

Feeling at home in an emergency: coping with death in the emergency department

All crew on deck. But keep the emotions stowed away

EVERY DOCTOR KNOWS the feel of a medical emergency. You're sitting at the nursing station when the patient in Bed 4 has an arrest. You're in the middle of performing a routine procedure on a patient when the patient's blood pressure plummets. You're sitting in the emergency department when an ambulance paramedic commands your attention — "Two multitraumas, doc. They're pretty bad."

Any normal person would be anxious or afraid or despairing, but you can't afford to be. Your attention is focused on the problem at hand. You run through the possibilities and formulate a plan of attack. The fact that the person in front of you is likely to die *in front of you* is only another element in the equation. You can't let emotions get in the way, or you'll be less efficient and less likely to succeed. You are working in a surreal, glassy atmosphere, temporarily detached from your emotional life. That's what is required in an emergency.

For most of us, though, emergencies are rare events, or at least have been since we left our intern and resident days behind. But, for the staff of emergency departments, emergencies are an everyday affair. What effect does this have on the staff? Does the frequent need to switch off their emotions change them in some way? Does it alter their relationships with patients? Does it affect their private lives and families?

No one doubts that exposure to traumatic events can have a profound impact on an individual. Post-traumatic stress disorder (PTSD) is well characterised and understood. People who experience PTSD often say that their most disabling symptom is a kind of "psychic anaesthesia", which may manifest as a constricted emotional responsiveness. They complain that they have lost the ability to fully engage with other people or fully enjoy normal activities.

Emergency department staff are not generally thought to suffer PTSD, but it may be pertinent to ask whether they experience some of the typical features of the disorder. Do they suffer a heightened general anxiety? Do they experience flashbacks of their work experiences? If so, we know very

little about it, as there is almost no published material on the subject.

In this issue of the Journal, four very different articles explore death in the emergency department from an individual perspective.

Edwards (*page 647*) shares with us a very personal perspective on his experiences as an emergency physician. Using a uniquely Australian analogy, Edwards says he copes with deaths in the emergency department by donning a "Ned Kelly suit of armour". As he looks back over his responses to a series of deaths, he wonders if his armour has remained a useful tool or become a prison. The metaphor of the man of iron is particularly apt given that the original suit was eventually to prove fatally flawed.

Articles by O'Reilly et al (*page 649*) and Fulde (*page 651*) examine the care of homeless people in the emergency department. They present case histories of homeless patients who had become well known to emergency department staff and eventually died. Both pieces examine the question of what sort of relationship emergency staff can have with this kind of patient. Both play on the tension between the fantasy that the emergency staff were the homeless men's "family" and the reality that the men had no family at all.

Humour is a tried and true defence against emotional trauma, and Fatovich's satirical study into the mortality of anonymity is as dark as it is funny (*page 653*).

For all of these contributors, the feeling of having to switch off emotionally when dealing with a crisis is probably all too familiar. Every doctor has experienced the same feeling from time to time, but what can it do to you if you feel like that all the time?

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