The End of Nice

Category: Stories
written by Rosalind Kaplan | September 23, 2011

“Mouse bite, one year ago” read the Chief Complaint entry on the chart I picked up from the “nonurgent” pile.

I was a second-year medical resident, on an eight-week stint in the Temple University Hospital emergency room. It was 3:50 am, the beginning of the end of the night shift. All hell could still break loose before my shift ended, but for now we were in a lull, and the less serious cases got our attention.

I looked at the time of triage for the mouse-bite patient. Five o’clock the previous afternoon.

“Mouse bite one year ago! And the patient’s been here eleven hours!” I exclaimed aloud to no one in particular. “What the fuck? What idiot sits here all night for that?”

“Nice potty-mouth, Kaplan,” commented Dave, the other resident on duty, as he wrote in a chart. “And where’s your compassion? Remember, that’s a suffering person you’re talking about.”

“Right. Do you want to see Miss Mouse-bite then?”

“No, I’ve got a guy with an insect in his ear, and I’m keeping him,” Dave replied.

It wasn’t always like this. *I* wasn’t always like this.

I started medical school a soft-spoken girl, a tenderhearted sort. As a medical student, during my third-year internal medicine rotation, I was the one my team (which included a senior medical resident, two interns and three students) sent in to talk with a patient who’d just been told she had lung cancer. On my surgery rotation, I was the one who naturally took the hand of a patient undergoing a painful procedure.

I’d made it all the way through medical school and to internship—medical residency’s notoriously harsh first year—with a gentle spirit. Most of the time, I still had empathy for the patients I treated, particularly the ones I got to know from my outpatient clinic or from my rotations on the inpatient services. I would take the extra minute needed to quell a patient’s anxiety, go the extra length to ask after a family member.

But the ER rotation was hard. If you were a good girl like I was—not so much because you didn’t ever drink or smoke pot or have sex (I was, after all, a child of the Sixties) but because you thought you were supposed to achieve and contribute and be nice, always nice—the ER was really hard.

It was hard to walk into a situation where things weren’t clear-cut or pretty, where so many people didn’t care how nice you were, or if you cared

about them, or even if you knew what the hell you were doing. ER patients wanted relief, quickly, and without regard to how it came about. I had thought being smart and competent and empathetic would be enough. But here, it wasn't.

I recognized the ER as a sea of desperation from the moment I walked into my first shift. That never changed. During the day, it was the gastrointestinal bleeders, with their coffee-ground vomit, and the chronic obstructive pulmonary disease patients spewing green mucus and gasping for air. The congestive heart failure patients getting 120 mg of intravenous diuretics—and getting angry when we wouldn't given them water to drink, although they were already drowning in fluid. A couple of times, I saw those thirsty patients get so frustrated that they drank their own urine from the urinals hooked onto the stretchers they lay on.

It got worse at night, when the gunshot wounds and stabbings and heroin overdoses started rolling in. Most of the trauma cases were not our problem—the surgical trauma team met the gunshot-wound cases and major knifings as they arrived—but sometimes the less serious injuries ended up on one of my gurneys.

"What happened here, sir?" I asked a young man I found lying on his back, looking perfectly fine except for the steak knife stuck directly into the center of his sternum.

"Nothing much."

"Well, there's a knife in your chest. How did it get there?" I persisted as I cut off his grimy T-shirt and examined the junction of sternum and blade. It looked superficial, but I would need to get an x-ray and call Surgery to pull it out; one never knew if a major bleeder was being tamponaded by the instrument.

"I was walking along the street holding my knife. I was going to my friend's to eat a steak. I tripped and dropped it and fell on it." He smirked at me and let out a mean little laugh.

"Okay, sir, that's what I'll write in your chart, then."

I had no desire for police involvement either, but the word that came into my mind as the exchange unfolded was "scumbag." It was hard to think that word when you were a nice girl, a good girl. But that's what came to mind.

The heroin overdoses always came to us medical residents. They were still and blue. Some of them were "frequent fliers"—hard-core junkies, people we saw periodically, who'd miscalculated a dose or gotten a bad batch. We knew that we'd treat them and they'd go home, only to be back another night. Sometimes we'd get the kids we'd call "white dopes on punk"—suburban teens who came to North Philly for a fix but knew nothing about the power of the drugs they were getting, the heroin much more potent than the stuff they bought from their skeevy dealers at home, who cut the drugs with God knows what.

We gave these pallid, unconscious, barely breathing people Narcan, an IV

medication that reverses the effects of heroin. Invariably, they sprang back to life, combative and furious that we'd ruined the best high of their lives. That's what they all said: "The one that nearly kills you is the best high of your life." So after injecting the Narcan, we learned to duck and run for cover. They yelled and cursed and spat at us.

"Fuck you for saving my life!"

It was hard to hear if you were a nice girl like I was. Hard to hear when you'd been a good girl all your life.

One night, early in my first year of residency training, the police brought in a middle-aged woman they'd found on the ground. She had been barely conscious when they picked her up, but by the time she hit the ER, she was in fighting mode, thrashing around, yelling incoherently. She reeked of alcohol.

Even though she was restrained, it took several of the larger male residents to hold her down while I placed an IV line for fluids and drew blood to test her alcohol levels and look for other causes of delirium. Her veins were so bad that I had to use her antecubital fossa—the inside of the elbow—instead of her wrist or hands, which were the preferable sites for IV access. Just as I was taping down the tubing, she picked her head up off the gurney, lunged at my hand and bit me.

"Shit!" I yelled and whacked her cheek with my free hand.

She resumed cursing and struggling with the guys. I stood stock-still, shocked at myself.

"I can't believe I just hit her!" I blurted out.

One of the men, a year ahead of me in training, laughed.

"Are you serious? Five of us are sitting on her, strong-arming her, and you're upset that you slapped her with your wimpy little slap? She BIT you! Did it break the skin?"

I looked down.

"No, but we're not supposed to hurt our patients, no matter what they do. I shouldn't have done that."

"Honey," my colleague said, "it's time for you to stop worrying about being nice and get real."

After that, I developed a hardness, a tough exterior and a way of speaking that I never would have imagined for myself.

The patient who'd been bitten by the mouse one year ago was a chubby, bleary-eyed woman in her late twenties sitting on the stretcher under the glaring fluorescent lights. She'd been lying asleep across several of the screwed-down plastic chairs in the waiting room when the nurse called her back to Room 9, which was really just a space along one wall, sectioned off from the

vast ER space by an orange-striped curtain.

I stood over the woman in my surgical scrubs and long white coat, my name with the official “MD” after it embroidered in red above the left breast pocket. My arms were crossed and my feet were planted firmly, slightly apart, in the white Reebok sneakers I always wore on my shifts. Her chart sat on the rolling *faux*-wood bedside table next to me.

“So this bite occurred a year ago?” I asked.

“Yeah, about that, maybe a little more. I know it was a mouse, but sometimes I get worried and think maybe it was really a rat.”

“Where did it bite you?”

“Here, on my ankle.” She showed me a spot of pristine, perfect skin.

“Is there pain there now?”

“No.”

“Can I ask why you would come to an emergency room a year later when there is no pain and no visible wound?”

My tone was sharp. I was not being nice.

“Sometimes I just worry. I start thinking about something and it gets bigger and bigger in my head, you know?” She spoke quietly, looking down.

I did know. But I wasn’t going there at 4:15 am.

“I started thinking about this yesterday and how it might have been a rat and I could have rabies. I never went to a doctor, and what if I die from this because I was stupid? So I came.”

“And you sat here for the last twelve hours.”

“Well, yeah, that’s how long I had to wait.”

“Okay, look, there’s nothing wrong with you from the bite. It’s been too long. If anything were going to happen, it would have happened a long time ago. Here’s the number for the psychiatry clinic. You have anxiety problems. We don’t treat that here in the ER.”

I handed her the number I’d written out on a prescription blank. I signed her discharge papers with a sigh. She looked down at the floor, ashamed. I felt ashamed, too. I could have been kinder. But it was the ER, and it was 4:30 in the morning.

I have not worked in an ER since the end of residency, twenty years ago. Now I work in a small ambulatory practice. We get to know our patients well. Mostly I am gentle, slow to judge or anger. I don’t send anxious or depressed patients away feeling ashamed, with just a phone number. In fact, much of what I do as a primary care doctor is to treat anxiety and depression-related

problems.

It took years of practicing medicine, watching the suffering of patients whom I got to know over time, as well as a significant illness of my own, to reach this place of patience and calm. When I've been through the birth of my patients' children with them, the death of their parents, come to know their hopes and fears, I don't feel impatient. I can't be curt. And all it takes is a flashback to the lack of control I felt as a sick patient—the need I had to hear something hopeful, and the pain an offhand negative comment from one of my doctors could inflict—and I lose any impulse to be dismissive.

Part of what patients seek when they come for medical care is kindness, and I hope I provide it. But that toughness from those ER days resides in me, too, and can't be dislodged. It became the part of me that thinks on her feet, the part that gets things done. It comes in handy when I have to set limits for my adolescent children, demand better work from an employee, stop a manic patient's ramblings or get an insurance company to pay for the medication they've been denying my patient.

Sometimes I have to use it to protect myself from others who really aren't nice: a critical relative or the guy at the car dealership who is trying to take advantage of my ignorance. And, yes, sometimes other doctors who haven't figured out that it really is better to be kind.