A PSYCHIATRIST WONDERS

HOW TO PREVENT WHAT HE CANNOT PREDICT.

other questions. No, she had never seen a psychiatrist and had no significant medical problems. One sister also had bouts of depression but no one in the family had ever been in a psychiatric hospital or attempted suicide. Despite her symptoms, she'd forced herself to continue working as the office manager of a local real estate company. Before coming to the hospital she'd dropped her children off to stay with her mother for the weekend.

Hilary's was a textbook case of what psychiatrists call Major Depressive Disorder. Besides her mood, she had many of the neurovegetative symptoms, things like loss of energy, appetite, and weight, trouble concentrating, and insomnia. Her prior response to medication was a good sign but she needed a safe place to resume treatment. I told her this and recommended hospitalization.

She agreed. Together, we walked to the waiting room where I left her before returning to the nurse's station to complete the paperwork needed for her admission.

A few minutes later, a nurse approached.

"Dr. Christopher? I just want to let you know Mrs. Asher changed her mind. She wants to leave."

"Why?"

"She found out she can't smoke."

In 1993, the Joint Commission—the not-for-profit group tasked with evaluating and accrediting U.S. health care organizations based on quality and safety standards—prohibited smoking in hospitals. It was a policy most physicians supported, one already enacted at many facilities. Its unintended effect, though, was to make smoking the nemesis of emergency room staff and on-call residents everywhere.

Smokers want to smoke. Regardless of their physical or mental complaints—chest pain, shortness of breath, vomiting blood, or suicidal thoughts—they invariably ask, "Can I smoke if I'm admitted?" I've heard the question from a fifteen-year-old girl with severe asthma and an eighty-year-old man who'd recently undergone surgery for lung cancer. The power of the addiction is unparalleled and nicotine replacement (whether patch, gum, lozenge, or inhaler) rarely suffices.

Physicians respond to this issue in different ways. Some argue if patients want to smoke so badly, then they can't be that concerned about their other problems. Barring a catastrophe, let them smoke. Others have a more paternalistic, "not under my watch" attitude. Patients can accept or refuse a nicotine prescription but they will not be allowed to expose themselves to further harm by smoking.

For psychiatric patients, the issue is more complex. Because so many are at risk of hurting themselves—not by the inevitable diseases of smoking, but more immediately—they cannot be left unattended. If they're going to smoke, hospital staff must bring them somewhere they can be safely observed. In fact, this is what many hospitals do for psychiatric inpatients. But emergency rooms are not designed, manned, or obligated to accommodate this need. Thus staff are left arguing with patients over the issue while others wait to be seen.

I did not want to argue with Hilary. Still, I felt hospitalization was the right option for her, so I went to speak with her again.

A different woman stood before me. Her voice now was edgy, insistent. "Listen," she began, "I had no idea I wouldn't be allowed to smoke. I would never have come here."

I pulled up a chair and invited her to sit down. Then I explained our hospital's smoking policy: after a short period of observation, if she was felt to be safe enough, she could go on scheduled smoke breaks with staff and other patients.

"I smoke two to three packs a day," she said. "I can't wait for a smoke break. How many are there anyway? Six? Eight?"

"There are four."

"Then there's no way I'm staying here!"

I took a slow, deep breath and fell back on a strategy that had proven helpful in situations like this in the past: I summarized her story. If she only heard again how bad things were she would remember that she desperately wanted and needed help.

"I know what you're doing," she interrupted me seconds later, "and I appreciate it. But I just can't stay. I'm better off at home." She smiled politely and moved to the edge of her chair.

I tried again, reminding her she wasn't just here for herself but for her children, too. It was clear, I told her, how much she loved them. "If they were here, they would want you to stay," I said. At this, her frame softened and she looked away for the first time since I'd come back into the room. We sat in

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silence and I ran through all the things I could say to her, looking for whatever might convince her to stay and settling, finally, on the truth.

"I'm really worried about you, Hilary."

She nodded weakly and suddenly began to cry. "Me, too."

I offered her a box of tissues. "Being here really is the right decision," I told her. She cried softly for several minutes and I sat with her, saying nothing. When she finished, she dried her eyes, looked directly at me and said, "I can't stay here, I won't. I want to go home."

What gives psychiatrists the right

to lock people up? The very idea of forcing someone to be hospitalized breaks one of the basic principles of medical ethics: patient autonomy, the simple notion that doctors should respect their patients' wishes.

Suppose, for example, a man goes to see a surgeon after his primary care physician finds a pulsating mass in his abdomen. The surgeon diagnoses a 7-centimeter aortic aneurysm. She knows that if it ruptures, this man has a 50 percent chance of dying, whereas if she repairs the aneurysm now, his risk of death drops to 5 percent or less. So she recommends surgery. The patient thinks it over and says, "You know, doc, I hear everything you're saying. But I've lived a good life and I think I'll take my chances." As long as the man understands his options and the risks of refusing care, he is free to do so. Why shouldn't the same be true for patients with psychiatric problems?

Actually, in many ways, it is. The majority of decisions about mental health are made by patients, not doctors: whether to start a medication, whether to stay on the medication if a side effect develops, whether to have electroconvulsive therapy. Many psychiatric patients even have advanced directives, documents indicating how they want to be cared for if and when they can no longer make decisions for themselves. For sure, doctors play a part in helping patients make these choices—that is, after all, their job. Most often, patients agree with their physicians' recommendations. But plenty of times they don't.

When someone comes in with a problem with the heart, or liver, or spleen, the doctor listens, discusses the options, and prescribes a treatment on which they both agree. But what happens when the affected organ is the brain? What if the ability to appreciate a problem—to think about it clearly—is impaired? When judgment fails, what then?

This is where the controversy starts. Can anyone with a mental illness like depression be involuntarily hospitalized so long as they are shown to have impaired judgment? Historically, the answer has been a qualified yes. For a long time, psychiatrists could involuntarily hospitalize patients for any number of reasons: at the request of a weary family member, because a patient refused to adhere to outpatient treatment, or because the hospital was seen as the ideal place to quickly bring a patient's symptoms under control. The extent to which a psychiatrist exercised this power depended on his or her professional judgment and the case in question.

In the 1960s and early 1970s, judges reigned in these broad powers. Their landmark rulings reflected what many patients and others had long felt: that the stigma associated with involuntary hospitalization outweighed the potential benefit gained by being there. Many psychiatrists, too, welcomed the change, having been uncomfortable with so much authority over their patients' lives. By the end of this reform period, psychiatrists were left with only a handful of reasons to justify such a restriction of their patients' freedom.

Today, mental health codes differ from state to state—for instance, in the number of days one can be held involuntarily before a court hearing (one in West Virginia, twenty or more in Georgia). What unifies them, though, is the theme of danger: to forcibly hospitalize mentally ill patients, a physician must believe they pose a danger to themselves or others, and the risk of this danger must be imminent.

If this sounds more like law enforcement than medicine, it's because psychiatrists (and other professionals who treat the mentally ill) must serve and protect, not just their patients, but society as well. In that sense, we are agents of the law. And some

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resent this part of the job description. How can patients trust us, they argue, if we use what is shared in confidence against them? Indeed, many patients whom I've treated in the hospital have told me how betrayed they felt when their psychiatrist had them hospitalized unwillingly.

But the main reason psychiatrists don't like this responsibility is that predicting someone's risk of danger is tough. There are clear examples, for sure: the man with a gun

who hears voices commanding him to kill his wife, or someone who's swallowed a bottle of sleeping pills. The majority, unfortunately, remain stubbornly unpredictable.

Most psychiatrists go about their work doing little to resist the duties imposed on them by the law. They may concede the limits of our knowledge but, in deciding to hospitalize someone, they believe that patient care remains the primary focus. Of course, our patients may not see it that way.

"Why would you force me to be here?" Hilary asked. "I'm not going to kill myself, I swear. I promise."

"But how do you know that?"

"Look," she said, "I came here voluntarily—"

"—asking for help," I added.

"Right, asking for help. And I know I need help. But this place isn't what I need. I'm telling you, if you make me stay here, it won't help. It will only make things worse."

The more she talked, the more composed and rational she seemed. Where had the sad and desperate woman I'd just listened to gone? Could her feelings have evaporated so quickly? Was she really no longer suicidal?

sity he gave his patients. He nodded a few times when I'd finished, indicating he had all the information he needed.

"So, what do you want to do with her?" he asked.

"Well, I'd like to hospitalize her. But she doesn't want to come in and I guess I'm not sure I can make her," I said.

"Tell me something. If she leaves tonight, how sure are you that she won't kill herself this weekend?"

"Not at all sure."

"Then I think you *have* to hospitalize her." There was no hesitation in his voice, no uncertainty.

Suddenly, I realized why the decision was so easy for him. While I had been worried about depriving her of her civil liberties, he was worried about saving her life.

Put that way, it made perfect sense. How could I let her go when just minutes before she was on the verge of ending it all? And though she seemed to be pulling herself together, who could say how long that would last? Maybe that was nothing more than her craving a cigarette. It had already been several hours since she'd last smoked. Later on, at home, would she find herself right where she'd been before coming to the hospital?

"You'd be even more worried about her if you'd let her leave," she said before returning to sleep.

That evening we met several residents at a restaurant for dinner. Inevitably, our conversation keyed on work and I told them the same story I had shared with my wife. Without exception, they all assured me they'd have done the same thing I had. Whether they were being honest or simply supportive of a fellow resident—and I do think they were telling me the truth—was, I later realized, beside the point. What troubled me was not the prospect that my decision to hospitalize Hilary might not meet their benchmark for patient care. Even if they had all disagreed with me—even if I was the one psychiatrist in a hundred who'd have chosen to hospitalize her—the appropriate time to make that mistake, if you could call it that, was during my residency. Medical training consists of hours and hours spent trying to avoid messing up. The irony is that the most powerful learning occurs in those rare moments when something goes wrong.

No, professional reassurance was not enough. I wanted to know that I'd made the right decision. I needed something to tell me

WHILE I HAD BEEN WORRIED ABOUT DEPRIVING HER OF HER CIVIL LIBERTIES, MY SENIOR RESIDENT HAD BEEN WORRIED ABOUT SAVING HER LIFE.

There's a saying among residents in all fields of medicine: never worry alone. With this in mind, I excused myself from the interview room and found Dr. O'Reilly, the senior resident on call with me that night. I'd worked with O'Reilly before and trusted his judgment.

I pulled him aside and presented my case. As I spoke, he listened with the same inten-

I went back to see Hilary again—for the last time—to inform her of my decision. She did not take it well. She pleaded with me, unsuccessfully, and then she cried for a long time.

The following morning I woke my wife and told her what had happened. Hilary belonged in the hospital. What could possibly satisfy such a request?

There was a time when predicting heart attacks held the same enigmatic aura that surrounds suicides. In the first half of the twentieth century, doctors watched as the number of deaths from heart attacks rose to epidemic proportions. With little knowledge of what caused cardiovascular disease,

they could do little to save the lives it claimed. But over time, researchers identified the factors at play in the development of heart disease: smoking, diabetes, older age, male gender, and high blood pressure and cholesterol. By targeting the ones that can be treated, our country has witnessed a 50 percent reduction in the rate of heart disease-related deaths.

If we're serious about predicting suicide—and thereby preventing it—we need to know as much as possible about what happens in the brains of people who carry it out. So far, we know that low levels of a breakdown product of serotonin—one of the brain's neurotransmitters—are often found in the cerebrospinal fluid of those who die from violent suicides. Also, post-mortem studies indicate suicide victims may have more serotonin receptors in the prefrontal cortex. This area of the brain sits directly above the eyes and, when damaged, often leads to disinhibited behaviors and cognitions. We know, too, that people who inadequately suppress cortisol—a hormone released in response to stress—when stimulated to do so, have a higher risk of completing suicide later in life. However, *most* of the "weak suppressors" do not kill themselves, and many of the normal suppressors do. This is important to understand: that the result of any laboratory test correlates with a higher rate of suicide says nothing about whether it causes suicide. This is why we don't test for serotonin or cortisol levels in our depressed patients. Even if we saw a particularly poor suppression of cortisol in a patient, that would be scant evidence on which to base a clinical decision. While we know these markers have something to do with suicide, what that something is remains elusive. We still need to understand the mechanisms—the pathophysiology—that cause suicides, as we do with heart attacks.

What about variables more easily discernable, such as family history, income, employment, and marital status? In the largest study of its kind, Danish researchers led by Dr. Ping Qin looked at socioeconomic and demographic data for the 21,000 people who completed suicide in Denmark over a seventeen-year period. They matched each individual with twenty control subjects of the same age and gender. Confirming what smaller U.S. studies had shown, the Danish suicide victims were more likely to be single, unemployed, and among the population's lowest income quartile. Having a child was a protective factor—the younger in age, the better.

By a huge margin, though, the strongest risk factor for suicide was a recent psychiatric hospitalization, and the more recently one had been discharged, the greater the risk. On the one hand, this makes sense. People who die from suicide are more likely to have serious psychiatric illnesses, ones often requiring inpatient treatment. But this doesn't explain why these victims were more likely to have died within days of leaving the hospital.

Were these patients discharged prematurely? Did their doctors decide to send them out before their suicidal thoughts and impulses had resolved? I doubt it. A more likely explanation is that the psychiatrists who treated these victims simply weren't able to predict who remained at high risk of suicide.

In general, doctors don't like being asked to make predictions. It's a lot easier to order a few tests or give a diagnosis. But when we have no choice, when we're backed into a corner, we tend to give the most conservative answer. That way, our patients may prepare for the worst but hope for the best. (At times, I've found myself doing the same. In the iffy business of suicide assessment, this has been especially true.) Yet prediction, with its shortcomings, is the bedrock of this work. For sure, my decision to keep Hilary in the hospital was based on a careful scrutiny of her symptoms and her history. But it was also based on my gut: it didn't feel right to let her go. That's not an explanation that any patient would find satisfying. I am not satisfied with it. But what I've learned about the practice of psychiatry is that often whom we keep and whom we let go says more about the doctor than the patient. Each of us develops our own sense of comfort in managing risk, one that continues to change over the span of a career. And, perhaps surprisingly, it's not always the novice doctor who will make a conservative decision. Many times, I've presented patients to attending physicians, and just as I describe my plan to send them home I am told, "No, they should be admitted, willingly or not." Their explanations, when I ask for them, usually don't go through the known risk factors for suicide or invoke any scientific study. Instead, what I hear is "this guy just sounds really sick," or "I don't think we can trust her."

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Remarks like these are at once comforting and disturbing. They mean no one is perfect; even the most experienced doctor may be unsure of what to do. They also offer a sobering appraisal of how little we really know.

One afternoon after seeing patients in the emergency room, I sat in with an attending to review the day's cases. I'd finished presenting a patient and waited as he wrote a note that would eventually accompany mine into the chart. When he finished I asked him how he felt about having kept so many people in the hospital who didn't want to be there—so many of whom probably didn't need to be—over the years he'd been in practice. He set down his pen and rubbed his forehead for a few moments.

"It's an awful dilemma. And it's worse than you think," he said.

I looked at him blankly, unable to think of what could make it worse.

"Yes, we're terrible at figuring out who'd really hurt themselves or someone else. But even if we could, many of the patients we hospitalize will end up doing it anyway. If someone really wants to end it all, eventually they will."

"Then what are we doing for them by keeping them here?" I asked.

He picked up his pen again to begin writing. "We're giving them the chance to reconsider."

The following Monday, I finished my shift and walked to the inpatient floors to check on Hilary. I wondered how she was adjusting to being in the hospital. Had she changed her mind and decided it was the right place to be? Would she say something to alleviate my uncertainty—my guilt—for having hospitalized her?

When I entered the unit most of the patients were on a smoke break. Looking around, I noticed she wasn't among the few who remained inside. I figured she'd been given smoking privileges. I walked into the nurse's station and stopped before the large dry-erase board on which was written the entire twenty-one-bed census for this particular unit. Next to each patient's name were the names of the attending and resident assigned to that case. I didn't see Hilary's name. Had I remembered it wrong? I looked again, giving each name the chance to jog my memory. Still nothing.

"Are you lost, Dr. Christopher?" It was the charge nurse.

"Hi, Donna. I think I might be. Do you know what happened to Mrs. Asher? I admitted her on Friday night. Was she transferred to another unit?"

"Nope. Discharged. She left on Saturday morning."

I blushed. Why would she be discharged on her birthday, the day she'd tried to hang herself a year ago? Unfortunately, there was no one on the unit to ask. The psychiatrist who'd seen her—and let her go—had only covered for the weekend. Besides me, no one else had evaluated her.

I left the unit and went to the one place where I thought I might find an answer: medical records. A receptionist typed Hilary's name into the computer. "Looks like it just came down from the unit," she said, and pulled a chart from the pile next to her and handed it to me. It was thin. Since she'd just left, the usual discharge summary was missing. Even if someone had already dictated it, it would be a week or more before the transcription service finished typing it, then it would be sent to the attending for a signature, and only then placed in her record.

"WE'RE TERRIBLE AT FIGURING OUT WHO'D REALLY HURT THEMSELVES OR SOMEONE ELSE…IF SOMEONE REALLY WANTS TO END IT ALL, EVENTUALLY THEY WILL."

I flipped open the chart and found my evaluation. Reading it over, everything was there: the details of her history, my description of her mental state, my formulation of her case—including a statement about why I felt she needed hospitalization—and a plan for treating her. The next page, a nursing note written when she first arrived to the floor, was perfunctory: "Patient oriented to unit, all questions answered. Slept overnight without incident."

There was only one other note, just a few lines scrawled by the psychiatrist who saw her on Saturday. A couple of sentences summarized her history. Nothing new. Skipping down to the bottom, I read the attending's assessment and plan: "No longer suicidal. Discharge home. Agrees to return if feeling unsafe. Mother to pick her up."

Just below this—as if a postscript—were the words, "Patient thankful for being kept safe on her birthday."

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