ONE

THE ER DOC

Who's Calling the Shots?

The activist psychiatrist R. D. Laing has this to say about the potentially coercive power invested in psychiatrists by society: "We should not blame psychiatrists because we give them such depth of power, especially when, to be exercised as expected, it *must* be exercised *routinely*."[1]

I guess we shouldn't blame psychiatric nurses, either. When I first started working as an attending psychiatrist at PES, I discovered that my most complicated workplace relationships were with many of the experienced nurses who worked there. They were the power players, and my education began even before I had worked a shift.

Throughout this book, it may seem as if psychiatric nurses and emergency psychiatrists are mentioned interchangeably. And that is no coincidence. In the psychiatric emergency setting, nurses and doctors work very closely, side by side, with each other. There is an egalitarian feel to the place. While it is the physician who has the final say and ultimate responsibility from a practical and a medicolegal perspective, it is a foolish emergency psychiatrist who does not collaborate with his or her

knowledgeable and experienced psychiatric nurse colleagues in making clinical decisions.

I had my reasons for choosing to work in psych emergency—some of them logical, others psychological, and many still to be discovered. My first paying gig was low-stress—a doctors' staff meeting convened by PES's medical director. Though he had hired me, the medical director would never be my role model. The son of a diplomat, he carried himself stiffly, a jacket-and-tie kind of guy, the product of boarding schools. He did not manifest the roll-up-your-sleeves style that I imagined an effective emergency psychiatrist should possess.

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My first night at work is an unseasonably warm evening in the summer of 1992. The customary layer of fog has not yet descended on the city. The psych emergency room is stuffy, the ventilation poor, the ceiling's air vents clogged with lint and dust. A faint whiff of fresh feces and old urine, ineffectively masked by a cloying cinnamon-scented spray, hangs about the place. It is then that I understand why state hospital psychiatrists smoke cigarettes on the job—to cut the stench. Though I had worked there for a week as a fourth-year resident just a few months earlier, this is my initial performance as an authority figure in psych emergency. At this point, I haven't worked a shift yet. I had just returned, lean and refreshed, from a month's holiday spent traveling with my wife in a 1984 Volkswagen camper van through the Pacific Northwest and the Rockies. I had enjoyed an invigorating taste of freedom on this trip, and now I was beginning my career on a lockdown. Though I was getting paid for my time and had chosen this

vocational path, I was still working in a place for which a key was required to get out.

Uncharacteristically, I arrive about ten minutes early. Two nurses, a man and a woman, sit behind the triage desk, a crescent-shaped structure about four feet high and twelve feet long facing four seclusion rooms, each with a heavy metal locking door, and each containing a steel bed equipped with four leather belt restraints (these days the belts are made of washable polyester and Velcro), one per extremity. The lights are dimmed.

To the right of the desk is the triage area, accessible by passage through double locked doors. This is where the police and paramedics enter to bring in patients from the streets. To the left is the sprawling dayroom, really a twenty-four-seven room, in which patients sit and sleep on pull-out chairs. Behind the desk, separated by a wall with two doors, is the cramped staff room. Sitting at the desk, the two nurses look like commanders of a starship, which in fact they are, as many of the ward's denizens are in some sort of orbit, psychiatric or otherwise. Christina, the shift's charge nurse, invites me over for a chat and a chocolate-frosted doughnut, which I enthusiastically accept. I sit down and begin eating. "Well, Paul," she says, "what do you think of this *cray-zee* place?"

"I like it here," I say, dropping crumbs on my shirt. "I like the chaos." I already knew Christina from my weeklong rotation. She had worked there since the old days, starting in the late 1970s or early 1980s. It takes me only a few minutes to surmise that she has a knack for getting her way, does not suffer fools gladly, and is not to be trifled with.

"That's good," says the man sitting beside her, the shift's triage nurse, "because I'm sure you'll soon find out that the staff

is near-lee as *cray-zee* as the patients." Bo, short for Beauregard, son of the South, giggles and sniffs twice before grooming his salt-and-pepper beard and adjusting his glasses in what seems like a single motion. "But I'm sure *you* can handle it."

"Oh, yeah," I say.

Just then the medical director walks by. I'm not sure if it's my imagination, but I think the director, normally flat and imperturbable, rolls his eyes and exhales ever so slightly when he sees me sitting next to the two nurses behind the desk. "Paul, the meeting starts in three minutes, so please join us," he says.

"Sure," I say, continuing to sit there. Once he is out of range, Christina turns to me and asks softly, "What do you think of *that* one?"

"Well, uh," I say, pausing, trying to think of something tactful.

"He's clueless," she says, not missing a beat. "A deforester. He's only good at creating new paperwork. He doesn't know a thing about what really goes on around here."

"Oh, *that* one," Bo says in a high-pitched Southern accent. "What a waste of training. If he'd just leave us alone, we'd be okay."

"Yeah, our last medical director was great," adds Christina. "He really knew his stuff. The patients loved him. But, Paul," she says, leaning closer, her voice dropping to a whisper, "*they* killed him off because he always took our side."

"Who are *they?*" I ask.

"*They* . . . are the administration," she says conspiratorially. "Especially the nursing leadership. *They* need to be in charge. Even though they don't know shit about what we do or what goes on down here." I had arrived during an era in which employee-management relationships in health care seemed

particularly precarious. The animosity ran both ways and contributed to the rising level of tension already inherent in a place like psych emergency.

"Well," says Bo, "our last medical director also left us because his wife was expecting and he could double his salary in Wisconsin. But they did kill him off."

I nod. "I see."

Suddenly, a rather large, unkempt man, a scowl on his face, stumbles out of one of the four seclusion rooms and ambles to the desk.

"What do you want, George?" asks Christina.

"I need to take a piss."

"Get back in that room, or we'll have to tie your ass up and give you a shot."

"But I need to go real bad."

"Get back in there. I'll bring you a urinal."

"I want to pee in a fuckin' toilet, not a fuckin' bottle."

"Get back in there, George. Now."

"Fuck you, you slanty-eyed bitch," he says as he comes half-lurching, half-lunging toward the desk.

"Staff!" yell the nurses.

"For that," Bo says, "he's going into points." The shorthand *points* is emergency room slang for the four points at which a patient's extremities are attached via restraints to a bed bolted to the floor of a seclusion room. I'm not sure, when Bo says "that," whether he's referring to the menacing stance or the racially charged barb or the whole package.

Since I am not officially on duty and am new to the place and generally inexperienced, I step back. Three staff members rush to the scene and grab George by the hands and around the waist

and escort him roughly to his seclusion room, where he lies down on the bed without a struggle. "Do we need to call IP?" asks one. At the time, the hospital was staffed by bona fide San Francisco institutional police officers, whose station was next door. We called them often.

"Nah," said Christina as she deftly encircles one of George's wrists with the belt loop of a leather restraint. All four of George's extremities are now strapped by restraints. Seemingly accustomed to this routine, George lies passively, his body supine on a clean white sheet.

"George, why did you have to go and do this?" asks a psych tech. "You're gonna get a shot now, too."

"Yeah, but I'm allergic to Haldol."

"Sure, George, sure."

A nameless, faceless doctor wrote the order for restraints and Haldol. Or maybe he just signed an order that the nurse had written herself on an order sheet. That was standard operating procedure in those days. Sitting in the staff room would be some MD who was happy to sign whatever order was placed in front of him. Technically the restraints could not be applied, and an injection could not be given, without a doctor's order. But who was really calling the shots?

This process was bluntly dubbed "shoot first and ask questions later" or simply "tie 'em up and shoot 'em up." It was also called "let 'em prove to us that they're okay to come out of restraints." The burden of proof lay with the patient. It might seem like a pathological need on the part of both nurse and doctor to control things, but the process of restraining and medicating a psychotic patient becomes a necessary and therapeutic step in the patient's treatment. Giving truly ill patients sedatives and antipsychotic

medications allows them a chance to regain a piece of sanity—to tamp down anxiety, hallucinations, and paranoia.

George receives a large injection, the solubilized medications mixed into a single syringe and delivered via an eighteen-gauge needle into the upper outer quadrant of his left buttock, where the thick muscle can soak up all those good tranquilizers and get them on their way to his brain. Venous capillaries absorb the drug, the blood then transports it via circulatory branches to the inferior vena cava, upward to the right atrium of the heart, down to the right ventricle, then to the lungs to pick up oxygen, back to the left atrium, and then down to the left ventricle, which ejects the blood carrying the drug into the ascending aorta and carotids into the brain.

George's brain, with its dopamine, histamine, benzodiazepine, and GABA (gamma-aminobutryric acid) receptors receiving the signals, decelerates to a resting pace. Not down for the count, mind you, but it descends to a mild snooze. The blockade of the dopamine receptors in the limbic system begins to dissolve the man's psychotic symptoms. Biologically, it's complex. Phenomenologically, it's a cakewalk: man goes to sleep crazy; man wakes up calmer, if not saner.

As I was soon to discover, the medication process was perpetuated because Christina and a few of her peers had become pretty talented mental health clinicians by dint of their experience. And, of course, she was someone to be, if not feared, then at least approached with some caution. By then, several of my physician colleagues were streaming past me toward the meeting room. "Thanks for the doughnut," I say. "You know, Bo, this place reminds me of a bitter and twisted summer camp, and we're like the counselors."

"Oh, yes, honey, you are *so* right," he says.

"Or maybe something like a twenty-four-seven casino, and we're just like the blackjack dealers or the floorwalkers."

"It *is* kind of like that," says Bo. "And much, much more. You just wait and see, girl."

When I leave the meeting an hour and a half later, I see George the patient careening around in front of the triage desk, none the worse for wear. He has slept off his injection, and I'm sure a psych tech helped him pee into a urinal while he was in restraints. (They wouldn't let him piss himself in points. They weren't *that* mean.) And, frankly, it seems that George has woken up from the shot much less irritable and at least a bit less crazy. It did him no harm.

But does the end justify the means?

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Just a few weeks later, I find myself in a minor power struggle with Christina over medicating a patient. For ten minutes, a young woman in a locked seclusion room, supposedly manic but maybe also high on something, yells nonstop, her volume escalating, and now and again screams at the top of her lungs: "Fuck you, you motherfuckers, why the fuck did you lock me up in here? I want a lawyer, I want to use the phone, I want a shower, you guys had no right to lock me up in this fucking room!"

Her caterwauling grabs the attention of Christina, the shift's charge nurse. "Paul, can't you do something about her yelling?" she asks me.

"Well, she is behind a locked door, and she's not going to be able to hurt anyone." I know that the legal standard for emergent

involuntary medication circa 1992 (and today, in fact) is that of imminent danger.

The patient howls in a pitch reminiscent of an injured dog or a coyote. The content is similarly disturbing: "What are you guys? You are sadistic motherfuckers. Let me the fuck out of here right now. I mean it. I'm going to sue all of you motherfuckers when I get out of here!"

"Lovely, isn't it?" Christina says to me tartly.

"Do you think she eats with that mouth?" I say. "But she is exercising her freedom of speech."

The woman's soliloquy is now punctuated by bloodcurdling screams, the type that hearkens back to the days of true bedlam—the era of wet blanket wraps, straitjackets, and hydrotherapy—before psychotropic medications arrived at the state asylums. You can almost see Frances Farmer if you close your eyes.

"Paul, it's time to give her a shot," Christina says.

"Now I know why I had to get a hearing test before I started this job," I joke. I'm stalling a bit. I don't like the screaming, but I don't really want to medicate the patient. It's not as if she's going to break the door down and come out and club us to death.

"But Paul, we shouldn't have to listen to this kind of abuse."

"I can tune it out," I say, "if I try to."

"Well, I can't," she says. "You can't be serious. Can't you see her jacking up the other patients?"

I look around me and, no, I really can't see that, but I do want to listen to what she has to say, since she's worked in psychiatry at this hospital for more than ten years. I can see how all the yelling might have an agitating effect on the other patients, but all in all, the clinic is reasonably under control right now. In fact, no one is in points, and only one other patient is in seclusion.

"We should put her ass down," says Christina. "She's been refusing meds."

"Hey, I'd rather not give her a shot," I say. "She isn't hurting anyone. Yes, it is annoying, but she can't scream forever. She's just sitting on her bed; she hasn't even pounded on the door."

"But Paul, she's also as psychotic as the day is long. She's not going to get better with tincture of time."

Sooner rather than later, the young woman gets up off the bed and starts banging on the door, progressively louder and louder. Even I can now see that she might at least hurt herself with this thumping. "Okay, okay," I say. "Let's do it. Call IP, and we'll give her the old-fashioned—droperidol five, Benadryl fifty. I'll write the order."

Things go smoothly as we get the hospital police to help us put her in restraints and give her the injection. After we leave the room, taking off our rubber gloves, the med nurse safely disposing of the needle, the patient's screeching continues unabated for another four minutes. Then, finally, silence descends on the room. I look through the little judas window and see the woman sleeping peacefully on her back. The snarl and grimaces have melted away after the delivery of the sedatives. Within ten minutes, since she is deeply asleep, we untie her four-point restraints. We leave her door unlocked. She crashes for another two hours and then is able to come out, take a shower, eat dinner, and use the phone. Though still a bit cranky and suspicious, the woman is able to cooperate with staff and navigate the complex peer relationships of the dayroom.

Later, in the staff room, the nurse comes up to me and says, "See, Paul, see how much better she's doing?"

"Yeah," I say, tentatively, "you're right." It's weird. I feel bad that I had to order the shot at all, *and* I feel bad that I didn't give it sooner.

"Of course I'm right," she says, only half joking. "All those goddamn laws and rights don't take into account that we have sick people here who need treatment. We can't just let 'em scream for days, you know."

There it is again, that us-versus-them theme. I wonder if I will ever put things so bluntly myself. I still have a lot to learn, but at least I'm one of *us* now and not one of *them*.

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Why did I choose to work in psych emergency? Much of it had to do with a gut feeling that my style of thinking and relating on an interpersonal level with both patients and staff were tailor-made for the place. I wasn't obsessive enough to be a psychoanalyst or a researcher. I was a little too glib, a little too forthright, and far too much of a nonconformist, rebellious toward authority figures, to submit to the prevailing doctrines of either of American psychiatry's dominant paradigms: one rapidly rising, the biomedical explosion; the other gradually declining, Freudian psychoanalysis.

I wanted action. I wanted to see things evolving. I couldn't wait for several years of psychoanalysis to pass to see if my patient got significantly better. I couldn't wait for several years while slaving away at a research project just to see my name on a few articles and scrambling to ascend the academic staircase.

I wanted results, if not in the next five to ten minutes, at least in the next several hours. I wanted to say the calming words, right here, right now, and choose the ideal medication to soothe an agitated and psychotic patient, preventing him from winding

up in points or slugging somebody, getting him started, I would hope, on the road to recovery. I wanted to wade into the messy domain of clinical psychiatry, which is all the more shattered and tattered in psych emergency. The place forces one to make a decision; not much dithering or second-guessing or ruminating can be tolerated. It forces one to rely on gut instincts and common sense.

The players on the scorecard, both staff and patient, change from day to day. They are part of an ever-changing but tightly bound social fabric that exists in the evanescent here-today-gone-tomorrow, outta-sight-outta-mind atmosphere that very nearly defines the place. That hectic turnover appealed to me from day one. The work appeals to folks whose temperaments combine an odd mixture of low-grade attention-deficit disorder with a high tolerance, but a distinct need, for maximal stimulation. We are a subset of adrenaline junkies, a term often applied to ER doctors and nurses, paramedics, firefighters, and smokejumpers. Maybe we are the couch potatoes among adrenaline junkies.

My mentor, Dr. Bob Buckley, describes himself this way: "The sorry truth is that I'm pretty much other-oriented in terms of my motivation. Left to my own devices, I'll sit by myself and read books, not doing too much of any goddamn thing. But in the emergency room, I've always got something or someone up in my face. It means I get efficient and I get things done. I like that feeling."

I also liked the nearly impossible challenges, which gave me a chance to feel like I was working against all odds, with a chance to figuratively pull a rabbit out of a hat. I could put in my best effort and let the chips fall where they might. This was an antidote to my own perfectionism. Emergency psychiatry is messy.

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"Dr. Linde, are you sure this patient is medically cleared?" asks the evening charge nurse. She has worked here a long time and is known to be cautious and conservative when it comes to medical issues. She is also known to be a bit on the nagging and controlling side as well. I've been told by my colleagues that, as a rookie attending psychiatrist, I will be tested by all the nurses, a process that could take at least six months.

"Yes," I say definitively. "I spoke with the ER attending, and it's all pretty straightforward. Dehydration, low potassium, both corrected."

"But the patient looks awful."

"Yes," I say. "He does. He's lost nearly twenty pounds, and he's in the midst of a probable psychotic depression, almost catatonic."

"Well, is he able to keep himself hydrated?" she asks.

A reasonable enough question. "I hope so," I say. "He was drinking juice in the ER."

"Are we sure that his failure to thrive is not due to an underlying medical illness, like cancer? I mean, a twenty-pound weight loss in a man in his fifties could be cancer. He looks terrible."

Jeez, anyone could have cancer and have it go undetected, I think. I find the question a little unfair and off the mark. I'm getting moderately impatient but decide to continue to allay her concerns. Kill her with kindness. "Well, his vital signs are okay. He's acutely stable. No one can say for sure whether or not he has an occult cancer brewing, but that can get sorted out when he's an outpatient or when he gets admitted."

"If it were my father or my uncle, then I'd really want him to at least get a chest x-ray."

I burst, just a little. "Listen, he's not in the midst of a medical emergency. It seems like you don't trust my medical judgment."

"Oh, doctor, no, of course I do," she says, half convincingly. "It's just those ER docs, they sometimes disregard our patients."

That's true, I think, but still she seems overly cautious. If I thought she was questioning me purely out of concern for the patient, then that would be one thing. But I feel she's pushing me to find out what my threshold for medical wellness in psych emergency is (reasonable enough), and just how much BS I can take, and how and if I will set limits (unreasonable, but human nature being what it is . . .).

"You know," I say, "I'll be here until 11 P.M. If he goes south, we can just ship him back."

"I hope so," she says. "You know how the ER can be about our patients, always dumping on us."

Yes, in my early days in PES, the relationship between psych emergency and the medical emergency department was acrimonious, to say the least. And the mistrust ran high. I sigh. "Yes, I know." I'm familiar with this anxious, catastrophist mind-set.

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The nurses who gave me my informal orientation were trained, and had practiced for years, in an environment in which clinical decisions were made on the basis of a patient's need for treatment, at a time when state-of-the-art treatment was a combination of physical and chemical restraints for extremely disturbed patients. The nurses no doubt found that the new policies, regulations, and laws put a major dent in their ability to treat

patients. They were accustomed to being in charge. They were not accustomed to deferring to a patient's wishes. "How can *that* one provide informed consent, Paul? *He's so crazy,*" Christina might say. And she'd be right.

The practice of acute care psychiatry at this time was not far removed from that of the era of rapid tranquilization, when the theory was that a veritable boatload of injected antipsychotic medication could somehow ablate symptoms of psychosis. "Titrate to stiff and drooling" was the motto. After you're injected with one hundred milligrams of Haldol, usually delivered into the gluteus but occasionally the thigh or the shoulder, yes, pretty much everything (in particular your consciousness) is obliterated.

Oh, how some of the more experienced nurses waxed rhapsodically about the good old days of rapid tranquilizing. The old antipsychotics, like Haldol, Prolixin, and Thorazine, were also called neuroleptics, medications that caused neurolepsy, a term that roughly means shutting your entire nervous system down—a sort of short-term but reversible mental and emotional paralysis also referred to as a chemical straitjacket or chemical restraint.

When I was an intern working in SFGH's inpatient psychiatric ward in 1989, just three years earlier, I could order an intramuscular backup, a shot, if a patient refused his oral dose of antipsychotic medications. This clinical approach was considered legal simply because the patient had been detained on an involuntary psychiatric hold. In other words, the patient did not retain the right to refuse psychiatric medications. The legal and ethical principles involved were presumed to rest on the reality that the patient was in need of treatment. The patient was

deemed to be suffering from a treatable medical or psychiatric condition, and the system trusted the physician's judgment in deciding what treatment was most appropriate.

The notion, often referred to as paternalism in an ethical construct, is based on the concept of *parens patriae,* which was the standard for civil commitment until the late 1960s. This principle says that the state takes responsibility for people unable to care for themselves and identifies and treats patients on the basis of medical necessity or a need for treatment. Trusting the state was perhaps not as difficult then as it is now. *Parens patriae* presumed that the physician would act with beneficence and nonmaleficence even though this potentially interfered with a patient's autonomy.

According to the most authoritative textbook on American psychiatry, a patient's right to treatment was made paramount in the 1966 case *Rouse v. Cameron.* At the time, Judge David Bazelon noted that "the purpose of involuntary hospitalization is treatment and concluded that the absence of treatment draws into question the constitutionality of the confinement. Treatment in exchange for liberty is the logic of the ruling."[2] But by 1992, when I became an attending psychiatrist, I could give a patient involuntary medications only if I believed he posed an imminent danger to himself or others or if a court of law, presided over by a judge with no mental health training, had ruled that the patient was incompetent and did not retain the right to refuse treatment, which essentially referred to medications.

Case law stemming from a mid-1980s decision, *Riese v. St. Mary's,* in which a hospital was held liable for a patient's adverse reaction to medications received involuntarily, now directs hearing officers of the local mental health court to decide whether a

patient is competent to refuse psychiatric medications. These are referred to as Riese hearings. To the hearing officer, the severity of the psychiatric illness is essentially irrelevant. What matters is whether the patient can state somewhat coherently what he or she doesn't like about the treatment's potential side effects or toxicity. If the patient can do so, or be coached to do so by his or her public defender, then the hearing officer frequently finds that the patient is sufficiently competent to refuse treatment.

Ultimately, it is a physician's mandate to alleviate suffering and provide treatment. What I know, and knew even back then, is that prompt, aggressive psychopharmacologic treatment at the beginning of a psychotic episode often puts an individual on track to get much, much better over the course of days to weeks.

When a nurse advocates giving a patient a shot, he or she knows that it might be the beginning of a longer course of treatment that may not only reduce immediate psychotic symptoms but also literally give the patient his or her life back. That's huge. Though it's often difficult to anticipate just how much better a patient will get with treatment, the improvement can be dramatic. And the psychiatric nurses with whom I worked were much, much closer, sometimes fifteen years closer, than I was to the days when patients' treatments were based on the idea that the patients were sick with a remediable illness. How could one blame a nurse for wanting to treat the sick?