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THE LEARNER'S VOICE

Beyond the Binary of Salvation

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Eighteen Effexor tablets and one failed suicide attempt later and now Astrid finds herself in the inpatient unit before the medical student who only comprehends mental health through a misconstrued binary: that there are patients who can be saved, and those who cannot. What I know is that Astrid tried to overdose amidst a messy divorce battle and that Astrid, upon realizing the magnitude of what she had done, immediately called 911 and prayed for paramedics to arrive before it was too late. What I do not know is which side of the binary this patient — seemingly torn between wanting to live and wanting to die — would end up on.

Astrid emanated a warmth unfamiliar to the bleak, sterile hospital confines. She was mild-mannered yet spoke with fervor about what she loved: her children, religion, the horoscope section of Elle Magazine. I did not understand how a patient so colorful had attempted to end their life. My white coat, a contrast to the scarlet letter she brandished as a suicide survivor, never fazed her, and our conversations felt like those of two friends. But Astrid was complex — a patient with bipolar disorder and a history of med non-compliance and substance use, who somehow simultaneously boasted perfect attendance at group therapy sessions. It became apparent to me that she craved community but lacked the support she needed. So, we created a robust, trauma-centered treatment plan for her, and she seemed excited to begin her life anew. A patient on the salvageable side of the binary, I thought. After Astrid's discharge, I remained so optimistic about her prospects that I did not even notice her room's trashcan brimming with the self-help pamphlets I gave her. Before she left, Astrid shared with me every psychiatric patient's plight: wanting to get better but struggling with the emotional pain in doing so. I wondered if I could foster hope and purpose in moments where these sentiments felt sparse. But from eating lunch together to walking her to group, everything I did was governed by an overarching, genuine belief in Astrid's ability to recover. I wanted her to know I cared. I wanted to believe she carried that home with her.

Three weeks later and Astrid arrives in the ED with a cocktail of unpronounceable substances in her bloodstream before the medical student who only comprehends Astrid's life through a binary: that one moment she was here, and the next, she was gone.

I returned to her room following this news — the warmth I once felt replaced by a palpable agony that made the air heavy, as if bearing the weight of our failure in saving Astrid. And although I was but a distant planet in the beautiful universe that was her life, I still felt inextricably tied to her death. In medical school, we speak about the myth of infallible physicianship, but never about the guilt we feel when our interventions are not enough.

The thing about sudden loss is that no matter the richness of someone's life, you spend more time dissecting the intricacies of their death, dwelling over how it could have been prevented. This phenomenon is especially pronounced within healthcare, where we reduce the totality of someone's life to their illness and play a role in their final moments. But in a field like psychiatry, where we can effect change solely based on communication, the inevitability of working tirelessly to build rapport and still losing a patient to suicide was a bitter pill I could not swallow. For how could we, as mental healthcare providers, ever afford to fail at such a basic tenet of humanity: connection?

A professor of mine once said that patients speak frequently of three things: their life; their illness; and their treatment. The last is the only one we can account for. Somehow, it can also be the one that patients cherish most. Spending time on the wards, I discovered that therapeutic alliances could be forged out of simple gestures, and that the words I once considered pleasantries could make the world of a difference. I have learned that psychiatric care looks like mornings spent drawing with the cartoonist who fears that alcohol rehab will stifle her creativity. It looks like the

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utterance of "as salamu-alaykum" (peace be upon you) to the hijabi patient with anxiety because you, too, have grappled with your upbringing in such a culture that attributes mental illness to a lack of piety or virtue. It looks like on-call shifts spent consoling patients, whose sobs create melancholic tunes timed to the metronomic beeping of hospital alarms and heart monitors. But it also looks like the outpouring of gratitude from families to your care team, even after the death of their loved ones. Through these experiences, I begin to repair the wound in my spirit that Astrid left behind. My emotional churning and learned helplessness dissipate, and so does my fixation on the all-or-nothing binary of absolute salvation for every patient.

The trajectory of mental illness is unique as it cannot always be explained away by some genetic mishap or insidious pathophysiological process. In tracing the origins of one's psychiatric history, there is oftentimes someone or something to point a finger at. The web of mental anguish is one woven by the world's caprices and cruelties and there is no permutation of medication or therapy guaranteed to "cure" somebody. I have come to understand that successful patient connection is not defined by perfect longitudinal patient outcomes, but rather, by the warm smile on someone's face when I ask about their children, or my hands, tightly interlocked with another's in recitation of the Serenity Prayer [1]. Within our lives, there exist times when we are graced with a profundity of emotions that we cannot always adequately express. Where I cannot provide a cure, I can at least provide an outlet; a promise of hope; and be a purveyor of joy, even if only for a fleeting moment. That much, at least, I know I can do.

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Declarations

In order to adhere to confidentiality standards, I have de-identified all patient data by replacing any protected health information with fictitious information. Though patient names have been masked with pseudonyms, the overall message of the submission is unaltered.

Disclosures The author states that there is no conflict of interest.

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