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CREATIVE WORKS

The psych consult

"Stat consult for 55-year-old white female in room 12, agitated patient throwing food trays at nursing staff," reads the text message on my pager.

I'm disappointed. It's six o'clock on a Saturday evening. I had just left the hospital and was driving home. The urgency of the consult forces me to turn my car around and abandon my dinner plans.

In the doctor's lounge, I take a few moments to review the patient's electronic record. My disappointment turns to irritation as I scan the entries: "multiple admissions," "unexplained abdominal pain, likely irritable bowel syndrome," "negative workups," "pending litigation outcome."

My irritation grows as I take the elevator to the twelfth floor. I overhear a nurse talking to a student in the hallway as I head toward room 12. "Can you believe her? She's acting as though irritable bowel syndrome is gonna kill her!" she exclaimed. Her trainee rolls her eyes in agreement.

I stop walking. The urgency of the consult, the hopeless chart entries, the exasperated nurse, my disappointment and irritation — it is all an indicator of how the patient is feeling. Her psychological distress is infiltrating all those around her.

My irritation at my disrupted dinner plans made me miss this clinical sign. As a psychiatric consultant, I should have known better.

For the second time that day, I turn directions and head to the nurses' station. Moments later the nurse, her student and I sit in a triad. I hear about their challenging day caring for this patient, her relentless requests and questions about her diagnosis and its treatment. Her dramatic posturing when in pain, so flagrant that she accidently knocked an uneaten dinner tray off a table, its hot contents splattering all over a nurse's aide. The last straw.

Fred Sebastian

"Tough patient," I offer sympathetically.

The nurse nods and adds with an embarrassed tone, "I didn't mean to talk so loudly in the hallway. I just felt frustrated."

Back on course, I head toward the patient's room. I pause at the open doorway before knocking. Inside the darkened, quiet room she lay. A middle-aged woman, on her back, both hands resting on her belly, eyes closed, moaning quietly. I scan the room for flowers, cards, or slippers from home, the obligatory items people bring when a loved one is hospitalized. Nothing.

The introductions were frosty, but I push through, inviting her to tell me why she is here. In detail she describes her frustration with a different hospital, where, for a year, she had been receiving treatment for her abdominal pain.

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She has seen gastroenterologists, gynecologists, and urologists and had blood tests, ultrasounds, CTs, and MRIs but no luck, no cure. "They could not help me there. That's why I came here." She pauses as her face screws up in pain and she clutches her belly harder. "I met with my new gastroenterologist yesterday. I like him. I know he can help me."

I am leaning back against the wall, arms crossed, as I listen to her story. My arms and neck were tense as I ponder: "Why is she doing this?" Prematurely, I jump in, "Are you involved in some type of legal dispute?"

Her face falls as she tells me about a car accident 18 months ago. She admitted she was at fault and she was being sued. She has been very stressed by the subsequent legal wranglings. A few months later, the stomach pains had started. Things only went downhill after that. Poor health meant she gave up a job she loved and her husband had to work two to make ends meet. As a result, she hardly ever saw him.

A wave of embarrassment comes over me. I am ashamed of my inquisitorial stance and my judgment of her. As a psychiatric consultant, I should have known better.

Determined to turns things around, one more time, I take a chair and sit at her eye level. With a more relaxed tone, I ask her about her life. She tells me about her 20-year career as a creative director at a local company and her lifelong passion for art. How she would regularly host parties for local artists. As she talks, I could imagine her, stylishly dressed, a perfect hostess to an arty crowd, the chinking of wine glasses and the chatter of guests. As she reminisces, her hands leave her tummy and augment her conversation in gestures. She sits up. The pain disappears from her face and is quickly replaced with smiles. We have connected!

It seems she read my mind.

The talking stops, her hands move up to around her head, this time clenching the bedrails, and her body starts to writhe in pain. "Doctor, why is this happening to me?"

The anguish in her eyes says it all. At some unknown time, something really bad had happened to her. Her pain was real. The hurt from this unspeakable insult was so intense that the only way it could manifest itself was physically and the only way she could feel relief was in the dramatic environs of a hospital. This is my theory; I don't have proof. Could my theory heal her? No, but it cemented my empathy for her, and empathy is something that could heal.

I rack my brain for a technique to keep her connected, maintain her trust, and try to make her curious about her psyche. My thoughts are interrupted by the arrival of her gastroenterologist.

Her eyes light up. "Oh, Doctor, I am so glad you have come. I wanted to know more about those tests you were thinking of ordering." I watch as her hope for a cure transferred and became fixated upon him. The gastroenterologist and I exchange an awkward glance; our combined presence in this room is contradictory. So, I take my cue from the patient and say goodbye.

As I exit room 12, I realize I disappeared for her the moment he had entered. I had hoped I could have been the doctor who would have helped her. As a psychiatric consultant, I should have known better.

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Editor's note: The patient depicted in this article is a composite.