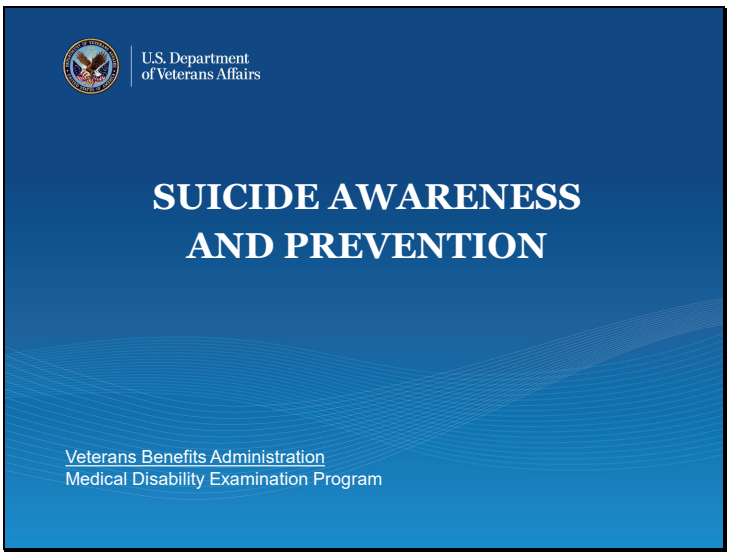
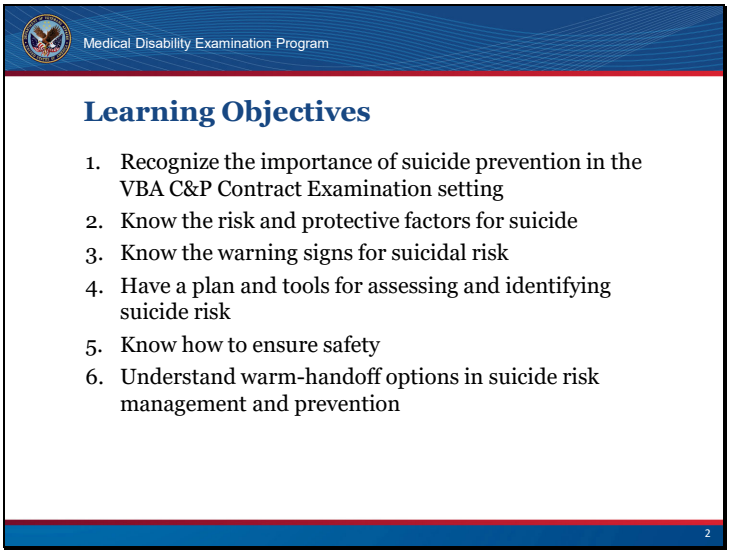
Slide 1

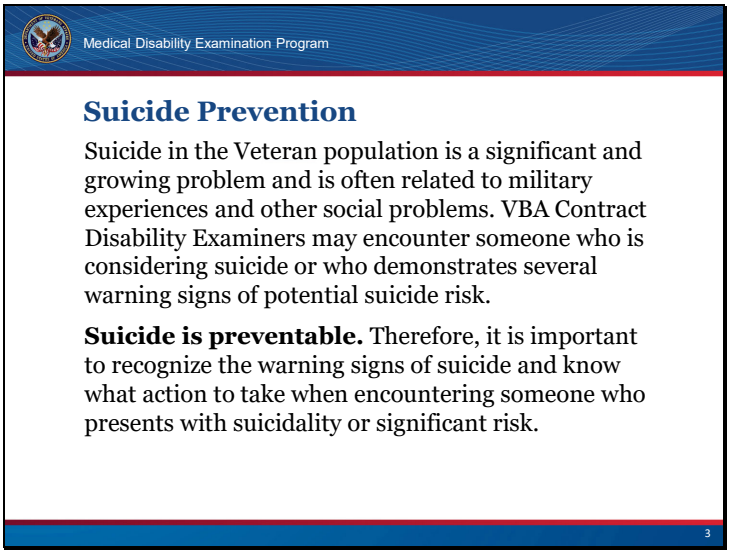

U.S. Department
of Veterans Affairs
SUICIDE AWARENESS
AND PREVENTION
Veterans Benefits Administration
Medical Disability Examination Program

Slide 2



Welcome to suicide awareness and prevention training. In this training, we'll explore risks and warning signs for suicide and discuss plans and tools for assessing and identifying suicide risk and the ultimate goal of ensuring Veterans' safety and welfare. The C&P disability examination is not a treatment exam, therefore a warm-handoff for Veterans who are at high or imminent risk or who may benefit from additional VA resources can be beneficial in the management of suicide risk and prevention.

Slide 3



Suicide is a public health challenge that causes immeasurable pain among individuals, families, and communities across the country. Suicide is also preventable. Veteran suicide is an urgent issue that the U.S. Department of Veterans Affairs (VA), along with its stakeholders, partners, and communities nationwide, must address. Suicide in the Veteran population is often related to military experiences and other social problems. VBA Contract Disability Examiners may encounter someone who is considering suicide or who demonstrates several warning signs of potential suicide risk.

Suicide is preventable. Therefore, it is important to recognize the warning signs of suicide and know what action to take when encountering someone who presents with suicidality or significant risk.

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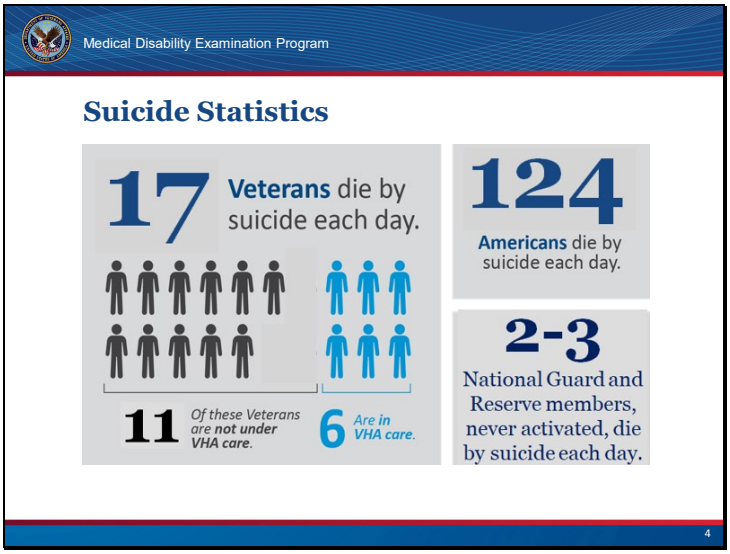
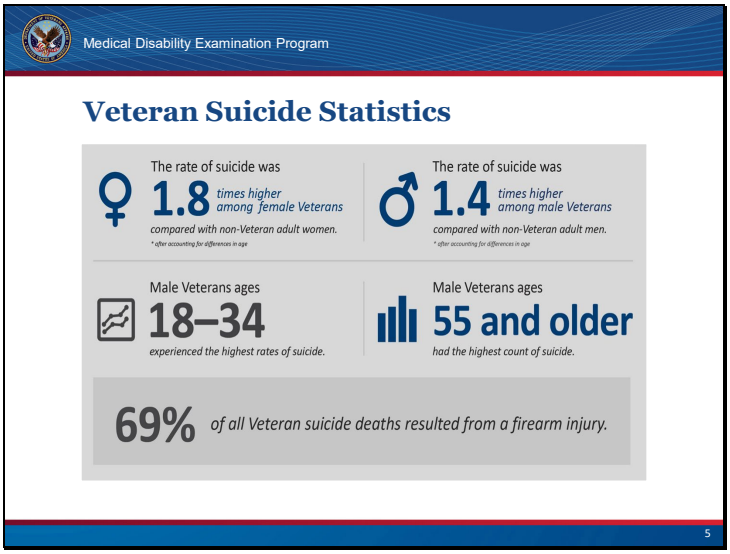


This data is from the VA National Strategy for Preventing Veteran Suicide based on 2017 data made available from the Centers for Disease Control and Prevention's National Death Index. Seventeen Veterans, on average, died by suicide each day while 124 of non-Veteran Americans died by suicide each day. Eleven out of the 17 Veterans were not under VHA care when they committed suicide. In addition to the 17 Veterans, two to three National Guard and Reserve members who were never Federally activated died by suicide each day.

Slide 5



The suicide rate for Veterans is higher than the non-Veteran population for both males and females. Male Veterans aged 18-34 have the highest rate of suicide and male Veterans 55 and older have the highest suicide count. Most of the Veteran suicide deaths resulted from a firearm injury.

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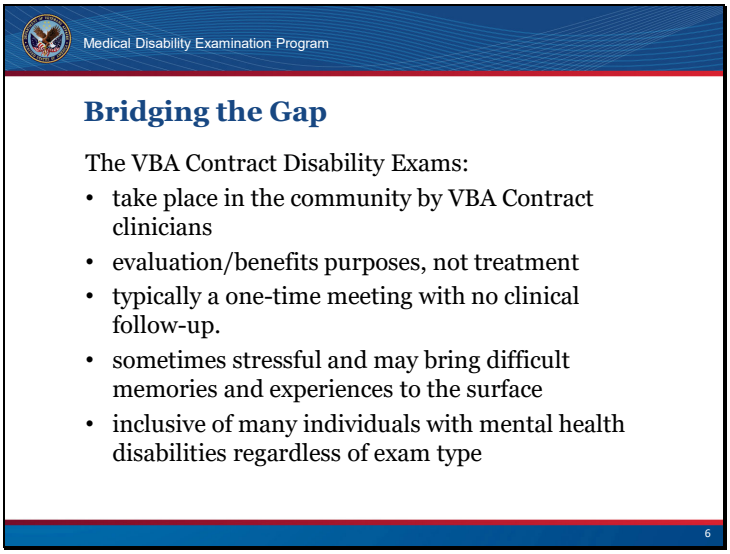
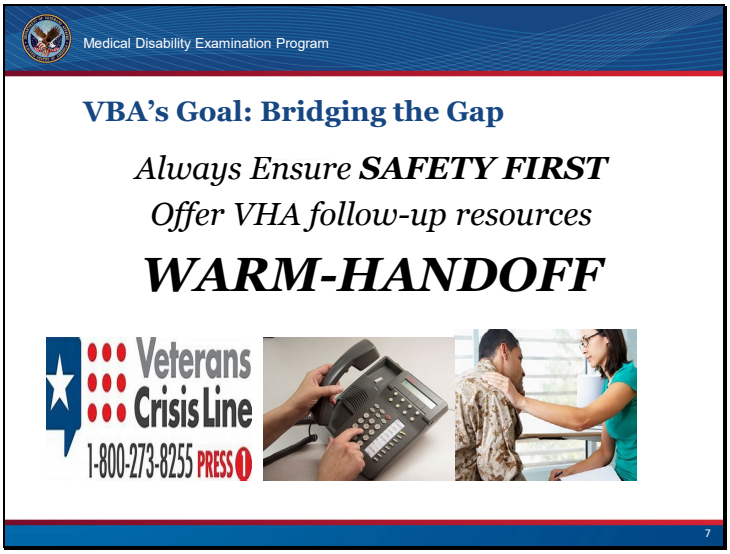


In line with the VHA's Suicide Prevention Program Priorities, the VBA is also committed to the promotion of Mental Health Awareness and Treatment. VBA Contract Disability Exams are unique for many reasons:

- VBA exams take place in the community outside of the VHA hospital setting and are completed by VBA Contract clinicians who don't have readily available VHA resources in their location.
- These exams are for evaluation/benefits purposes, not treatment so they lack a patient doctor relationship.
- They are typically a one-time meeting with no clinical follow-up.
- Because Veterans rely on the results for monetary compensation, they can sometimes be stressful. The examination may also bring difficult memories and experiences to the surface that have never been shared.
- Many individuals will have mental health disabilities, regardless of exam type.

Slide 7



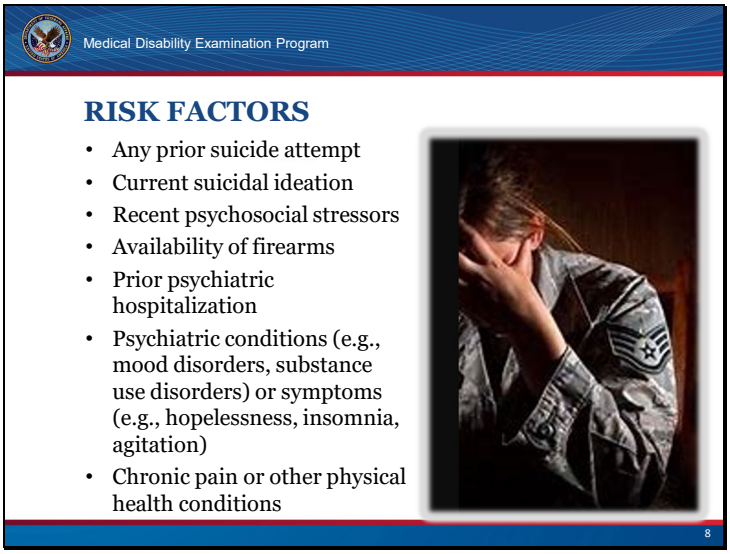
Given what we know about the Suicide Statistics and our VBA Contract Exam process, we must be prepared to properly care for any Veteran or Service Member who presents with significant suicide risk.

VBA's goal is to always ensure SAFETY FIRST. In the highest risk/imminent situations this may involve a WARM-HANDOFF to 911/local authorities to pursue the involuntary hospitalization process in accordance with the examiner's state ethical/licensing requirements and vendor protocols.

Additionally, given the non-treatment role of the VBA Contract Exam, it is also appropriate to inform any Veteran about VHA follow-up resources (i.e. VCL, local VAMC treatment programs) as a means of mental health care promotion and suicide prevention. It is considered a WARM-HANDOFF to encourage the use of additional VA resources after the C&P exam. While this might not necessarily be an in-person warm-handoff, it allows contract examiners to facilitate these connections to VHA services when appropriate to maximize care and prevention.

To achieve these goals, it is important that the examiner can identify which individuals may require or benefit from the warm-handoff options. This is done by properly assessing for suicide risk.

Slide 8



First, let's look at some of the known risk factors for suicide.

VA/DoD Clinical Practice Guidelines highlight several known suicidal risk factors.

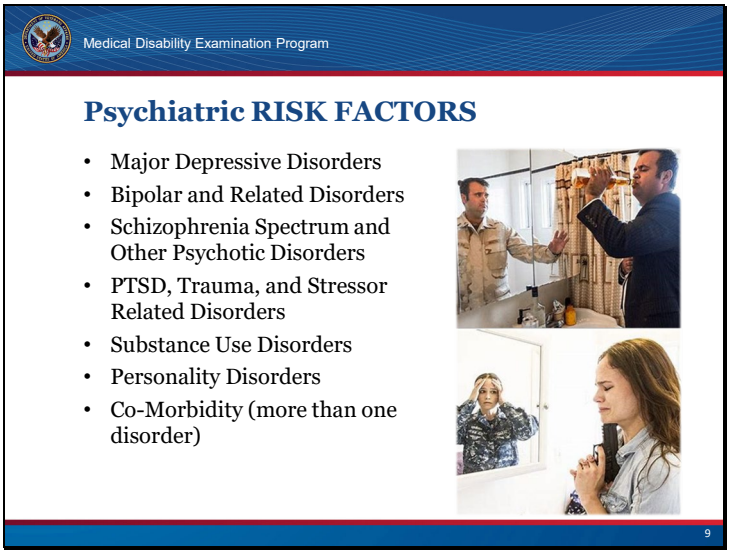
However, these risk factors are not necessarily closely related in time to the onset of suicidal behaviors – nor does any risk factor alone increase or decrease risk. Population-based research suggests that the risk for suicide increases with an increase in the number of risk factors present. When more risk factors are present at any one time, they more likely indicate an increased risk for suicidal behaviors at that time.

Known factors that may increase the risk for suicide include:

- Any prior suicide attempts
- Current suicidal ideation
- Recent psychosocial stressors
- Availability of firearms
- Prior psychiatric hospitalization
- Psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, agitation)
- Chronic pain or other physical health conditions

A history of a suicide attempt is the strongest predictor of future suicide attempts and death by suicide. Intentional self-harm (i.e., intentional self-injury without the expressed intent to die) is also associated with long-term risk for repeated attempts as well as death by suicide.

Slide 9



Suicidal thoughts and behaviors are commonly found at increased rates among individuals with psychiatric disorders, especially major depressive disorder, bipolar disorders, schizophrenia, PTSD, anxiety, chemical dependency, and personality disorders.

Psychiatric co-morbidity increases risk for suicide, especially when substance abuse or depressive symptoms coexist with another psychiatric disorder or condition.

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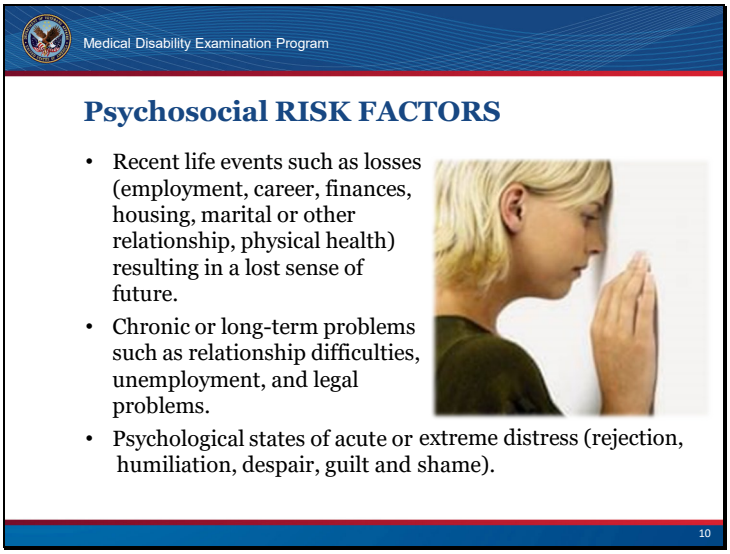
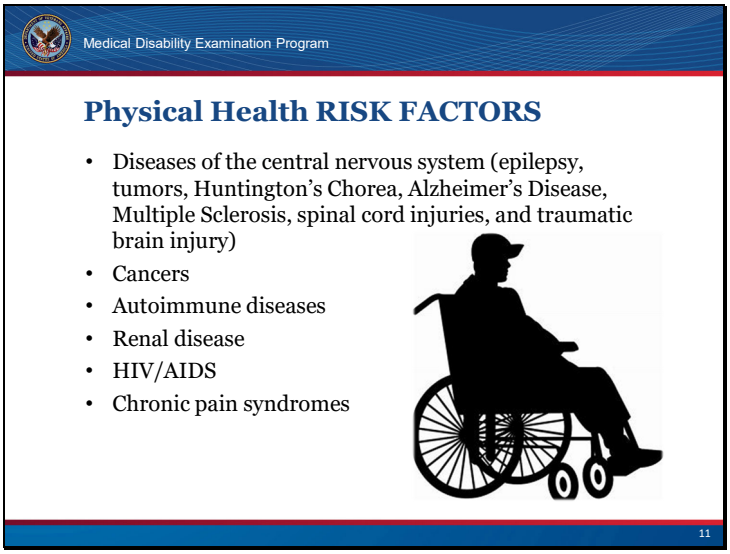


Several psychosocial factors are also associated with risk for suicide and suicide attempts. These include recent life events such as a loss of employment, career, finances, housing, marital relationship, physical health and other loses that result in a lost sense of a future. Chronic or long-term problems such as relationship difficulties, unemployment, and problems with the legal authorities (legal charges) are psychosocial risk factors as well as psychological states of acute or extreme distress such as humiliation, despair, guilt and shame. These are often present in association with suicidal ideation, planning and attempts.

While not uniformly predictive of suicidal ideation and behavior, they are warning signs of psychological vulnerability and may indicate a need for mental health evaluation to minimize immediate discomfort and to evaluate suicide risk. This would be a good example of when a VBA Contract examiner, given the limited nature of the C&P exam, might provide the individual with local VHA information or VA Crisis Line resources to facilitate a warm-handoff and encourage follow-up care.

Slide 11

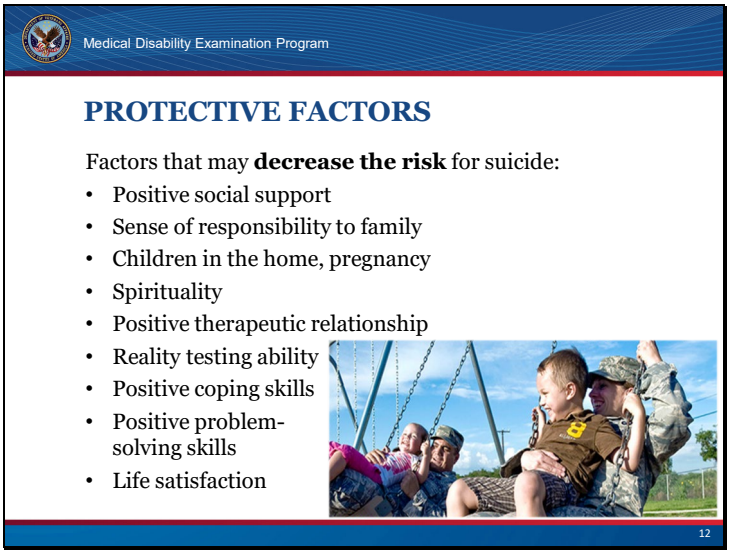


Certain physical disorders are associated with an increased risk for suicide including diseases of the central nervous system, cancers, autoimmune diseases, renal disease, and HIV/AIDS. Chronic pain syndromes can contribute substantially to increased suicide risk in affected individuals. And Veterans with traumatic brain injuries may be at increased risk for suicide.

In comparison to the general population, TBI survivors are at increased risk for suicide ideation according to a study by Simpson and Tate in 2002, increased risk for suicide attempts according to Silver et al. 2001, and increased risk for suicide completions according to a study by Teasdale and Engberg in 2001. TBI-related sequelae can be enduring and may include motor disturbances, sensory deficits, and psychiatric symptoms such as depression, anxiety, psychosis, personality changes, and cognitive dysfunction. Cognitive impairments include impaired attention, concentration, processing speed, memory, language and communication, problem solving, concept formation, judgment, and initiation. Another important TBI sequelae that contributes to suicidal risk is the frequent increase in impulsivity.

These impairments may lead to a life-long increased suicide risk that requires constant attention. If these are present, take the opportunity to inquire about current treatment participation and encourage the use of VHA resources as a warm-handoff mechanism to follow-up care.

Slide 12



Just as there are factors that increase risk for suicide, there are also factors that decrease the risk for suicide and serve to protect the individual from mental health deterioration. When assessing the level of suicide risk, it is important to consider both risk and protective factors.

Factors that may **decrease the risk** for suicide include a positive social support system, having a faith or spirituality, and feeling responsible for family or children in the home. Individuals who are satisfied with their life, possess the ability to test reality, and who have positive coping and problem-solving skills have a decreased risk for suicide. And, individuals who have a positive therapeutic relationship also have a decreased risk.

While we can't force participation in mental health treatment, we can ensure that individuals have the information and resources needed to initiate contact with their local VHA or the VA Crisis Line to maximize protective factors.

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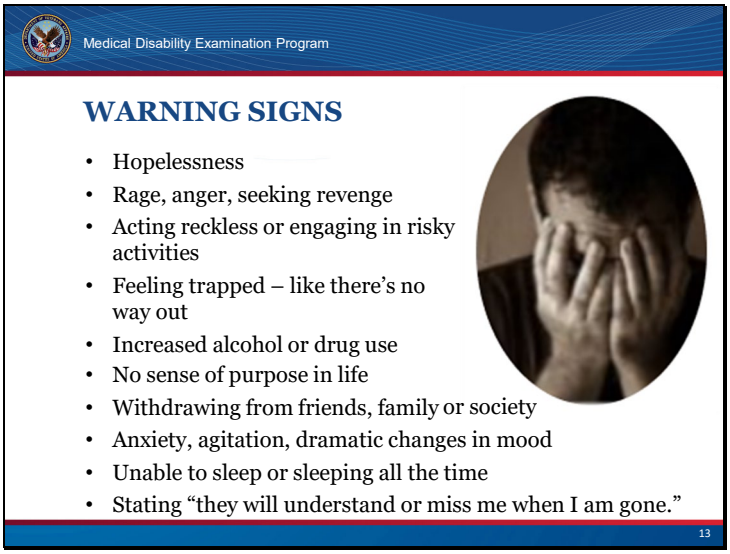
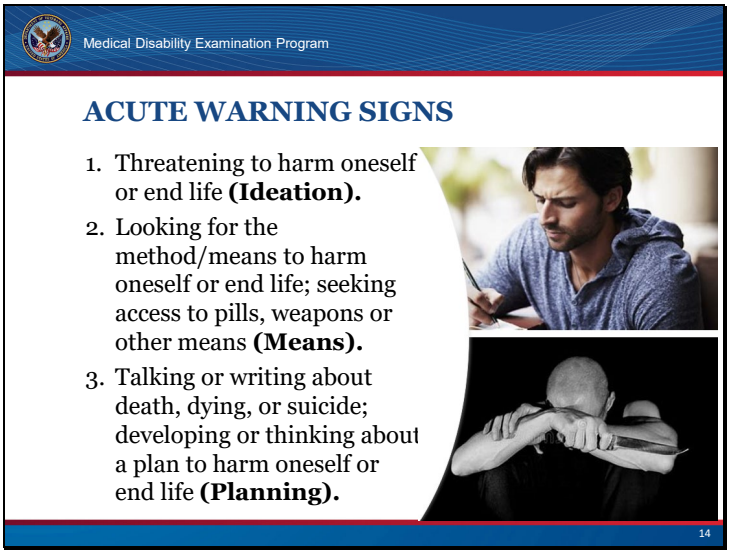


In addition to risk and protective factors, in many cases there are overt warning signs that can indicate that an individual is at risk for suicide.

Examples of warning signs include but are not limited to:

- Hopelessness
- Rage, anger, seeking revenge
- Acting reckless or engaging in risky activities
- Feeling trapped – like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family or society
- Anxiety, agitation, dramatic changes in mood
- Unable to sleep or sleeping all the time
- No sense of purpose in life
- Making statements like "they will understand or miss me when I am gone."

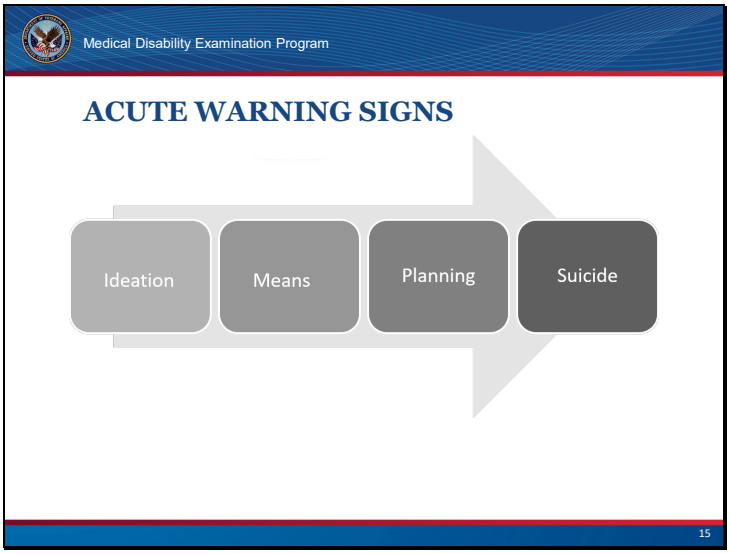
Slide 14



In some cases, there are more Acute (current/serious) warning signs related to suicide that should alert the clinician that precautions may be needed IMMEDIATELY to ensure the individual's safety, stability and security. These warning signs typically appear in a sequential order.

1. Threatening to harm oneself or end life is (Ideation).
2. Looking for the method/means to harm oneself or end life such as seeking access to pills or weapons substantiates (Means).
3. Talking or writing about death, dying, or suicide and developing or thinking about a plan to harm oneself or end life constitutes (Planning), the highest risk.

Slide 15

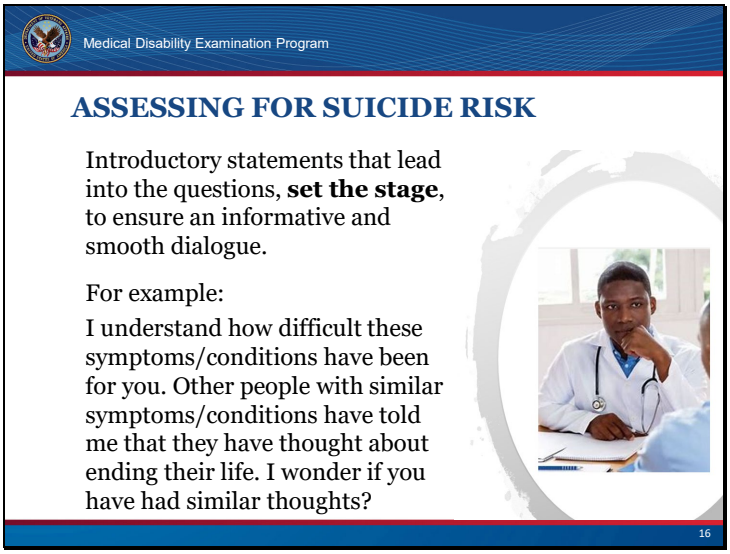


The Acute Warning Signs are seen here in the form of a progression towards Suicide. There is often a transition that takes place along the continuum from ideation to means to planning and then to suicide attempt or suicide.

In most cases, suicidal ideation is believed to precede the onset of suicidal planning and action. Suicidal ideation can be associated with a desire or wish to die (intent) and a reason or rationale for wanting to die (motivation). Hence, it is essential to explore the presence or absence of ideation – currently, in the recent past, and concurrent with any change in physical health or other major psychosocial life stress.

Many individuals will initially deny the presence of suicidal ideation for a variety of reasons. Even if denied, certain observable cues (affective and behavioral) should prompt the clinician to remain alert to the possible presence of suicidal ideation. Asking about suicidal ideation and intent does not increase the likelihood of someone thinking about suicide for the first time or engaging in such behaviors. In fact, most individuals report a sense of relief and support when a caring, concerned clinician non-judgmentally expresses interest in exploring and understanding their current psychological pain and distress that leads them to consider suicide or other self-injurious behaviors.

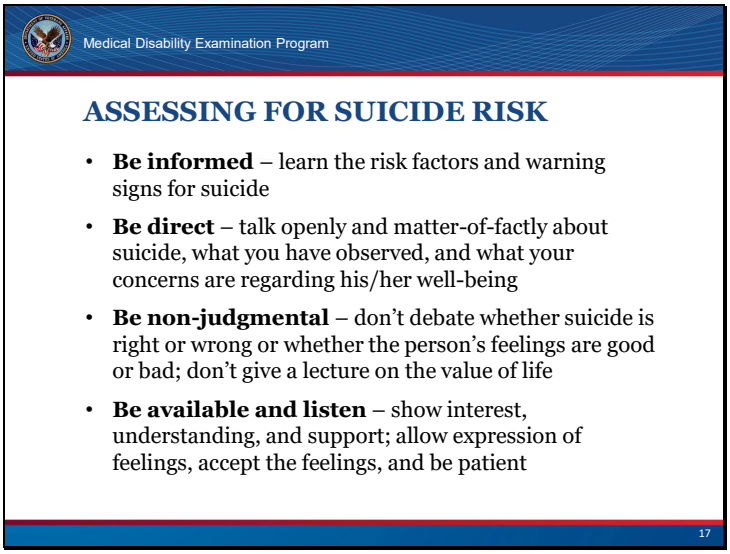
Slide 16



Not all examinations have a component that will elicit questions regarding suicidal ideation, and many may never lead to assessing suicide risk. Mental Health examinations most often lead to this assessment as the mental health history and symptomology may identify warning signs to be explored further during the examination. However, any examination may lead to the Veteran disclosing how ongoing pain or traumatic memories effect his or her daily functioning and the impact on daily life. If the Veteran begins to share information that becomes emotional or expresses thoughts (warning signs) that lead you to be concerned, then asking questions to assess risk may be prudent in ensuring the Veteran's safety.

Introductory statements can help open the conversation and set the stage for risk assessment questions and make them a natural part of the examination and overall assessment of the current problem. A great deal depends upon the clinician's familiarity with the key screening questions and his or her comfort with the topic and asking the questions. Introductory statements that lead into the questions set the stage to ensure an informative and smooth dialogue for assessing suicide risk. The slide shows one example, but you may develop other approaches that work for you. It is important to ask screening questions whenever clinically appropriate; however, asking Veterans how they're doing in any exam is good clinical practice.

Slide 17



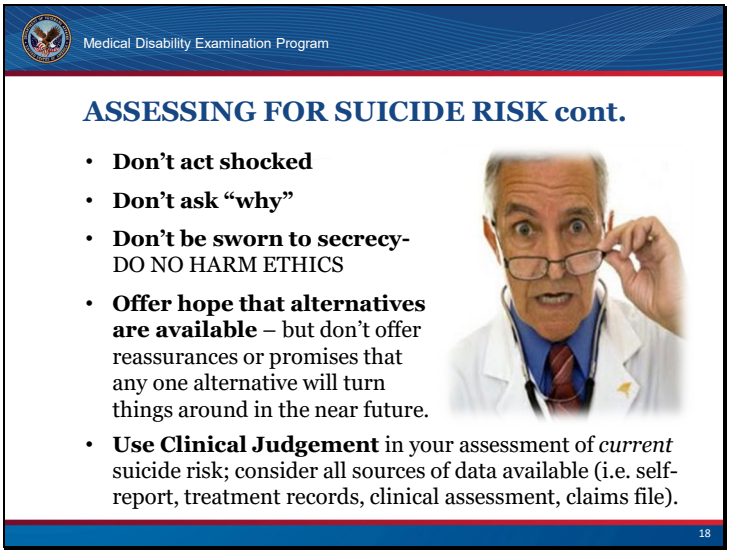
Assessing for suicide risk requires you to **be informed** of the risk factors and warning signs for suicide. It's important to **be direct** and talk openly and matter-of-factly about suicide, what you have observed, and what your concerns are regarding his/her well-being.

Be non-judgmental – don't debate whether suicide is right or wrong or whether the person's feelings are good or bad; don't give a lecture on the value of life

Be available and listen – show interest, understanding, and support; allow expression of feelings, accept the feelings, and be patient.

All of these will allow you to most accurately gauge the risk level and actions needed to ensure safety.

Slide 18



It's important to be aware of your responses when assessing for suicide risk.

Don't act shocked

Don't ask "why"

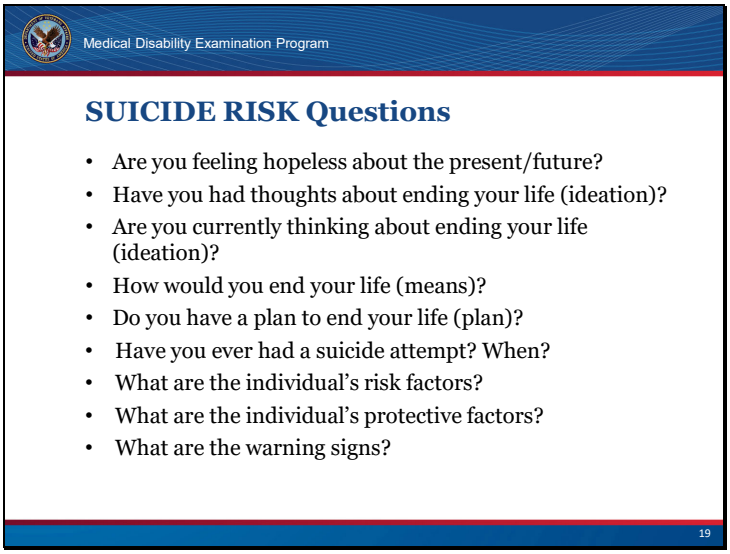
Don't be sworn to secrecy- DO NO HARM ETHICS

Offer hope that alternatives are available – but don't offer reassurances or promises that any one alternative will turn things around in the near future.

Use Clinical Judgement in your assessment of CURRENT suicide risk and **consider all sources of data** available to you (i.e. self-report, treatment records, clinical assessment, claims file).

All suicidal ideations and suicidal threats need to be taken seriously.

Slide 19



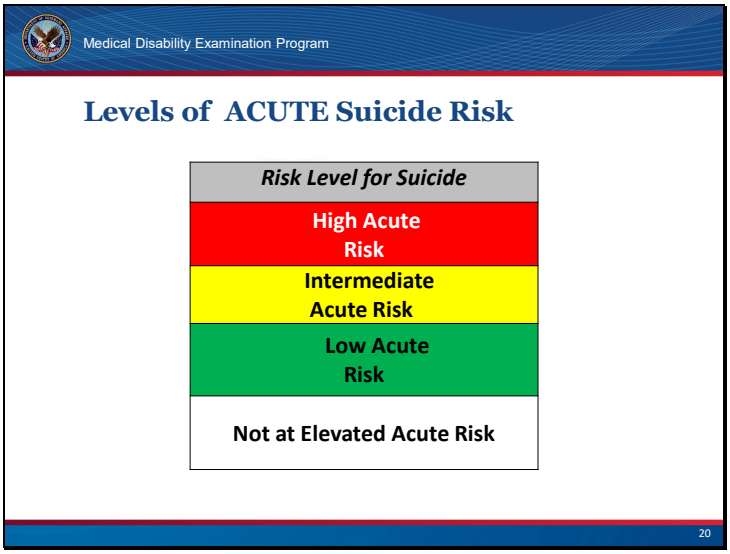
These are some common questions that can be asked to further assess suicide risk. For example: Are you feeling hopeless about the present/future? Have you had thoughts about taking your life (ideation)? How would you do it (means)? Do you have a plan to take your life (plan)?

For each of these questions, you should ensure the Veteran's immediate safety and formulate what action is clinically appropriate to address the suicide risk.

Keep in mind that suicide can be understood as an attempt by the individual to solve a problem, one that they find overwhelming. It can be much easier for the clinician to be nonjudgmental when he/she keeps this perspective in mind.

Hopelessness – about the present and the future – has been found to be a very strong predictor of suicidal ideation and self-destructive behaviors. Feelings of helplessness, worthlessness, and despair are associated with hopelessness. Although often found in depressed patients, these affective states can be present in many disorders – both psychiatric and physical. When these are present, it is important to explore these feelings with the individual to better assess for the development or expression of suicidal behaviors. Some clinicians are not comfortable asking these questions, yet they are very important in risk identification and suicide prevention.

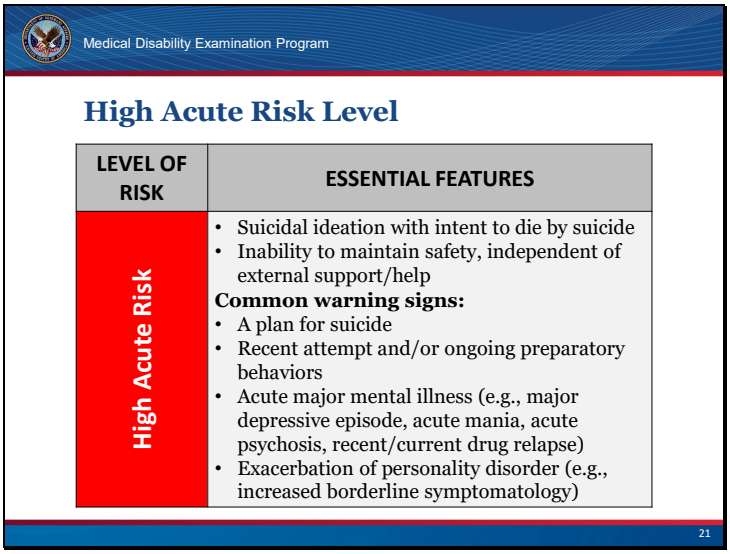
Slide 20



Now that you understand the Risk Factors, Protective Factors, Warning Signs, and tools for Assessing Suicide Risk, it is important to synthesize that data to identify the LEVEL OF ACUTE RISK that may be present during the VBA Contact C&P exam process.

These levels of risk are from the VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide and can be a helpful tool for examiners. Ultimately, the VBA Contract examiner should identify if there is an acute risk of suicide during the examination or indicate that no risk was present if applicable. It is important to note that suicidality is not exclusive to Mental Health examinations; therefore, all examiners should be well equipped to effectively identify and manage risk when present in a C&P examination.

Slide 21



These next few slides will give you a snapshot of each level of suicide risk based on the VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide. This information can be gathered in your clinical assessment and records review while also taking into consideration the risk factors, warning signs, and protective factors.

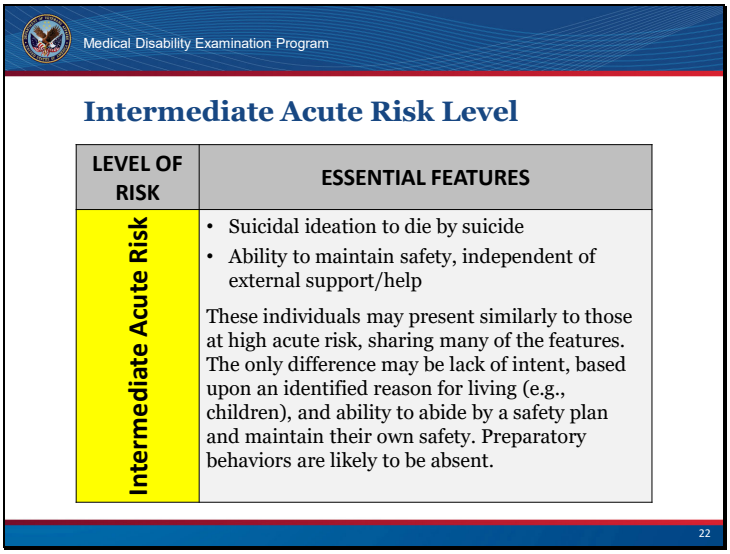
The High Acute Risk indicates that the essential features at this risk level include suicidal ideation with the intent to die by suicide and/or an inability to maintain safety, independent of external support/help. The High Acute Risk level is determined when one or both of these essential features are present.

Common warning signs include:

- A plan for suicide
- Recent attempt and/or ongoing preparatory behaviors
- Acute major mental illness (e.g., major depressive episode, acute mania, acute psychosis, recent/current drug relapse)
- Exacerbation of personality disorder (e.g., increased borderline symptomatology)

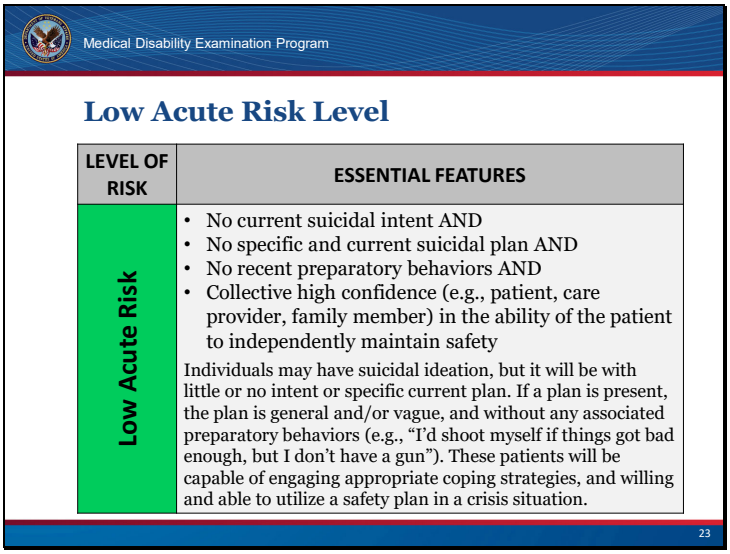
Both immediate and careful action is needed to ensure safety and a warm-handoff. If the individual is at the High Acute Risk level for Suicide, it is important to maintain direct observation of the individual, limit access to lethal means, and to pursue hospitalization in accordance with the state/local, ethical/licensing and contractor protocols.

Slide 22



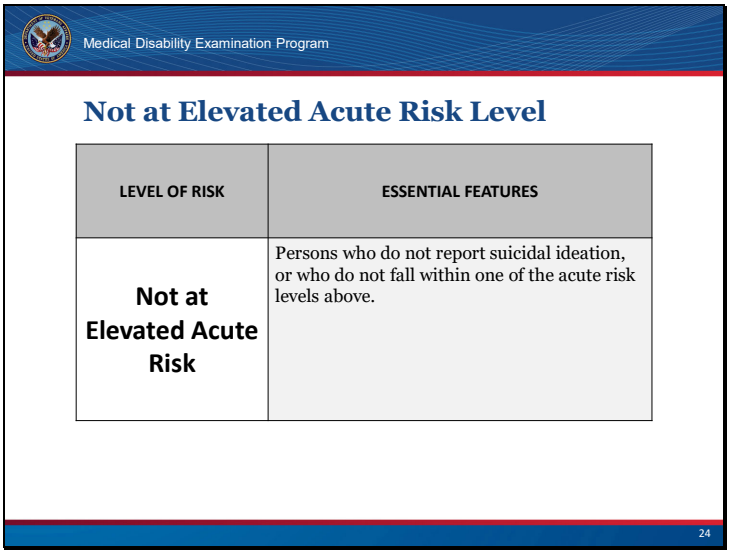
This is the Intermediate Level of Acute Risk for Suicide. The essential features include current suicidal ideations to die by suicide. Though these individuals may present similarly to those at high acute rise and share many of the same features, they lack intent, usually based on their identified reason for living and their ability to maintain safety independent of external support/help. The Intermediate level is still significant because any change in risk or protective factors could lead the individual to being at the high risk level. However, with additional support and resources, the individual's level of risk can also improve.

Slide 23



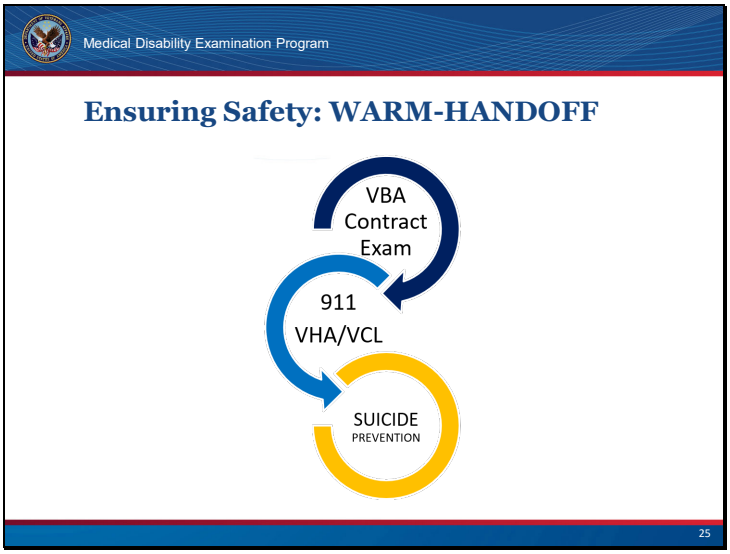
This is the Low Acute Risk Level for Suicide. The essential features indicate that there is NO current suicide intent, NO specific and current suicidal plan, NO recent preparatory behaviors, and there is collective high confidence in the ability to independently maintain safety. However, there may still be suicide ideation. These individuals are capable of engaging appropriate coping strategies and are willing and able to utilize a safety plan in a crisis situation.

Slide 24



Hopefully, most Veterans and Service Members seen in our VBA contract examinations will fit this description of Not at Elevated Acute Risk. These individuals do not report suicidal ideation and/or do not fit within any other risk level. They, therefore, are Not at Elevated Acute Risk for Suicide an no action is warranted.

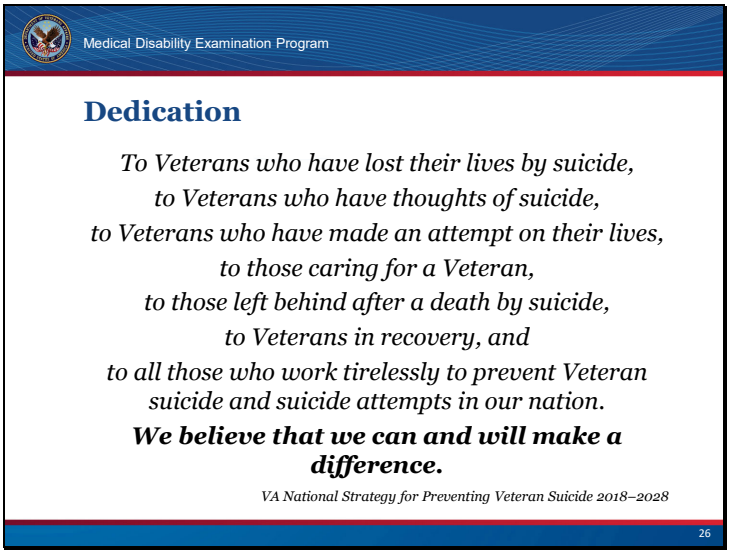
Slide 25



If you recall from a previous slide on suicide statistics, of the 17 Veterans per day that die by suicide, 11 are not in VHA care. Therefore, to maximize safety and suicide prevention, our VBA Contract examiners must ensure safety and recognize the importance of the warm handoff.

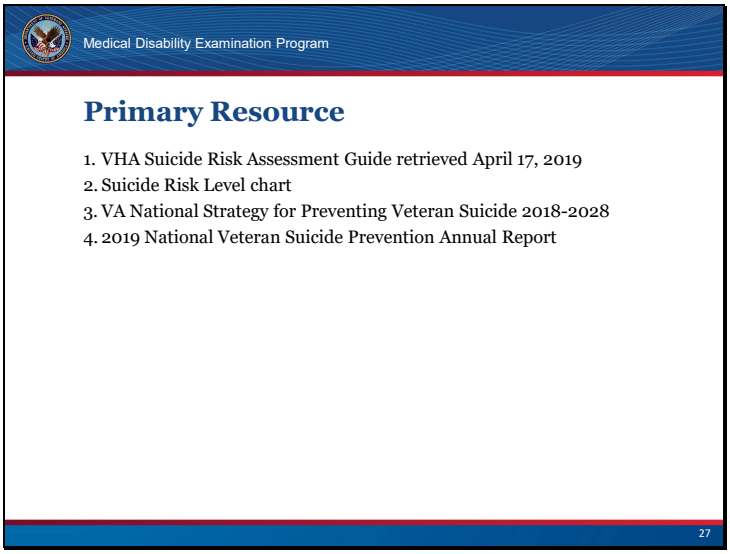
This warm handoff may include utilizing 911/local authorities to maximize safety and ensure transfer to an emergency hospitalization setting in extreme cases but must always include the Veterans Crisis Line. It is also very important to encourage and facilitate the use of VHA resources for future use in crisis management/prevention. For example, providing the Veterans Crisis Line information, informing Veterans about treatment options at their local VA hospital, or encouraging that they reach out to their local VA to see what services are available can help connect individuals to VA resources. Though it is ultimately up to the individual to accept and/or utilize these resources, a show of concern and support and sharing resources can make a difference in preventing suicide. Always be sure to follow your vendor's guidance for handling situations involving Veterans with suicidality.

Slide 26

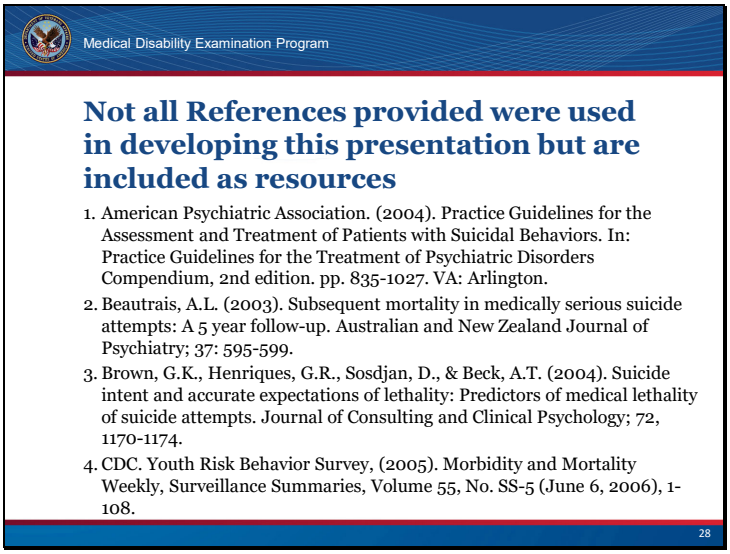


Everyone has a role to play in Suicide Prevention. We believe that you can and will make a difference. Thank you for all you do to help promote Mental Health Awareness, Safety, and Suicide Prevention for Veterans and Service Members!

Slide 27


Medical Disability Examination Program
Primary Resource
1. VHA Suicide Risk Assessment Guide retrieved April 17, 2019
2. Suicide Risk Level chart
3. VA National Strategy for Preventing Veteran Suicide 2018-2028
4. 2019 National Veteran Suicide Prevention Annual Report
27

Slide 28


Medical Disability Examination Program
Not all References provided were used in developing this presentation but are included as resources
1. American Psychiatric Association. (2004). Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors. In: Practice Guidelines for the Treatment of Psychiatric Disorders Compendium, 2nd edition. pp. 835-1027. VA: Arlington.
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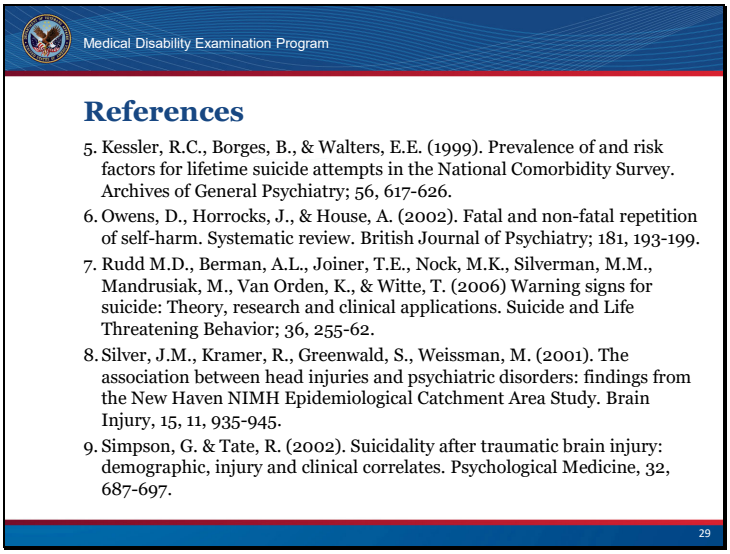
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9. Simpson, G. & Tate, R. (2002). Suicidality after traumatic brain injury: demographic, injury and clinical correlates. Psychological Medicine, 32, 687-697.
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10. Teasdale, T.W. & Engberg, A.W. (2001). Suicide after traumatic brain injury: A population study. The Journal of Neurology, Neurosurgery, and Psychiatry, 71 (4), 436-440.
11. Other references that may be useful:
12. Suicide Information Web Sites:
13. American Association of Suicidology: http://www.suicidology.org
14. American Foundation of Suicide Prevention: http://www.afsp.org
15. Suicide Prevention Action Network (SPAN): http://www.spanusa.org
16. Suicide Prevention Resource Center: http://www.sprc.org
17. US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov

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1. Berman, A.L., Jobes, D.A. & Silverman, M.M. (2006) Adolescent Suicide: Assessment and Intervention. NY: Guilford Publications.
2. Brown, G., Ten Have, T., Henriques, G., Xie, S., Hollander, J. & Beck, A. (2005). Cognitive Therapy for the Prevention of Suicide Attempts, A Randomized Controlled Trial. JAMA, 294(5). 563-570.
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8. Maris, R. W., Berman, A.L., & Silverman, M.M. (2000) Comprehensive Textbook of Suicidology. New York, NY: The Guilford Press.
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15. Simon, R. & Hales, R. (2006). Textbook of Suicide Assessment and Management. Arlington, VA: American Psychiatric Publishing, Inc.

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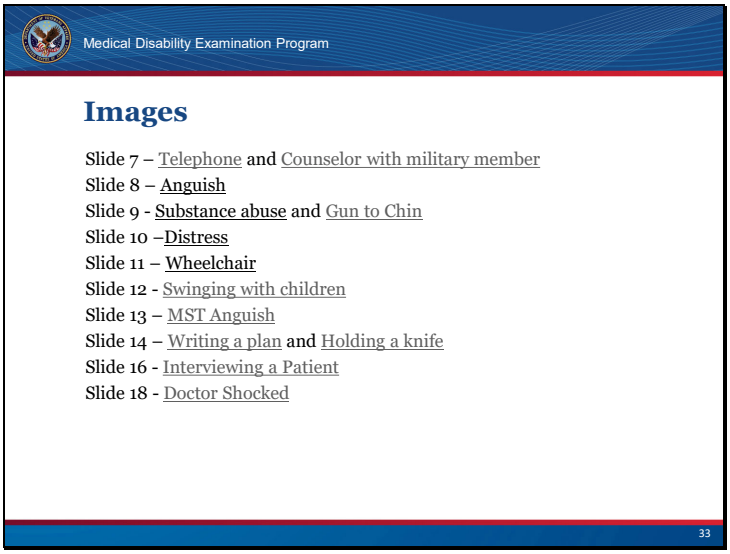

Image Links

Slide 7 – Telephone: https://medicine.wustl.edu/wp-content/uploads/phone.jpg and Counselor with military member: https://www.opencounseling.com/uploads/news-pictures/82062-traverse-city-blog-post-image-20180420164054.jpg
Slide 8 – Anguish: https://www.bing.com/images/search?view=detailV2&ccid=Ve%2f72fX2&id=C74A6E74FD673F9D0EBF5F588CBB739A3C3F49CB&thid=OIP.Ve_72fX26aQO8fEnsXk45AHaFj&mediaurl=https%3a%2f%2fi.ytimg.com%2fvi%2f38stIubduUw%2fhqdefault.jpg&exph=360&expw=480&q=Trauma+Woman&simid=608042505718596645&ck=F9367392940E7BDA96F94B972BDDD344&selectedIndex=27&ajaxhist=0
Slide 9 – Substance Abuse: https://www.bing.com/images/search?view=detailV2&ccid=v5JISabY&id=6EDD9A914B61D59230C091B6B7AB2154FE254C75&thid=OIP.v5JISabYctjXSHzWQzexvgHaFp&mediaurl=https%3a%2f%2fmedia.breitbart.com%2fmedia%2f2015%2f04%2fScreen-Shot-2015-04-01-at-1.28.12-PM.png&exph=607&expw=795&q=VA+PTSD&simid=608029002276537078&ck=7872267893708CA34044081EFC112DB1&selectedIndex=265&ajaxhist=0 and Gun to Chin: https://www.bing.com/images/search?view=detailV2&ccid=1sUfasnG&id=9AD39E393EC2370C8F66367C852DBE691DA3D6FD&thid=OIP.1sUfasnGXBbmKYqqkjqzCAHaE8&mediaurl=https%3a%2f%2fi.pinimg.com%2foriginals%2fdf%2fd2%2f0e%2fdfd20e82c8580f1e3fd175898d075a40.jpg&exph=660&expw=990&q=What+Looks+Like+PTSD+Veterans&simid=607989767729709352&ck=843700F57146B16AB784686F35154714&selectedIndex=5&ajaxhist=0
Slide 10 – Distress: https://www.bing.com/images/search?view=detailV2&ccid=YRX9ncZ5&id=68E983979ECAFB0CECFF8D6DAE121CB25906BD03&thid=OIP.YRX9ncZ5rdGeDfBH3hJYqwAAAA&mediaurl=https%3a%2f%2fi.guim.co.uk%2fimg%2fstatic%2fsys-images%2fGuardian%2fPix%2fpictures%2f2009%2f11%2f4%2f1257335445105%2fmental-health-at-work-

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Slide 11 – Wheelchair:
https://www.bing.com/images/search?view=detailV2&ccid=KW6ZZPa6&id=932ED9FA9402D10DBD5B2C188AB8FBD2AB4C5F20&thid=OIP.KW6ZZPa6mvoIyUg4KIfoCAHaH7&mediaurl=http%3a%2f%2fwww.supercoloring.com%2fsites%2fdefault%2ffiles%2fsilhouettes%2f2015%2f05%2fman-in-wheelchair-black-silhouette.svg&exph=822&expw=768&q=Wheelchair+Silhouette&simid=608000574022484926&ck=CCD4F84982EFC99F8ACA5B58DAF05CE7&selectedIndex=1&ajaxhist=0
Slide 12 – Swinging with children: https://www.veterantraining.va.gov/parenting/index.asp
Slide 13 MST Anguish:
https://www.bing.com/images/search?view=detailV2&ccid=gqEyG8%2fM&id=483334ED6B9ED757A9CFC47B5CF2E7D238A8E446&thid=OIP.gqEyG8_M7dfc6gJxIO4qdQHaEy&mediaurl=https%3a%2f%2fthemighty.com%2fwp-content%2fuploads%2f2016%2f05%2fxscreen-shot.png.pagespeed.ic.4cpV-vOHtg.jpg&exph=453&expw=700&q=Female+PTSD&simid=608042935198419629&ck=3A3D6F90AEEB4FC06E507892F973222A&selectedIndex=230&ajaxhist=0
Slide 14 – Writing a plan:
https://www.bing.com/images/search?view=detailV2&ccid=PXLv2aXf&id=F581ACACDA8BE8EDCA8EF960E7CFB0421E24F4AC&thid=OIP.PXLv2aXfmLeA11uXe7z6JQHaDt&mediaurl=https%3a%2f%2fs-i.huffpost.com%2fgen%2f1687176%2fimages%2fo-MAN-WRITING-NOTEBOOK-facebook.jpg&exph=1000&expw=2000&q=Man+Writing+in+Journal&simid=607987963933296322&ck=451D44D02C61F1D100F854225EFC2462&selectedIndex=11&ajaxhist=0 and Holding a knife:
https://www.bing.com/images/search?view=detailV2&ccid=zGYTD2pX&id=65F6FC5D069868FBE6A0EAAF6EEB4E0635964BB8&thid=OIP.zGYTD2pXk1tsC0rH0DbanQHaE6&mediaurl=https%3a%2f%2fthumbs.dreamstime.com%2fb%2fdepressed-man-knife-suicidal-thoughts-dark-image-black-background-black-white-82781237.jpg&exph=531&expw=800&q=Dark+Thoughts+of+Suicide&simid=607993775095351631&ck=DC71D05DDE25B8413E77874E8BFD58B2&selectedIndex=194&ajaxhist=0
Slide 16 – Interviewing a patient:
https://www.bing.com/images/search?view=detailV2&ccid=d%2bCKEUmK&id=0FF6349B39CBA739ECD00D9D2D14DE3DE78B27AB&thid=OIP.d-CKEUmKTeF3M_L_2tHYoAHaE7&mediaurl=https%3a%2f%2fmdedge-files-live.s3.us-east-2.amazonaws.com%2ffiles%2fs3fs-public%2fDoctor_listening_to_patient_web.jpg&exph=733&expw=1100&q=Doctor+Listening+to+Old+Patient&simid=608053444925917393&ck=2BD66FBAFFAB852F9644522F56166883&selectedIndex=28&ajaxhist=0
Slide 18 – Doctor Shocked: http://reggierivers.com/wp-content/uploads/2013/05/Doctor-Shocked.jpg