Patient Interview Write-up

On the second night of my ward experience in Emergency Medicine, a 28-year-old patient (V.B.) came into the ER for "suicide attempt." The resident asked me if I wanted to try interviewing the patient. Surprised by her offer, I felt a sudden tide of anxiety as I had never interacted with a suicidal patient. However, I agreed to give it a try and as I walked into the room, I was at once terrified yet determined.

As I entered V's room, I introduced myself and the resident to the nurse who was watching over V. V was lying in her gurney hiding under her sheets. I pulled a chair up next to her and lowered myself so that our eyes were on the same level. Consciously try to use the warmest and kindest tone that I could muster, I gently introduced myself and asked, "V, would you like to tell me a little about what happened today?" She unwrapped herself from the sheets and I noticed that she was bald and very thin. She then proceeded to tell me how she was hooked on pain narcotics and just wanted to find someone who would help her wean off her medications. I asked her why she was taking the narcotics and she explained that she had a terminal disease and that neither her family doctor nor the rehabilitation center would accept her and help her wean off. She wanted to try holistic medicine and just wanted to be able to live the last few months of her life with a clear mind unclouded by medications.

However, no one would help her and she felt there was nowhere to go. Hopeless, she decided that if no one would grant her last wish, then there was no point in living anymore. I gently asked her what she had tried to do to take her life, surprisingly she responded, "Nothing. That's why I came to the ER. I was thinking about ending my life so I came to the ER for help." That statement resounded strongly with me because I felt that all hope was not lost for her, and she still was trying one more route before resorting to suicide. After asking a few other questions for the HPI, I finished my interview by telling her how brave she was for deciding to come to the ER. I said that I understood how painfully frustrating and hopeless it felt to have no help from the healthcare system, but I reaffirmed how she had made the right decision in coming to us instead of taking her life. I also pointed out to her that her decision showed that she had not completely given up, and encouraged her to hold on to that sliver of hope. Before I left the room with the resident, I told her how happy and thankful I was that she had come to us for help, and that we would do everything we could to help her.

Reflecting upon that encounter, I felt I was able to connect with V on an empathetic emotional level. As she told her story, I felt and acknowledged her frustration and hopelessness. However, I was also aware of some barriers to my connection. I was running a checklist in my head of all the questions I needed to ask her, and I was wondering what type of terminal illness she had. I had asked her twice but she mumbled so quietly that I could not hear her, and I was uncomfortable with prodding her to answer again. Because I was anxious trying to remember what to ask while also trying to connect with her, I was not able to connect to the environment. I connected personally with the patient's health condition because my mother in law recently also died from terminal lung cancer and was also refused help when she asked to be weaned off her narcotics toward the end of her life. The spiritual issues that may arise include the patient questioning where God was to help her at the end of her life. After I spoke with V, I felt she

connected little with me because her tone changed from dull recall of information to a louder and stronger tone when she thanked me for my words of encouragement. She quickly slid back into a depressed state after the interview, but I felt there was a moment when her eyes opened wider and she felt more engaged in the conversation.

When I was listening to her, V mostly focused on her emotional state, which was her most vulnerable side at the time. She repeatedly said that if no one will help her, then she should just end her own life. I was concerned during the interview because she was not very detailed in giving her history, and so I tried to elicit more answers by first reaffirming that she had done the right thing, and that I was there to help her. I think that strategy encouraged her to continue talking to me. I think in her situation, listening played a significant role, as she came into the ER because she felt that no one was listening and following through with her needs.

When I was interviewing her, I tried to focus first on the physical area of her story to make sure she was not in any immediate danger. I then focused mostly on her emotional state because it was where she was most vulnerable and needed help. I felt that emotionally, what she needed most was to feel hope again. I then focused on her relationships because it was important for her to feel she had support during this time. Lastly, I focused on the spiritual area by asking her about her faith and whether she would like us to say a prayer with her, but she said that she felt too nauseas to continue speaking or praying. I discovered that even though she was saying she was suicidal and had no hope left, she clearly was still holding on because she came into the ER to tell her story. That one action was so important, and I tried to remind her of that as much as I could during my time with her. My goal for myself was to listen intently to her story, and my goal for V was to help her recognize the strength that I saw in her.

After we left the patient room, I asked the resident which department we will refer her to help her wean off her narcotics. Much to my dismay, the resident informed me that because she was a terminally ill patient, "no one will touch her" and give her what she wants. When I brought up that she specifically came for that help, the answer I received was "Well that's not our problem, we just need to make sure she will not die in the next few hours, and then Psych can take care of the rest." Disappointed with the answer, I inquired around the ER and someone mentioned that Palliative Care may be able to help. I looked up the number for Palliative Care, and after getting the approval from my resident, went back to the patient room to give the number to V. V was asleep by then, so I gave the number to her observational nurse. I also took that time to get to know the nurse a bit more, asking him where he trained and how his night was going. I could tell that we were connecting because he became very excited and enthusiastic to talk to me about how he was just getting back in school for nursing after postponing his education to take care of his grandmother. I shared with him my similar life situation with my mother in law, and I felt that he was excited to have someone to share similar life stories with. I felt that by bonding with V's nurse, I was more reassured that he would give her the number when she woke up, and be more interested in her wellbeing as an indirect responsibility to me, to whom he had connected with.

Unfortunately, I was unable to see the conclusion of V's visit nor the attending's visit with V because it happened several hours after my shift had ended that night. I tried to see V the

next day because I knew she was admitted, but she had already been discharged by the time I went back.

From this experience, I learned that I am able to be compassionate and can find the right words to say to patients who are struggling emotionally. This has always been a concern to me because I was so used to reading books instead of talking to people, but I realized that night it came naturally to me. From the patient, I learned about the obstacles to meeting one's health needs in our current health system. I am upset that she was turned down by many facilities because of her terminal illness. I also learned that much of healing is emotional and relational. Often patients need not just the physical healing but also someone to acknowledge their condition and point them in a better direction than where they were heading. I also learned about the division of labor and responsibility of different departments of medicine. As a professional, I understand the need to refer out when a medical area is not my area of expertise, but I do not think that any emotional area of need should be addressed solely by the psychiatric department. I think that every physician has the capacity for compassion and I will exercise mine to help my future patients in all aspects of their health.