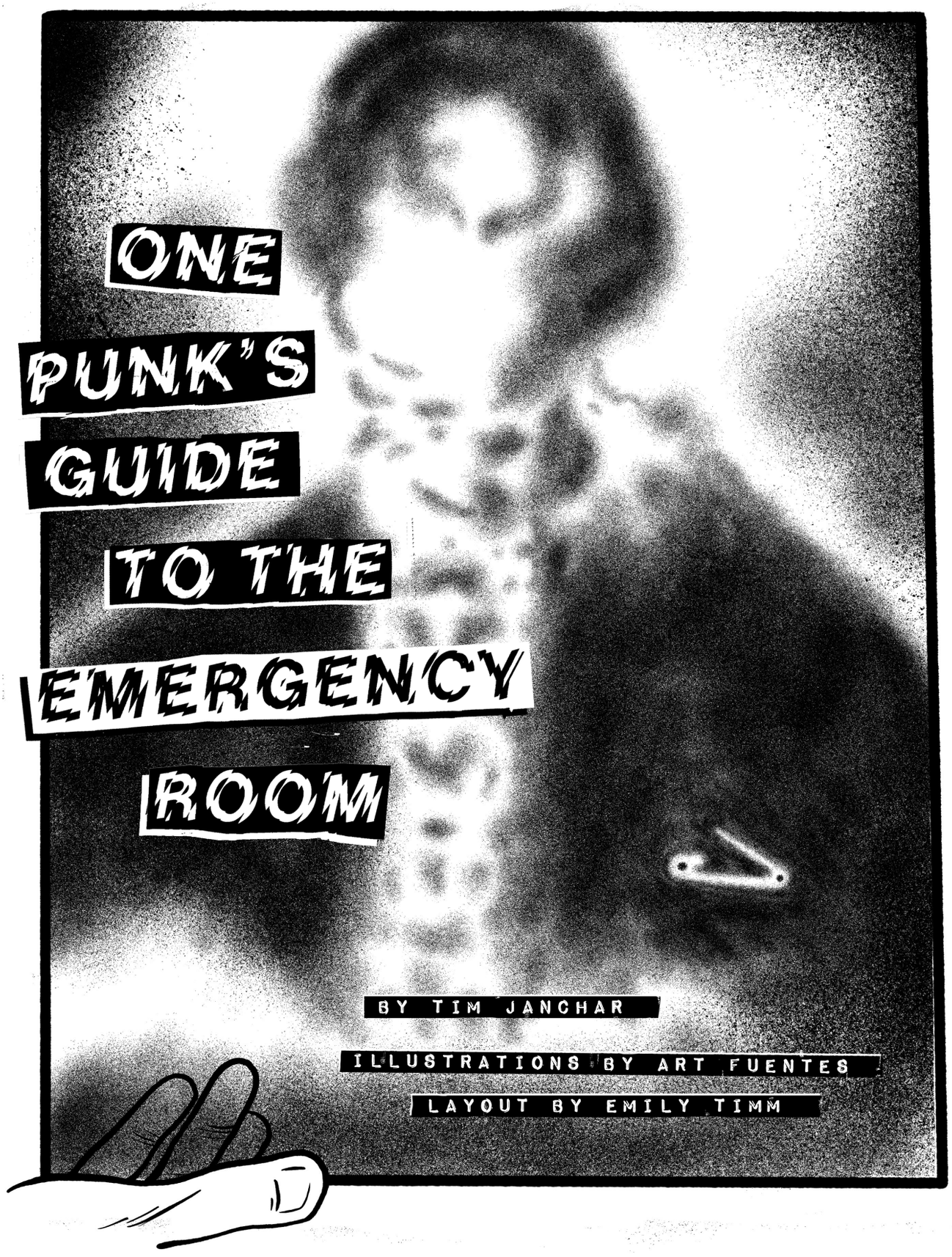


"Medicine is a science of uncertainty and an art of probability."
–Dr. William Osler

It sucks to have to go to the emergency room. Last year while walking my dog, I was hit by a car in a crosswalk. It was early morning, and the driver was ironically an ICU nurse getting off her night shift. It was only supposed to be a quick walk and my outfit, this being early winter in Oregon, was a pair of boots, a hoodie, sweatpants and yup, no underwear. During transport to the hospital, I had the hazy realization that I was going to be a trauma patient at the very same emergency room where I work. My co-workers deftly cut my clothes off as they examined me from head to foot before rushing me to the CT scanner. I was lucky that I only had a wicked scar across my head and a nasty concussion, despite getting thrown twenty feet. The concussion was so bad it took several weeks for my brain to get back to normal. During that rehabilitation time I did a lot of reflecting on the vulnerability and helplessness I felt as a patient and how tenuous our health and bodies really are. What we have, physically or mentally, shouldn't be taken for granted. Nothing is assured and everything is at risk every day.

I have worked in emergency rooms for the last twenty years and have identified as a punk for even longer. There's a lot of overlap between the two microcosms. I have no doubt the things that drew me in and anchored me in a creative, DIY punk community are the same reasons I work in the ER. The term "punk" is perpetually polysemantic, but in my personal definition, it is being creative, improvising, and making do with what you have in front of you. It's reactionary, non-conforming, and doing what is necessary, needed, and right at the time. It's being open and inclusive to people of all ethnicities, sexual orientations, and socioeconomic backgrounds. All these skills play out in the emergency room and are necessary in navigating through a shift.

I'm an emergency physician. I was brought up to be socially conscious and to take care of my community. Listening to bands like 7 Seconds, Propagandhi and The Clash became the soundtrack and ethos for bucking the status quo, committing to helping people, and making change. Playing in and touring with bands, running a nonprofit record label, and operating DIY music and art spaces have been how I've equally contributed to and received from the punk scene. I realized that medicine, particularly emergency medicine, could be the tool that would allow me to do that same kind of work in the other parts of my life. I never fit in nor was I comfortable with the formality and cliques of the educational system, but I was stubborn—like most punks I know—and had a goal. I went to medical school on the East Coast at an old school, ivory tower institution and had a hard time with the pretentiousness and patriarchy of the medical system. This system created an informal sterility and lack of real personal connection. Yes, there are technical skills and a body of knowledge you need to master, but I felt dealing with the personal and often serious life and death situations could make the connections between people stronger, not more distant. And everyone was *so serious,* but as M.O.T.O. sang, you don't have to be a dick about it. I couldn't see myself going into a specialty like neurology, surgery, cardiology, or radiology. I was fortunate to find there was one place in the hospital where all the irregulars and unusuals ended up, and that was the emergency room—the place that would always take you in without pretense or judgment.

The faculty at my medical school—esteemed specialty surgeons and distinguished specialists—referred to emergency physicians as practicing "blue collar medicine," which only made me want to pursue the specialty more. My last job before going to med school was working in a gas station in Ohio and my spare time was spent trying and failing to learn Op Ivy bass lines and sneaking beers into punk shows at Stache's on High Street in Columbus, Ohio. The emergency room seemed to be the most real and intimate place to practice medicine. This was a place where improvisation and making do with the limited resources and time you had were just as important skills as technical precision and medical knowledge minutiae. A place where the well-timed swear word got you further with staff and patients than a verbose medical vocabulary. A place where any person could walk into at any hour of the day and be seen for *any* complaint. Nowhere else was humanity on such display. The exhibition of how we take care of ourselves and each other and then function together as a society was all right there in the emergency room, in all its naked, bloody, vomit-and-piss-filled twenty-four-hour nonstop show. I had found a home.

I trained in Los Angeles at a county hospital, where most of the patients were uninsured and had no other access to care. Many were not U.S. citizens, didn't speak English, and had no means to fill prescriptions or pay for follow-up visits. The emergency department, with its waiting room times often over twelve hours, was all they had. Currently, I work in an emergency room in Portland, Ore. that serves a similar population. It's a trauma center in an urban setting and many of the visits are in some way related to drug or alcohol use. The impact of the methamphetamine and narcotic problem in this country is evident every shift, similar to its impact in the punk scene. Many mental health patients end up there, and those who need to be admitted to a psychiatric facility may wait several days for a bed to become available. I work night shifts when the ratio of patients with mental health problems, injuries from physical violence, and drug and alcohol use is much higher. Immersing myself in this environment felt natural and aligned with my punk ethos, being able to help others while remaining creatively uncouth.

Part of living is getting hurt. There is a necessity of enduring trauma, both physical and mental, in navigating our way through life. It's not good versus bad or sick versus well, but a spectrum. Health and wellness can't exist without having sickness and suffering to define them. There can't be healing without an injury first. On the microscopic level, skin must be disrupted by trauma before healing cells are released to generate new tissue. On the psychological level, philosophers and artists have long looked at suffering and injury as necessary components of understanding well-being and health. Nietzsche believed that an understanding of life is impossible without enduring pain. Haruki Murakami said, "Death is not the opposite of life, but a part of it."

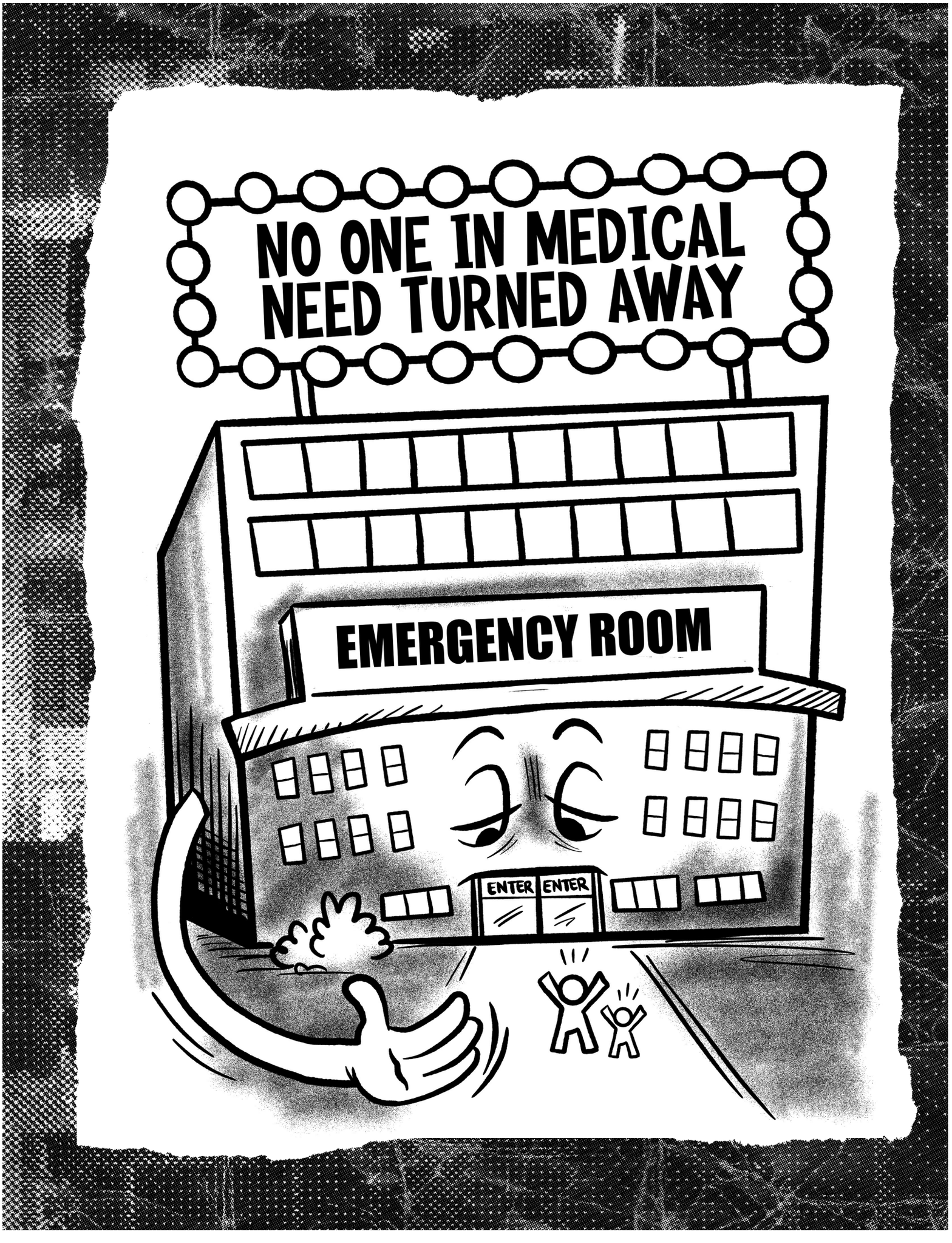
One out of five people will end up in the ER at least once over the next year. The ER was initially created to simply send people somewhere else. Today it serves a broader function beyond giving emergency medical care to providing mental health care, addressing drug and alcohol problems, providing temporary shelter and food, sexual assault examinations, police clearance, and most importantly, the only access to health care many people have. The emergency room functions as a central point of contact and care for many communities.

STICK YOUR NECK OUT!

Dr. Daryl Wilson is the lead singer for The Bollweevils, one of the best punk bands out of Chicago. While singing for the band in the '90s he went to medical school and trained in emergency medicine. He is now an ER physician in Naperville, Ill. and The Bollweevils are still going strong, playing Riot Fest and releasing a new album on Red Scare in 2022. We talked about the balance and interaction of punk and the ER:

Dr. Daryl Wilson: "Emergency medicine keeps you grounded because you're dealing with everybody and any person, whether you're the most highfalutin' prince or princess, or the person who just was found passed out on the street. They're all coming to seek your care. And we don't care about your ability to pay, your sexual orientation, your creed. We don't care about any of that. We take care of you because that's what we do. And it's really human care; it's humanity.

And to hear music and to play it and produce it and to have other people hear it and be affected by that, it can connect you in a way that you really can never connect with people in such a deeper fashion. But we do it all the time as emergency physicians. We connect with people on such an intimate level in a short period of time. It's wild.



And if we couldn't find an outlet to dump that, it's going to just wipe you out as a human being.

"At a show, you let your freak flag fly and, in the ER, your freak flag is flying all the time. I mean, come on. Some of the things you see are not things you typically would get anywhere else. It's definitely a place that's almost a free for all, but it's organizing that free for all into some kind of semblance of order. A punk show is definitely a free for all, right? But there's some order to the chaos that comes together. When you're up on stage and you're orchestrating some of that chaos—because you're inciting the crowd or doing these other things—you still have to make sure it doesn't get way out of control. And that suddenly, there's a fire set in this place, or this person's being assaulted or something. You have to have some semblance of control. You can dance on that razor's edge for a period of time, but you still have to have some way of pulling it back and saying, 'You're on the brink of doom, but we're not going to do that. We're going to put you right over here where it's safe again.' And I think every punk show has that possible element when you go on to play a show."

22:45 TRIAGE NOTES: PT WAS FOUND ON MLK NORTH OF FREEMONT, WAS RIDING BIKE AND HIT BY CAR THAT DIDN'T STOP. MARKED DEFORMITY TO LEFT LEG AND FACE. NO HELMET + ALCOHOL.
23:02 TRIAGE NOTES: PT REPORTING HE HAS PNEUMONIA. HAS BEEN COUGHING UP GREEN STUFF FOR THREE DAYS. PT ADMITS TO LIVING ON THE STREET FOR THE PAST 13 YEARS.

A BRIEF HISTORY OF THE EMERGENCY DEPARTMENT

Before the 1950s, hospitals were places the poor went to. Doctors made house calls to the middle and working class. If you were sick and had money, the hospital was a place you avoided at all costs. If you were injured in an accident you were lucky to get carried home and have the doctor come to you rather than risk it at the hospital where the risk of infection was high and resources scarce. Transportation to the hospital was often done with hearses that did double duty with the funeral homes. That all changed after WW II when hospitals started opening emergency rooms—and they were literally a single room that could care for simple conditions. The staffing of these emergency rooms was done by inexperienced interns and residents—junior doctors in training— or medical students. You might get a newly trained radiologist or dermatologist taking care of the heart attack or car crash victim. Rounding out the staff were misfit doctors and nurses with substance abuse or legal problems who would end up working in the ER, when no other place would let them practice.

As the number of people wanting immediate medical attention increased, so did the ER visits. However, the care given there was still suspect and substandard. The reason for this was no one was trained to be an emergency doctor; the idea that someone would spend their career only working in the ER seemed absurd. The thought was the best care could be provided by specialists in their offices and the ER was just a place you started in before getting sent somewhere else. It wasn't a place where problems actually got fixed.

In 1961 a group of physicians in Alexandria, Va. had a revolutionary idea to staff the emergency room twenty-four hours a day with doctors and nurses solely dedicated to practicing emergency medicine. A few years later, the first training programs dedicated to training physicians to work exclusively in the ER were formed. This was met with resistance by many in the hospital communities who couldn't understand why someone would want to work exclusively in such a pedestrian place like the ER and simultaneously felt it was a threat to their income. The opponents viewed the patients as a source of income, but the people trying to develop this ER model were just trying to deliver the best care at the right time to people who had nowhere else to go.

Since that time, the number of ER visits continued to increase as did the technology and care delivered there. The Vietnam War also pushed the boundary of what emergency care could look like. Observations were made that a person injured in the fields of Southeast Asia could get better and quicker care than someone in inner-city Detroit. Many programs started training medical school graduates to become emergency room physicians in the 1970s. Despite the necessity of emergency care—it is one of the youngest medical specialties. It is also one of the fastest growing.

We've also seen the explosion of urgent care clinics in this country. These are set up to quickly take care of minor injuries or illnesses, but the spectrum of what they are seeing is quickly expanding. Many have their own CT scanners now and offer ongoing primary care. The main difference with these clinics is that you need cash or insurance up front. They can turn you away if you don't have the money or an I.D. In Oregon, one of the largest urgent care providers in the state won't even see you if you have state-sponsored insurance. Also, the capabilities of the facility and access to many treatments may not be available and you'll end up getting referred to an ER for further care if you're "too sick for them," and then unfortunately get billed for two visits.

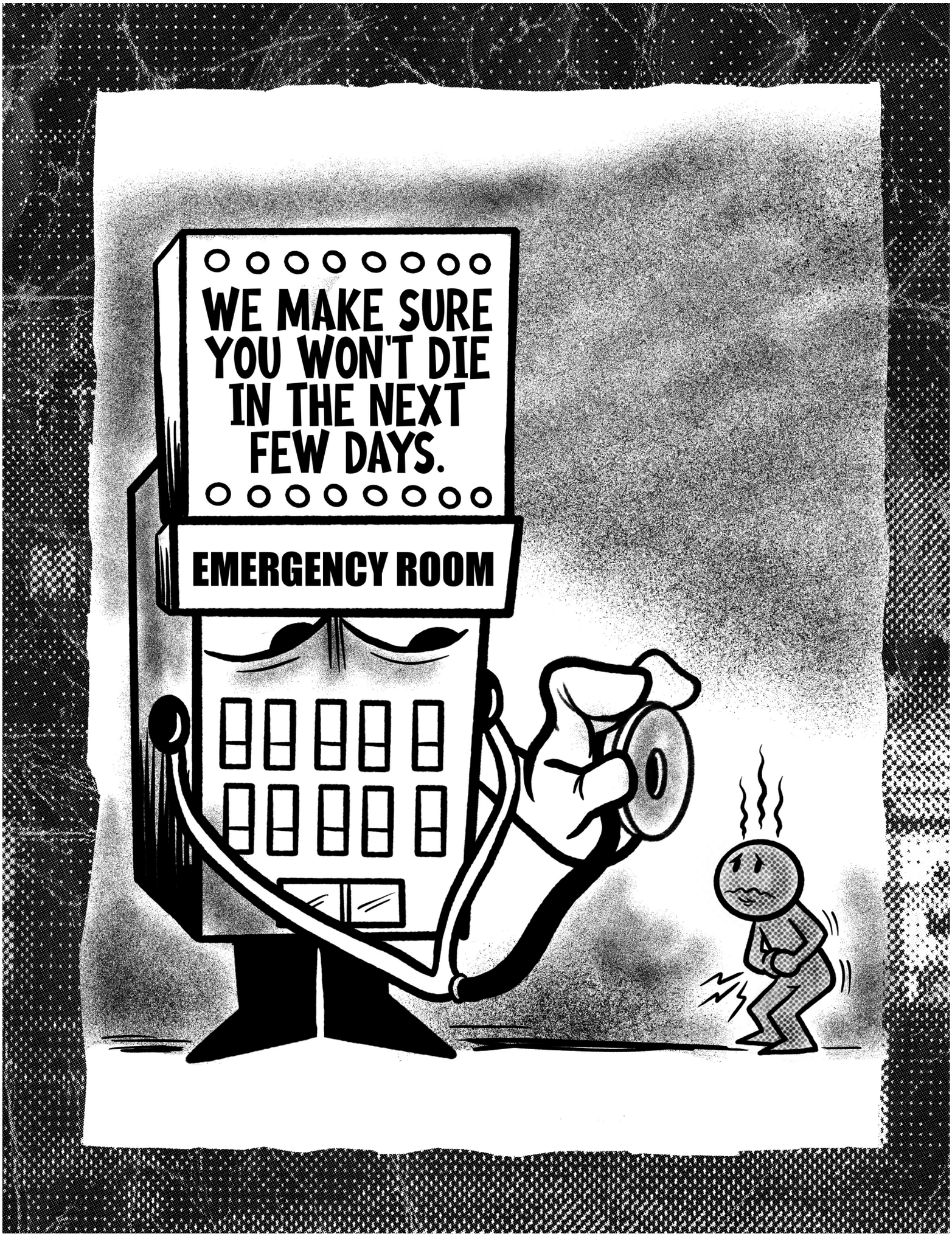
23:55 TRIAGE NOTES: ARRIVED BY PORTLAND PD INTOXICATED AND ON METH. PT ARRIVED MAKING STRANGE STATEMENTS, TANGENTIAL AND PRESSURED SPEECH, STATES SHE IS "7 MONTHS PREGNANT" AND "PRINCE CRAWLED UNDER MY BEDROOM DOOR AND RAPED ME." PT TOOK A SWING AT ER PHYSICIAN ON ARRIVAL INTO ROOM.
01:20 TRIAGE NOTES: PT CALLED 911 FROM A PAY PHONE C/O ALL OVER BODY PAIN ESPECIALLY LEGS AND INCLUDING CHEST PAIN. EMS EKG WAS NORMAL. PT REPORTS BEING CONCERNED ABOUT HER CHEST BECAUSE HER FATHER JUST DIED OF A HEART ATTACK
02:18 TRIAGE NOTES: PT WAS BROUGHT IN BY EMS AFTER PASSING OUT. PT APPEARS INTOXICATED AND STATES HE TOOK PILLS WITH HAPPY FACES ON THEM.

NEARLY HALF OF ALL U.S. MEDICAL CARE IS DELIVERED BY EMERGENCY DEPARTMENTS.

THE ER AS SAFETY NET

There is a lot of debate about how to fix the medical care crisis in this country. While we spend billions on the military and foreign endeavors, there are untold numbers of people in this country who lack basic medical care. Conservatives will fight against socialized medicine, claiming it is a step towards a "Marxist society," but the reality is that the ER functions as America's version of socialized medicine. George W. Bush said in 2007, "People have access to healthcare in America. After all, you just go to an emergency room." Bush was talking about socialized medicine whether he knew it or not. As misguided as his statements were, there is truth in that.

The government enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986, which obligated hospitals to care for all patients who entered the ER regardless of the ability to pay, insurance coverage, citizenship, or legal status. And although Congress has never provided funding for this mandate, the physicians,



nurses, and other healthcare team members who work in ERs continue to perform this vital function despite the financial losses. Hahnemann Hospital, which served a largely minority and underserved population in inner-city Philadelphia, closed due to financial pressures in 2019. Many of those patients were left without care.

Since EMTALA was enacted, the U.S. spends an average of forty billion dollars a year on uncompensated care, the majority of that through the ER. EMTALA was created to stop the practice of "patient dumping"—which is when a hospital transfers or refuses admission to someone because of an inability to pay. With EMTALA anyone who comes to the ER must be stabilized prior to transfer or discharge.

The lack of government funding has been a strain for many hospitals, especially rural or inner-city hospitals that see a large percentage of uninsured patients. There are two government-funded insurance programs. Medicare is provided to those older than sixty-five (or younger persons with a disability) while Medicaid is provided to those with low income. Many young people with limited income may be eligible for Medicaid but can't navigate the complexities of enrolling. When the Affordable Care Act (otherwise known as Obamacare) was passed in 2010 it shifted the responsibility of Medicaid onto each state and was successful in getting insurance coverage for millions of low-income families. Obamacare also protects patients with pre-existing conditions from being denied insurance, despite Trump's attempt to dismantle it. However, you still have to pay a fee to enroll in these programs and if you're unable to, the only other option is the ER.

Nearly half of all U.S. medical care is delivered by emergency departments, according to a new study by researchers at the University of Maryland School of Medicine. Emergency physicians are only four percent of all physicians but provide healthcare to over two-thirds of the uninsured people in this country. The emergency room functions as a safety net for the uninsured and vulnerable patient populations, largely due to the current healthcare structure inadequately providing care for many of our nation's citizens. There could be structured racism within this EMTALA mandate, as a 2019 study found that EMS are more likely to transport a Black or Hispanic patient to a safety-net hospital than their white counterparts, even when such patients come from the same ZIP code.

practice in an insane environment. And then when COVID hit, we were on. I knew it was like, 'Boy, this is what we trained to do.' We're ready to respond to this environment. We're going to go in there like gangbusters and take care of it. We're going to solve problems because that's what we do. And we did. And people were applauding us. 'You're doing a great job.' Great. 'We're getting you more pizza.' It's like, we don't really need the pizza, but could you make sure that you keep our staffing up?... Oh, wait. Oh, you think COVID's done so you're not going to keep us staffed anymore? Oh, I see how you feel about us. I get it. I see, we're back to that thing again, where it's just like, 'You guys do a great job, keep doing it. No matter what, we'll give you smaller amounts of rope and try and hang yourself with them if you can.'"

03:30 TRIAGE NOTES: PT WAS DISCHARGED TWO DAYS AGO AFTER HAVING HER APPENDIX REMOVED. PT STATES "MY HAND IS NUMB." PT IS BREATHING VERY FAST AND CRYING, VERY RESTLESS. SHE WAS GIVEN VICODIN AT DISCHARGE WHICH SHE STATES IS NOT WORKING.
04:49 TRIAGE NOTES: PT CALLED 911 FROM JANTZEN BEACH AND TOLD POLICE OBAMA WAS COMING TO KILL HER. WHEN POLICE ARRIVED PT WAS SMOKING CRACK, PARANOID AND AGITATED. PT WAS BROUGHT HERE AND STATES "THIS IS NOT A REAL HOSPITAL."
05:30 TRIAGE NOTES: MECHANISM OF INJURY-POSSIBLY WHILE WRESTLING WITH HER BOYFRIEND A MONTH AGO.
06:21 TRIAGE NOTES: PT HERE ABDOMINAL PAIN THAT STARTED TEN YEARS AGO. HAS HAD MX. WORKUPS, CT SCANS, US AND "NO ONE KNOWS WHAT'S WRONG WITH ME."

MENTAL HEALTH CRISIS

The Kennedy administration enacted the Community Mental Health Act in 1963. Its intent was to focus mental healthcare on the community level rather than the traditional model of housing the mentally ill in state-run asylums. The goal was well intentioned, as

SHORTLY AFTER BEING ELECTED PRESIDENT, REAGAN REPEALED THE MENTAL HEALTH SYSTEMS ACT... SINCE THAT TIME, THERE HAS BEEN A NINETY PERCENT DECREASE IN THE AVAILABILITY OF IN-PATIENT BEDS.

Dr. Wilson lyrically talked about the about the role the ER plays in a broken medical system:

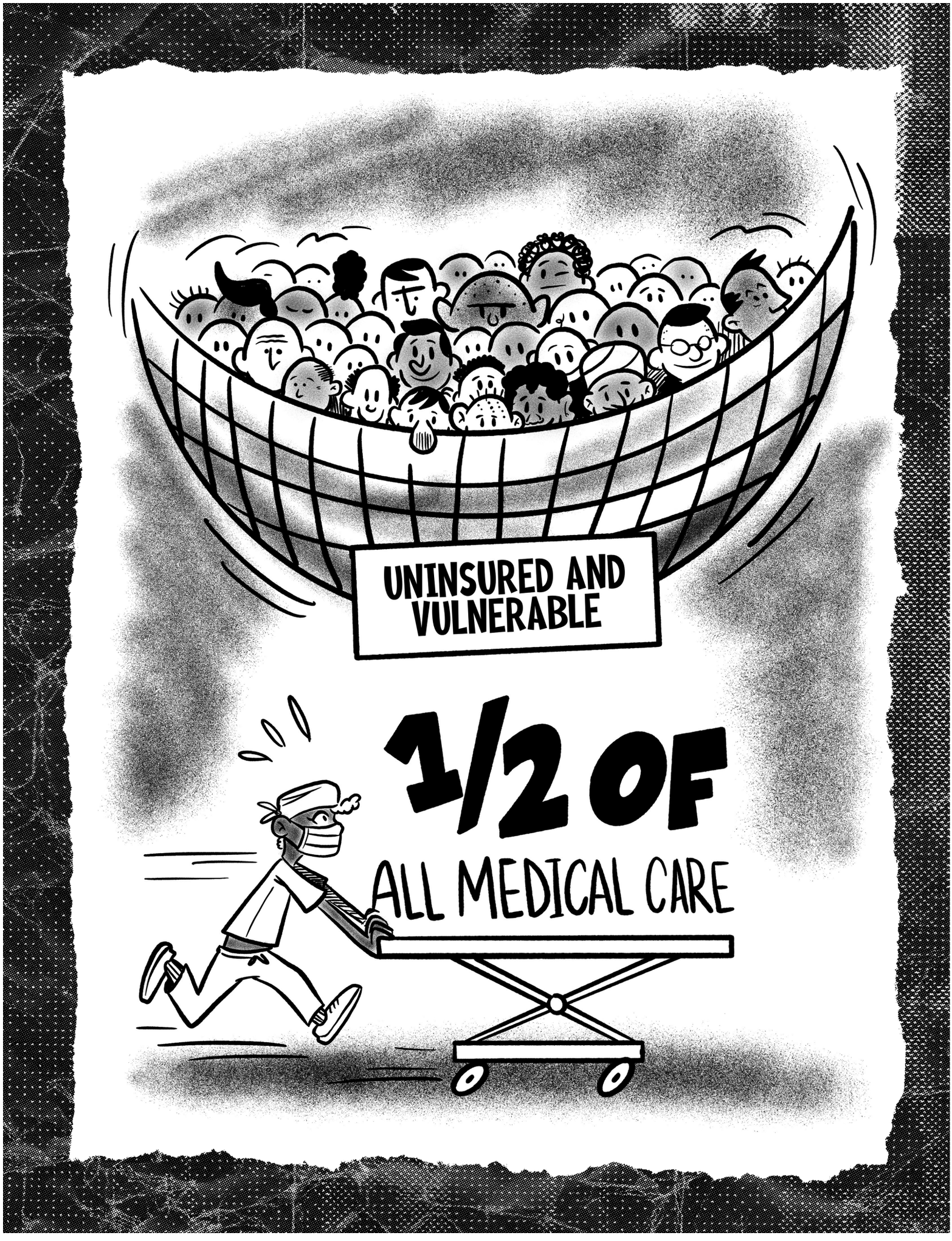
Dr. Daryl Wilson: "I mean, we're the open door to the world. I've always pointed out that we're the last bastion of humanity. You have order versus anarchy, in some sense. We're always skating that line between chaos and order and trying to pick things up and keep things in order no matter what. And it is dealing with people at their worst, whether it's their physical illness, whether it's their psychiatric illness, whether it's just their general personality, and trying to still put all the pieces together. What we're doing most of the time is just trying to solve problems. A lot of the things we get are not necessarily medical conditions. The medical condition could be the secondary thing to a greater problem. We don't choose who we see. We see everybody. Despite our own personal feelings on things, we can't sit back and discriminate. I can't be the guy who gets referrals and declines you because you don't have the money.

"We'll try our best. But stuff we try to solve sometimes becomes this continual bottomless pit, not to mention a Bollweevils old song, 'Bottomless Pit.' But this complete circle of falling into the same trap every time, which, truly, it makes us insane. Right? We basically

care in these state asylums was often terrible (think of *One Flew Over the Cuckoo's Nest*), but as with many government acts, there was not the funding given to support local and state healthcare teams to build local facilities or provide care for these at-risk patients.

Shortly after being elected president, Reagan repealed the Mental Health Systems Act and blocked all resources going to states to assist in mental health care. Since that time there has been a ninety percent decrease in the availability of in-patient beds and many of the patients ended up in communities that did not have the facilities or expertise to deal with them. Many patients wound up in adult homes or with their families, or houseless in large cities, without the mental healthcare they needed. Today, most ERs do have mental health counselors who can assist those in crisis but access to psychiatrists and in-patient beds are critically lacking. Patients who need in-patient care often wait several days in the ER awaiting placement where the loud, busy over-stimulating ER environment is not beneficial to them.

07:14 TRIAGE NOTES: PT RIDING HIS BIKE TO WORK AND TIRE STUCK IN TRAIN TRACK, PT CRASHED AND HIT FACE AND BROKE TEETH.



08:27 TRIAGE NOTES: WORK INJURY @ PRINTING PRESS. PT WAS USING MACHINE AT WORK, PRINTING FOLDER, WHICH CUTS PAPER INTO BOOK SIZE. BLADE CAUGHT GLOVE AND PULLED HAND INTO MACHINE. CUT OFF R 2ND/3RD FINGERS. HAS FINGERS IN ICE.
09:29 TRIAGE NOTES: WIFE CALLED 911 BECAUSE PATIENT WAS SWEATY. PT STATES HE HAD "NERVOUS BREAKDOWN" THIS AM. EMS EKG SHOWS ACUTE HEART ATTACK.

TRANSGENDER CARE IN THE ER

During my emergency medicine training in Los Angeles, one of the doctors I worked with in the ER was Madeline Deutsch, who after working as a physician in various ERs in Los Angeles opened up her own transgender clinic and then went on to develop the transgender program at the Los Angeles LGBT Center. She is now the director of UCSF Transgender Care in San Francisco and the president elect for the U.S. Professional Association of Transgender Health while still working a few ER shifts a month. Dr. Deutsch is also a prolific musician and managed to balance playing in several indie, garage, and punk bands during her medical career including Fight Dirty, Asteroth, Pet Eggs, the Push Buttons, the Downtown Kicks, and solo as Bacon Tears Up Business.

I had the opportunity to interview her for this article. I asked her about the barriers trans patients face in the emergency room:

Dr. Madeline Deutsch: "I think the ER is probably the scariest place to be if you're trans, for so many reasons. Right off the bat, usually you're there because there's an eme rgency or because it's the de facto safety net system in this country. All this stuff adds up: lack of insurance, lack of legal protection, structural bias, structural transphobia. There are higher rates of unemployment and economic insecurity in the trans population. It makes you less likely to have health insurance. They are more disenfranchised persons, so you're not just plugged into how the system works. When you start getting into intersectionality, like trans people of color, there are intersecting levels of disparities that occur. So all of these things, if you're uninsured or you don't have healthcare, then you're more likely to use the ER.

"But then also if you just show up in the ER, hurt or sick, and the last thing you want to deal with is somebody who's got their own agenda, or who just doesn't have empathy and just doesn't give a shit, calling you by the wrong name or pronoun. Which we know, in the clinic world, the number one thing we say is if that patient comes into clinic and they have a polyp in their colon and they have undetected high blood pressure and depression, and they walk up to register at the front desk and the clerk says, 'Can I help you, sir?', and you don't want to be called sir, you're going to take off and you might not ever get any of that stuff taken care of. So imagine you're in the ER where you need a doctor now, and you have that experience. You don't have any power and maybe you can't walk out. And then there's—like you get brought in and people take off your clothes—and it's just very scary and vulnerable place to be. It's very dictatorial and authoritarian."

The work Dr. Deutsch did to start her own independent trans clinic was a complete DIY endeavor. It's inspirational to anyone wanting to make a difference and needing to create your own framework to work in:

"So basically, I was like, I'm going to open up this side gig—integrative, community-based, bargain basement medicine and step out of the system. Charge fifty bucks a visit and focus on the LGBT community. I totally bought this sketchy malpractice policy for $5,000 a year, went around L.A., found this office that I rented in West Hollywood in a suite that had a common waiting area with a hypnotherapist and a video editor, and the next suites over were a DUI school and a leather goods. I started doing that and then really quickly a lot of trans people started coming and it got really big. I spent days in the UCLA medical library reading every article there is on trans care and I just figured it out. I even wrote my own electronic medical record using Microsoft Access. I did that during downtime on night shifts when working in an ER.

"Then I moved to a bigger space in downtown L.A. and things got really busy. The short story is I got recruited to start the transgender medicine program at the Los Angeles LGBT center—which is a huge LGBT center and clinic. I launched a program there and ran it for four years. Then I got brought up here to San Francisco to do the same thing. When I left the program in L.A., there were around a thousand patients there and I'd hired a psychologist. I got a research grant and then somebody else took over and then I've been doing the same thing up here. So it's very DIY. All of the people who I know who are doing this work are DIY. I was so perturbed about the concept of working in a for-profit system. I don't think healthcare should ever, and nobody should ever, make a fucking dime off of healthcare. You have a $2 billion-a-year hospital to run. You need to get $2 billon and one dollars a year in revenue, and then the rest of that money needs to get poured back into the hospital and the community."

I DONT THINK HEALTHCARE SHOULD EVER, AND NOBODY SHOULD EVER, MAKE A FUCKING DIME OFF OF HEALTHCARE.

Dr. Deutsch's work is exemplary to the idea of healthcare existing primarily for the betterment of the health of individuals and community rather than being a place for companies to make billions of dollars. I think that most people—doctors, nurses, paramedics—have a drive to help people and get into medicine for the positive impact part of it, and certainly all should be getting fair working wages. But it's the big corporations, mega healthcare systems, and the pharmaceutical industry that are using human suffering and illness as an opportunity to make a fortune.

TIPS FOR GOING TO THE ER

Prepare and know your medical history

Having a solid grasp of your medical condition can smooth out your trip to the ER. Certainly, if you have had extensive care at a particular hospital, especially a surgery, going back there can be beneficial. But many times, particularly in an emergency, this isn't possible. Even in this day of electronic medical records many hospitals are not linked together, and the system has its shortcomings, so your records from across town may not be available in the ER you end up at. Think about the "what next?" Do you need a ride home if you're getting sedating medications, or who is going to watch your cat if you have to spend the night?

Advocate for your chosen name

Dr. Deutsch advises, "So if you have to go to the ER and your name and pronoun don't match what's listed on your legal ID, that you be very clear when you get there, that "Look, this is my name and this is the pronoun that you should call me." I think a lot of trans people feel very disempowered, especially in the face of the authority of the medical industrial complex, but I encourage people to take that ownership, because you do own it. You're totally entitled to be called by the name you want, the pronoun you want."

You might not see a "doctor" and that's just fine

Many hospitals now staff their ERs with nurse practitioners (NPs) or physician assistants (PAs) to see many of the patients. These are

well-trained professionals. Some of the smartest people I've worked with have been NPs and PAs. It irks the staff and gets eyes rolling when an entitled patient refuses to be seen by anyone but "the doctor."

Be prepared for the wait

It's not on purpose, and it sucks. People who work in the ER are some of the most impatient people in the world and it bothers them as much as the patients. ER waiting room overcrowding and ER boarding (patients who are admitted but who stay in the ER waiting for a bed upstairs) is a huge problem and only getting worse. Also, sicker patients will get taken back first and there may be traumas and critically ill patients entering through the ambulance bay you won't see while you're in the waiting room.

You may not end up in a bed

Because of high patient volumes and lack of space, most ERs utilize their hallways and chairs to see patients in. Don't worry, the care is the same and they're doing it to speed things up.

Don't be afraid to ask questions

Be upfront about what you want and need. Nothing you bring up will shock a triage nurse or doctor. Be honest. ER staff shouldn't be judgmental. They've heard it all and probably done most of it. They're human like you. Be clear about your discharge plan. If you're not sure about what to do next, please ask. If you get worse, come back. The ER worries about what happens next as much as you.

Consider lowering your expectations

The ER is very good at ruling things out—making sure you're not going to die in the next few days. It's not the place where a chronic condition that has been seen by many other specialists with prior testing is going to be magically figured out by an ER doctor. Also, we're limited in the tests and specialists we have access to. It seems like it takes an act of god's congress to get an MRI in the ER I work at. And I'm not sure how the urban legend started about plastic surgeons coming into the ER to repair face lacerations, but I've never seen it happen. I also work part time on the Oregon coast at a critical access hospital and we transfer many patients by ground or air to get to a bigger hospital or a specialist.

You can dispute your bill

Mistakes happen, especially with something as complex as medical billing. There is an estimate that up to eight out of ten hospital bills will have some type of error. Ask to see an itemized list of charges. Also ask for a price reduction. Hospitals will very frequently honor these requests and work with you on payment plans to meet the balance.

The pain scale is frustrating

After checking your blood pressure, heart rate, respirations, and temperature, the triage nurse is required by federal law to ask you how you would rate your pain on a level of one to ten. The well-intentioned idea of the pain scale was started in the late-'90s by patient advocate groups as, rightfully so, physicians we not treating pain adequately. However, several times a shift someone will say their pain is an eleven, fifteen, or thirty out of ten and it's hard to take that seriously. A ten is when you're delivering a baby or have a knife lodged in your chest. Know that many ERs now bill themselves as "narcotic free." This is a reactionary move from the over-prescribing of narcotics in the late '90s and early '00s. Interestingly, when the federal government mandated in 2000 that the pain scale must be documented on every patient as "the fifth vital sign" (after your blood pressure, heart rate, respiratory rate, and temperature), drug companies simultaneously began pressuring physicians to prescribe, and the public to ask for, narcotics for any and all types of pain. Subsequently, prescription narcotic addiction and abuse skyrocketed and has destroyed countless lives. Many physicians overreacted by not prescribing narcotics at all and many patients turned to heroin or street fentanyl to cope with their medically-induced addiction. In a just society, big pharmaceutical companies would fund addiction rehabilitation and counseling services for those afflicted with opioid addiction, but there's no profit in that.

Don't worry about the drugs

Don't hesitate to bring a friend in who overdosed or who drank too much for fear of getting in trouble. The ER doesn't call the cops or report

this stuff, and many of us have ended up in similar situations. ERs will often dispense Narcan to counteract narcotic overdoses and are starting to prescribe Buprenorphine, a drug that can help with opioid dependence.

ENDINGS

At the beginning of a recent night shift, the paramedics brought in an older guy who had passed out intoxicated while fishing next to the river in downtown Portland. That river is rumored to be so polluted that swimming in it poses serious risks of bodily injury and infection, so I'm not sure if he was planning on eating the fish he caught, or it was just a midnight drinking sport. Regardless, he did manage to catch a foot-long, greenish-brown fish that was sitting in a five-gallon bucket next to him when the EMS crew found him. Not wanting to leave the fish, they brought it in with him, as well as all of his fishing gear. Every room was full, so they stuck him on a gurney in the hallway to sleep off the booze. They put the bucket with the fish on the floor next to him. The nurses were diligent in changing the water and feeding the fish bits of crackers from the break room. The shift was busy, as it was a full moon on a Saturday night, and we soon received a call that we were getting three people from a house fire. The charge nurse activated a Code White. Every hospital has their way of announcing that a critically sick patient is coming in, and I've worked at places where it's been called a Code Black, Code Blue, or a Code Three. The Code White always seemed a little too casual to me, like someone was going to bring you a tray of tea sandwiches rather than a patient in shock with a heart attack.

The two people who were inside the house ended up having minor smoke inhalation injuries, but the fire had started on the back porch where an intoxicated grandmother was smoking a cigarette while wrapped up in a blanket and self-immolated when the flaming ash caught the blanket on fire. She had third-degree burns on almost her entire body and was barely alive when she arrived at the ER, her face so badly burned her screams were unintelligible. The injuries were not survivable, and we kept her comfortable with fentanyl and propofol as she died.

I filled out her death certificate and was preparing to file it, but noticed there was already one in the slot from the same shift. Puzzled, I read it and realized that with all the commotion, the staff was too busy to attend to the fish and it had died as well. A sardonic staff member had filled out a death certificate for the fish. So, we had lost two on that shift. Some days are like that when you can't even keep a fish alive.

That story stuck with me as an allegory for what happens in the ER. You get all kinds of people, no one's turned away. There's some absurdist humor in all of it. The people who work there are crazy but dedicated, and despite all your best efforts, the outcomes may be lamentable. But like Sisyphus, we'll all be back tomorrow for the next shift, because sometimes just showing up and working hard is all you can do.

EPILOGUE

Rest assured, when I was hit by that car while walking my dog Eddna last year—she was totally fine and escaped unscathed. She sat diligently by my bloody, concussed body until the ambulance arrived. She remains apprehensive of that crosswalk to this day.

PUNKS WILL END UP IN THE ER

Inevitably when people hear what I do for a job they ask about the grossest and craziest things I've seen. Mostly they're hinting about what objects had to be pulled out of which orifices. Those aren't really the most fascinating stories to me and more than being astonished at the "you put *what…where?*", I feel empathy for the abject embarrassment some of the patients feel having their private lives exposed to an ER staff. I'm always humbly thankful that I've been two steps and a stone's throw away from an embarrassing ER visit myself. Rather than trying to remember some of the myriad of stories that are buried in my subconscious, I asked some other punks about their ER experiences:

Justin Maurer

(Clorox Girls, Maniac, LA Drugz)

When the Clorox Girls were on tour in Madrid, mid-set I slipped on spilled beer and cut my right elbow open on broken glass. We finished the show, but I was escorted to the ER in a taxicab. In the hospital, they stitched me up, and I asked my hosts if I should give a false name or if we should run quickly out of the hospital because I didn't have any money to pay for medical services. They laughed and told me that Spain has nationalized healthcare and that I wouldn't have to pay a cent. My right arm became so painful and swollen to the point of not being able to strum the guitar. For the next week or so, Kevin Goggin who was filling in for The Feelers, strummed my guitar from over my shoulder. He wore sunglasses and a Buzzcocks shirt. I played the chords with my left hand and Kevin strummed. From certain angles it looked like he was jerking me off. We managed to play the rest of our shows in Spain and France with Kevin as an additional band member literally acting as my right arm. Kudos to Kevin for helping us out far more than he could have imagined on that tour. I owe you a shot of Malört.

Chris Mason (Dirt Cult Records)

When I was in high school, I loved safety pins because I thought they were super punk. I would put them on things that weren't even torn or in need of fastening like my hats, my backpack, and my jeans. One day after school I was hanging at a friend's house, getting high and listening to music and was unthinkingly chewing on a safety pin. While I was zoning out, the safety pin popped open in my mouth, and I swallowed it. After a momentary freakout I went home and told my mom. She took me to the emergency room. All the nurses were calling me "safety pin boy" and lightly making fun of me. A nurse pulled me aside, and to make me feel better, told me about a kid who came in a few days prior after putting his mother's pearl necklace in his urethra. HIPAA violations aside, I thought the attempt to console me with the story was unnecessary because swallowing an open safety pin was clearly the punkest thing sixteen-year-old me had accomplished.

After the technician took X-rays, they placed them on a table and walked away. I quickly grabbed them and stuck them under my shirt. I'm not entirely sure how I smuggled them out, but I still have them. When they told me they were going to have to put me under and suck the safety pin out of my stomach, they asked me if I had eaten anything in the last few hours. Because I was high, I totally forgot I had walked with my friends to a local ice cream shop and eaten an entire banana split by myself and said "Nope!" Since they figured my stomach was empty, they put me under for ten minutes, which wasn't close to enough time to suck the ice cream out of my stomach. So, I woke up midway through the operation with a tube down my throat, gagging while a nurse tried to keep me cool.

Ben Snakepit

Summer of 2006, I was traveling around the U.S. and staying with my friends in Pensacola. They had a bed in a spare room and let me stay there for a few weeks. The room wasn't used much, so there were some critters living there. After sleeping in the bed for a few nights, I noticed a bug bite on my stomach. I didn't think much of it, until a few days later it got hard to the touch and painful. When I finally broke out in hives all over my body, I decided it was time to go to the hospital. I sat in the ER for a few hours (I didn't have insurance, so I gave a fake name and SSN) before a doctor gave me a dose of morphine, then took a big syringe and sucked all the gross stuff out of the bite. He packed it with gauze and told me to take the gauze out in a few days. "Take it out myself?" I asked. "Yep, just pull it out slowly and throw it away. Then keep the hole clean with peroxide." A few days later, I pulled out three feet of wet, beige gauze. It was really gross.