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Inexperienced Meets Unexpected

Shivkumar Bhadola

Family medicine was my first third-year clerkship. This was the rotation where I started to happily put on my white coat and went to work, as I looked forward to speaking with people, helping patients, learning, and getting away from board review materials for some time. On my first day, I learned about the Centor criteria that would offer suggestion to the utility of a rapid strep test in someone who comes in with a sore throat plus or minus other symptoms. I tried to pick up on styles from different residents and attendings, hoping to blend them into my own. I made connections, such as when a middle-aged obese male opened up to me about his depression after he and I talked about how his current health affects his musical career. I made memories, such as when I interacted with an older woman who has Lupus. She was my first patient with Lupus, and she reminded me of my aunt, in more ways than sharing a medical diagnosis alone. All the while in family medicine, I tried to learn and prepare for the future. I wanted to gain skills and build habits that would come in handy later on. However, I learned medicine would require me to be ready on a moment's notice.

I was about four weeks into my first clerkship, when I was preparing for a patient who was coming in for a follow-up on a trigger finger. I read about the condition online prior to seeing her, and I talked about it amongst the clinicians and medical staff. I thought it would be a routine visit but I, the inexperienced, early-third-year medical student, was soon faced with the unexpected.

It was a 38-year-old mildly obese female who was presenting for a follow-up visit concerning her trigger finger. She had a stone face on during the initial parts of the interview. I couldn't read her at all. I was alone with this woman, in a patient room with a table, yet we were both sitting on chairs at eye level with one another. We briefly discussed her hand, and then some new foot pain. She referenced how she recently had an "incident," so I asked her to expand on that. She looked at me and, after a pause, said she doesn't care about her hand and, "I want to kill myself."

My mind had a thousand thoughts swirl through it in a moment. I start asking myself whether there could be any chance that this statement lacks truth, that it could be nothing more than a joke to tease the fresh, pearly, short white coat. She kept her calm composure and the feeling in the room went from sunny to sullen. I realized she was not in fact kidding and she meant what she said. I composed my thoughts, hopeful that I didn't lose her faith by looking distracted or taking an awkward pause, and proceeded to acknowledge her statement while asking her to tell me more.

She told me more than I anticipated she would, and I was once again facing the unexpected. I had never had a patient who was actively suicidal, and I was unsure I was fit to handle the task of interviewing someone in such a predicament. However, I knew leaving her to get help at the moment she opened up to me would be the opposite of what she would want. She repeatedly said she didn't want to get "locked up," which, for her, was involuntary hospitalization, and she consistently showed ambivalence about her decision of verbalizing her desire and details about how it almost came to fruition. Seven days prior to our meeting, T was in the middle of a river in a town half an hour away from her home, with nothing but an empty bottle of Bacardi, a straight edge razor blade, a cell phone, cold legs, and lonely thoughts. She still had some level of fair judgment – stating she did not drive after drinking because "children are on the road." She picked this particular town because she knew no one there and believed it would have been difficult for others to identify her. At one point, she desired loneliness. When she had it, she called her friend, while her emotions were high and hopes were low. The next thing she knew, she was being pulled out of the river with a police car, fire truck, and ambulance all called to rescue her.

She was saved in the moment, but needed more help later on. T told a story of being lost to follow up due to lapses in the system. She stated she was not given a follow-up appointment following discharge from the hospital she was taken to from the river. When she showed me her discharge paperwork, the first thing I noticed, in large Times New Roman, all-caps, bold font, was "**PSYCHOSIS.**" That was her diagnosis.

The interview she and I had moved around. It was initially like watching a game of poker, how she could convey depressing remarks and thoughts with simple and stagnant faces, but then it became fluid. At one point, she repeated she had something wrong with her. In between these statements, she wished she had cancer so she could let the illness take her body. She cried and stopped herself from crying multiple times. T told me she felt worthless, stating, "I'm almost 40 and almost homeless," and she went on to talk about her lack of energy, erratic sleep, past suicide attempt by Tylenol overdose, and her feeling that, "I don't want to live." She also told me she wants anti-depressant medication, after refusing to take her current medication regimen, and she desired a psychiatrist. I had trouble following her thoughts as I tried to use the interview tools I learned prior to my clinical years. I attempted to leave the room to get the physician I was working with, but I was met by resistance and a desire to leave the clinic each time I mentioned leaving her alone. Moments later, it would be her who was attempting to leave and me who would step in to stop the abandonment.

T ended up with involuntary hospitalization as she was deemed to be a potential harm to herself. She received the last thing she wanted, as she was "locked up." I struggled with this decision for weeks. I, an inexperienced third-year medical student who was caught in the middle of a raging

battle a woman was having with her mind, had trouble analyzing whether what happened to his woman was right or wrong. I feared potential loss of faith in the healthcare system but I was pleased with her short-term safety being solidified. I wondered how I would have acted had I been more experienced or perhaps more expecting. While I accepted I would never be able to find the answer to such a question, I realized experience not only comes from witnessing and living through encounters, but also through imagination and preparing for future events. Following my meeting with T, I planned how I would interact with the next patient I meet who is actively suicidal or recently attempted suicide. I meticulously thought of the questions I would ask and how I would approach certain topics. I attempted to increase my experience by raising my awareness and expectation of the situation. Thus, when I am next presented with a complaint I had not been preparing for, I hope to have been expecting it nonetheless.