emergency medicine. I am comfortable on such weekend nights, at ease with the people I work with, the maladies and mishaps I would see, my own strengths and gaps as a clinician.

Despite the team's skill and my experience, a creeping dread wells within me as I scan up and down the hallway. It is my birthday, and while I am used to working holidays of all kinds and at all hours, this particular moment collides jarringly with all my years of effort, learning, triumphs, mistakes, hopes, and deaths in an unsettling pang in my gut and chest. In every room in our emergency department that night, while the ill and injured are getting what they need and we are chewing steadily at the backlog of patients piling into the waiting room, a bigger problem waits—no, *grows*—outside and beyond, unhurried, unstoppable, and inevitable. Nowhere does this unsettling gloom stick more than in my nose. The smell of blood, alcohol, feces, urine, anti-septic wipes, plastic tubing, vomit, and air freshener mix in my nasal cavity and settle like fine dust into my brain. Years before, when I was thinking of medicine and not yet doing it, I might have gagged. Now I just take a deep breath. It is not the smell of living.

“What you thinking, Scary Larry?” Dana, the charge nurse, appears at my elbow with a slight tug. “Big things or right-now things?”

She and I have worked together long enough to have earned our mutual nicknames for each other: Super Nurse and Scary Larry. I have worked with her while she handled two critically ill patients as the primary nurse while she held the charge nurse helm at the same time in the middle of the night. She can meet the wave. She knows my tendency to arc from micro-focus on the things at hand to macro meanderings

on the source and end of what we see. She's more practical and fixes her mental gaze on getting through the shift.

"Big things," I say.

She smiles, and the tug turns into a nudge. "Keep moving. We can hear about it later when it quiets down." She gives me a wink before she moves past me: *Shifts don't run us, Scary Larry. You and me—we run them.*

As I suspected it would, the night swells into repeated waves of patients. They are unique and different individuals, but the patterns are familiar: strokes, heart attacks, overdoses, self-mutilation, asthma, domestic violence, rodeo mishaps, farm trauma, bar fights. I keep moving, patient to patient, through late Friday into early Saturday morning. Until then, I don't eat, and I don't go to the bathroom. Neither does anyone else on the team.

The shift eventually ebbs like all waves do, falling back quietly into the night. By 4:30 in the morning, only two patients are left in the department. Both are resting, with no surprises lurking. One of them snores under a morphine blanket covering the pain of a broken leg, and the slow sound keeps the tempo of the deep night.

Five nurses and I sit at a round table a few feet behind the high counter of the nurses' station. I'm sifting through some blood and urine culture results from the lab, and they are getting ready to "count narcs," the frequent process of ensuring that all the potentially addictive drugs we use are all accounted for. I am reminded of being in a duck blind as a young boy with my dad, waiting out of the wind for ducks to sail in and disturb the quiet water around us.

"Good work, everyone. We cleaned up that board nicely," Dana says. She pulls out her auburn ponytail and redoes it. "And now, Scary Larry, what were those big thoughts bouncing around in your head while we were all moving so fast last night?"

"I was just thinking we're getting killed. What's outside that door is growing faster than we can keep up." I saw them looking at me. One of them rolled her eyes. "And it's getting bigger, not better."

“What are you talking about?” Mavis had been in the department a long time. She grew up on a wheat farm in eastern Montana and had worked hard her whole life. “Five years ago it would have taken us a whole day to get through what we just did in eight hours. We were rolling.”

I smiled even as my bones felt heavy with fatigue. “It’s not that. We run a shift just fine. Better and better every day, really. But society creates more disease, manufactures it actually, faster than we can keep up. The harder and better we work, the farther behind we are against a disease burden that’s getting bigger, not smaller. Not in the shift, not in the department, but in the big picture. You ever have that feeling?”

“All the time . . . and then I stop thinking about it,” said Kim. “It’s too much for me. Too big. I just think about my kids and my family and try to be a good nurse.”

“What did you expect? It’s an emergency department,” Judy said. “People get sick and injured in more ways than anyone could imagine, and we pick up the pieces.” Judy had worked in the department for 15 years. In her view, humans were fallen and flawed creatures, and we suffered the consequences.

“I think of it as job security,” said Shelly. A couple years later, she would be a nurse practitioner and would leave us for the cardiology department. “No illness, no disaster, no job.”

The Problem That Won’t Go Away

They were right and sane and rational, of course, those exquisitely capable nurses in the middle of the night at the tail end of a busy shift. Living and working at the back end of a massive bloom of unhealth and disease tends to make us feel very small. Think about it too much, and you go nuts. You can only go without food and bathroom breaks for so long. You have a job and a family and a life. The shift ends and you have to get some sleep.

Yet the question remains: What will we do about these “too big things”?

As good as we were that shift in August 2003, we were falling behind then, and we are falling behind now. The prevalence of illness we were dealing with that night was—and still is—ominous and exponential: we have epidemics of obesity, high blood pressure, domestic violence, opioids, anxiety, cervical cancer, smoking, meth, HIV, teenage suicide, disinformation.

We have created fancy, distancing words for these things—disease burden, pathology, psychosocial determinants of health—but up close, staring at you with sweaty foreheads and bluish lips, gushing out of wounds, groaning from half-opened mouths, these words cannot sterilize the sensory experience: sickness is on the move.

We spend hundreds of millions of dollars creating a vaccine for influenza every year, educating people, holding flu shot clinics, and influenza still erupts *every single year*. Worse, when you look at what causes illness and death, lost wages and jobs, lost productivity and the high societal cost of health care, you find a sobering truth: we are creating the epidemics we are trying to stop. They are not mere accidents.

As a doctor intent on creating the reversal of injury, the return to health, some sort of positive impact for and with the patients I cared for, the scale of it drowned me that night in 2003. I had been trained to treat disease and injury, to pull alongside ailing people and, with my hard-earned priestly wisdom and science and human compassion, help them restore themselves. Sometimes it worked, sometimes it didn't, but I had not anticipated that the exponential surge of these things would overwhelm not just me, but all of us. I had been taught that the combination of technical knowledge, well-designed and well-practiced process, and collaborative teamwork was the answer. If not, then sleep deprivation, skipping meals, and not going to the bathroom until the shift was over would surely do the trick.

Was I being foolish to believe the unspoken promise of my training and mentors? Had I been sold a naïve myth unsuited for a cynical world?

That birthday night when the overwhelming reality of what was flowing through the ER doors crystallized in my awareness, I was neither a novice doctor nor an entry-level leader. I had chaired our department as we rose on the efforts and ideas of a hundred people from an apathetic culture and subpar quality to a place patients flocked to when they got sick. I was a senior executive in our larger organization as it was on its way to becoming *Consumer Reports'* number-one safety organization in 2012.

I had been “leadership developed” since high school and would be throughout my entire executive career. I had been tested, tooled, evaluated, lectured, boot camped, accredited, certified, promoted, fed-back, coached, videotaped, and fish-bowled. In response to the question, “What do you want to focus on?” at a leadership institute, I replied that I wanted to understand how to go from linear to logarithmic, to understand how to move entire systems so they could respond without relying on running people ragged as a workaround. I saw eyes widen—just barely, but I saw it—and then heard a hastily formed reply uttered in a soothing voice: “We start with ourselves, the only thing we really can control, and you can only do what you can do.” Perfectly sensible.

Yet the flu rolls on, and so does Ebola, Zika, H1N1, MERS, SARS, and now COVID-19. And so does the exhaustion and the pace. In my native sector of health care, over 50 percent of physicians are burned out,¹ and the literature clearly shows how that physician epidemic impacts quality and cost, not to mention patients' lives, limbs, families, and peace of mind.² Over half of executives in health care would quit if they could.³ If you lost 40 percent of your blood volume in short order, you would be experiencing what we call class IV hemorrhagic shock. We would consider that class of shock a collapse of the 300-trillion cell system known as you, defined by death unless a trauma team resuscitated you. We can see lots of “collapse” numbers like these—honeybees, cancer, environmental data, employee disengagement. The people I talk with—executives, small business owners, consultants, associates, partners, young, old—all note the same trend: things are moving so

fast, there's not enough time in the day, and one little person cannot move these big rafts of inertia. Even if we could, we're all exhausted. According to a recent Gallup study, two out of three employees experience burnout at some point in their jobs, with secondary effects on their health and ability to function at home.⁴

Sleep-Deprived Insight

After the conversation with the nurses, patients began to trickle in as morning arrived. I finished the shift and drove home to where I lived west of town. I opened the ranch gate to our place and paused to take in the land where I lived. It was a quiet ritual of mine that created space between the sights and sounds of my job and the world of my family. Depending on which shift I had just worked, I took a few minutes under the stars or the bright sun to let the insights of the work settle in and to let the sometimes assaulting nature of it wash out onto the ground.

The bright morning air, still cool, held the hint of another hot day, and the slanting sun cast dark shadows on the sun-washed ponderosa coulees and grassy ridges. There is nothing better to wash the olfactory memory of alcohol, blood, urine, and pus from one's brain than the morning smell of sage and Ponderosa pine, nothing better to replace the beeping of monitors and moans of the sick than the breeze wandering in the grassy air. Surrounded by healthier sounds and sights in my sleep-deprived, almost-to-sleep ease, it struck me that the epidemics that cause such ill consequence among us—obesity, cardiovascular disease, HIV, gun violence—were playing by a different set of rules than the ones underlying how I had been taught to respond to them.

I stopped at the corral to feed our two horses. Randomly, my dad's offhand observation about why horses are beautiful wafted across my mind: *They've retained their wild shape*. We had bought our place six years before, and like so many of the patients I encountered in the

emergency department, it was in a degraded state when we found it: overgrazed, eroded, barren of its original biodiversity, its history largely erased. Our hope was to help it heal, and if the ER was an exercise in meeting people in an arc of health that I might never see again, the land was an arc that stayed with me and under my feet, beginning long before me and extending far after. Although the grass crunched yellow in the high summer of a 10-year drought, the ecosystem was surging back to health, not falling behind. Life was recovering here: grasses and shrubs were rebounding, insects and birds were returning, water and soil were recharging. If the ER shift had exhausted me with its physical pace and psychic implications, the sights and smells of the land in the sunny morning inspired and soothed.

I had grown up here in this place of big land and teeming life, raised and surrounded by people who had me in it early and often. I had long wondered how the elegance of biology, so essential to the enduring vitality of every person and every living thing on this planet, did not seem to translate to how we designed organizations, leadership approaches, team dynamics, or even our internal mindsets. The exponential trends that bedeviled me as a doctor and inspired me as a landowner were playing by biological rules; our responses seemed to be so much more mechanical and rigid. And slower. And ineffective. And falling behind.

In the fuzzy haze of near-sleep consciousness I would endure for another 30 minutes before I crashed onto my pillow, a meandering thought surfaced for the first time: if epidemics organize and spread by different, biological rules, what if we could harness the rules and link them to positive realities—to cures, to answers, to ideas, to swarms of positive impact? If I was serious about health, if I was serious about understanding how to multiply adaptive capacity in the face of too much to do and not enough time to do it, I was going to have to answer—positively—the question posed by the epidemics that flowed across the threshold of the ED in that unstoppable wave. How could we create positive phenomena that spread just as powerfully, exponentially, into

every nook and cranny, the way epidemics overwhelm our defenses against them?

I wasn't thinking of epidemics as leadership that morning. I only knew at that time that I was on the right side of wanting to be helpful and the wrong side of the way things launched, grew, spread, and moved. From the patients I attended to the land I lived on, I understood biology held vitalizing, relentless capacity. Beyond that, I was out of ideas, and I was too long without sleep.

I went down into the darkest room in my house and fell into the motionless, dreamless sleep of the night worker.

Notes

1. Tait D. Shanafelt, MD, et al., "Changes in Burnout and Satisfaction with Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014," *Mayo Clinic Proceedings* 90, no. 12 (December 1, 2015): 1600–1613, <https://doi.org/10.1016/j.mayocp.2015.08.023>.
2. Maria Panagioti et al., "Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction: A Systematic Review and Meta-analysis," *JAMA Internal Medicine* 178, no. 10 (October 1, 2018): 1317–1331, <https://doi.org/10.1001/jamainternmed.2018.3713>.
3. "The Impact of Burnout on Healthcare Executives: A WittKieffer Study," WittKieffer.com, online survey conducted summer 2018, <https://www.wittkieffer.com/thought-leadership/impact-of-burnout-on-healthcare-executives-witt-kieffer-study/>.
4. Ben Wigert and Sangeeta Agrawal, "Employee Burnout, Part 1: The 5 Main Causes," *Gallup Workplace*, July 12, 2018, <https://www.gallup.com/workplace/237059/employee-burnout-part-main-causes.aspx>.

