Steve Server//

At about 3:30 am during my first week in the Emergency Department, I realized that the space was different from anywhere else in the hospital. Though it was my second night shift in a row, I wasn't tired. Or if I was tired, there were too many signals, too many sights and sounds and feelings that begged for my attention. The cold, white light overhead had a way of dissipating the misty somnolence that under normal circumstances gave my circadian rhythm the upper hand in the wee hours of the morning. Like the light reflecting off the floor, the various beeps and trills, moans and groans, the occasional laughs reverberated off the Department's many sleek glass, plastic, and metal surfaces. One quickly learned which of these sounds portended threat, and which were simply variations on the normal sounds of life that were common outside of the Department. Each, however, demanded at least a modicum of attention, as the timbre of Not Sick could transmute to Sick in a matter of few seconds.

The blipping telemetry monitor in the corner of the physician's pod regularly bared this out. A normal cardiac rhythm regularly wobbled into something not quite right, and back again. You could never totally accept that the telemetry monitor must have erred: each in-and-out of Not Sick demanded a trip to assess the patient—"Any chest pain? Any shortness of breath?"—and a return to the pod, still vigilant, still on the lookout for Sick.

The attentional economy of the Emergency Department can best be described as pulsating, humming, breathing, whatever other bodily metaphor to convey that the ED's rhythms are fundamentally *human*. And that is the full spectrum of *human* as it pertains to a person's health—from needing a medication refill to needing chest compressions. Consequently, as someone providing care in the ED, one must develop a productive working relationship to the sort of

controlled chaos that plays out moment-to-moment there. It demands a crystal-clarity of purpose so as not to get lost in the kaleidoscopic array of stimuli that insist, demand upon your attention. That purpose is sifting through the morass for flashes of Sick and then making sure that Sick is kept at bay. If Sick, make sure the patient is stable and then admit. If Not Sick, make sure that patient does not become Sick, and then either admit or discharge.

And what do we mean by Sick? We mean actively decompensating or imminently dying. We mean the ventricular tachycardia that can lead to cardiac arrest. We mean the pneumonia that has progressed to sepsis causing rigors so vigorous that the telemetry picks up on the vibrations. We mean the ruptured ectopic pregnancy causing an abdomen filled with a liter of blood. That is Sick. Not Sick is a lot of the rest. Not Sick may still be serious, but stable for the moment. Not Sick is addressed eventually, after Sick is banished for a few moments and attention can finally be mustered to clear some of the less serious concerns from the Department. Then, we can take some more patients out of the waiting room and be on the lookout for Sick again.

"Upstairs," as the rest of the hospital is referred to in the ED, there often misguided derision for the work undertaken in the Department. Sure, in the ED, the definitive diagnosis is often not arrived at. It is not a field that has the luxury to dwell in the abstract art of diagnosis that some specialties do. As it sees patients who can have any number of disease processes of any severity, emergency medicine concerns itself with the *practicalities* of diagnosis, embracing distillation to cut down on divided attention, leaning on regimented lines of thinking to not miss things, etc. These cognitive dynamics are not a failure of emergency medicine. They are a feature of the work. That is, arriving at a definitive diagnosis and treatment is not necessarily the *raison d'etre* of physicians in the ED. What is? Finding Sick.

As Sick looms so large in the ED, working there is also emotionally different. Because the ED sits as the first and last line of defense for many, it is at a critical fault line in the American health care system. Daily, physicians are confronted with the many ways in which the amount of Sick they encounter may have been avoided with better access to preventative care, health insurance, affordable medications, nutritious food, and social supports of various sorts. Bearing witness to this sort of structural violence can burn people out. It was hard, particularly when sleepless and stressed and, I will admit, afraid, to reckon with the sheer amount avoidable suffering and violence.

With the weight of the world swirling around the Department, I followed the model of the ED physicians and residents I worked with to cope: I shared how I was feeling. I felt a part of the system of camaraderie that supported the physicians in the ED. When these physicians had free moments, they heard my anxieties and validated my work. They gave me confidence I needed to keep on guard against the ubiquitous threat of Sick. During free moments, when labs and imaging were in process and Sick was not apparent in the Department, I discovered another to dissipate some of the anxious energy I was experiencing. At 4am, when I was body-tired, but busy and brain-anxious-and-preoccupied, I derived comfort from the small, brief human gestures I could offer my patients outside of the official diagnostic process: bringing a sandwich or a warm blanket,

allowing them to sleep for a little while longer, patting them on the shoulder or the arm and giving them a smile.

For all the sturm and drang, for all the electronic din, for all the distraction and stress, there was something remarkable about taking a moment to express human solidarity. Finding Sick was disorienting and alienating. Celebrating human connection—even in brief moments amid the chaos—gave me something solid upon which I could sustain myself. It reinforced the reason for finding and exorcising Sick in the first place.

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