



**DR. RICHARD C. CHRISTENSEN  
MEMORIAL ETHICS  
CURRICULUM**

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## OPENING LETTER

We could fill several pages with Dr. Richard C. Christensen's awards and accolades. Dr. Christensen, beloved professor at the University of Florida Department of Psychiatry and founder of the street outreach program at Sulzbacher Center in Jacksonville, had an undeniable positive impact on the people he encountered – patients, colleagues, students and others. His prolific publications imparted his wisdom to a wider audience and testified to his dedication to the underserved, especially the homeless. Dr. Christensen's positive impact did not end when his life was cut short in November 2015. The PEARLS book, this ethics curriculum and the memorial website use his articles to further his legacy.

The PEARLS book consists of concise teaching advices coined and published by Dr. C, supplemented by interviews with former clients, colleagues and friends who miss him dearly. This ethics curriculum consists of articles, filmed clinical vignettes, handouts, PowerPoint slides and more, melding Dr. Christensen's writings with material created for the curriculum by the Editorial Board team. The memorial website will continue to grow throughout the years, acting as a forum for education and action, an active pursuit of the "covenant of care" that characterized Dr. C's medical practice.

Several individuals involved with the Christensen Memorial Project never met Dr. C, but were inspired to dedicate themselves because his cause resonated with them. Dr. Christensen believed in empathic listening and the recognition of his patients as human beings, first and foremost. One can't help but recall his famous aphorism: "I see you. I hear you. You are not invisible."

No matter who you are, you can take up the mantle of serving the underserved and spreading knowledge. If you, like Dr. Christensen, believe that "the practice of medicine is a moral endeavor that is grounded in a covenant of care," then his legacy continues with you.

Caroline Nickerson  
Christensen Project Editorial Assistant

# SLANG 'ON BOARD'. A MORAL ANALYSIS OF MEDICAL JARGON

McCrary, S. and R.C. Christensen, Slang 'on board'. A moral analysis of medical jargon. Archives of family medicine, 1993. 2(1): p. 101-5.

Medical jargon is commonly used by health-care professionals. The use of such jargon is sometimes criticized as insensitive or callous. Rather than generalize, we identify four basic types of medical jargon and discuss their relevant moral distinctions. Our characterizations of jargon include medical acronyms, euphemisms, and initiatory and derogatory language. Physicians should be aware of the ways in which they use medical slang. Jargon can serve useful purposes but its moral status is often dependent on the function it serves and the context in which it is used. Jargon that is clearly derogatory can reflect negatively on the moral character of the medical profession and should be avoided when possible. (Arch Fam Med. 1993;2:101-105)

In medicine, as in all professions, the use of specialized language abounds. A significant body of literature exists that discusses the novel uses of language in medical settings, yet little has been written that directly addresses the moral implications of

medical jargon. Despite the pervasiveness of jargon in medical settings, controversy persists regarding the propriety of using slang in the context of human suffering. Some have argued that jargon is “deliberately obscure speech,”<sup>3</sup> and there are possible connotations of insensitivity if the slang is derogatory in nature. It could even be suggested that use of jargon in the medical milieu is inappropriate because it diminishes the humanity of patients at times when they are most vulnerable. Rather than uncritically adopt this generalization, we prefer to categorize medical jargon into various types and, by examining particular cases, attempt to discern morally relevant differences between these types based on the functions they serve and the contexts in which they occur. We identified four basic types of neologisms prevalent in modern medical practice, and will examine the salient characteristics and moral appropriateness of each. Examples of each of the identified types are shown in the **Table**.

Moral Categories of Medical Jargon	
Category (Nonexclusive)	Examples*
Technical Jargon	NPO; CABG; PO2; coded; extubated
Euphenisms	Expired; passed; going out
Initiatory Jargon	On board; crashed and burned; hit; house; shrink; flea
Derogatory Jargon	Positive Q sign; crispy critters; circling the drain; pb3; GOMER

\*NPO indicates nothing by mouth; CABG, coronary artery bypass graft; PO2, partial pressure of oxygen; pb3, pine box by bedside; and GOMER, get out of my emergency room.

## TYPES OF MEDICAL JARGON

The first type of medical jargon that we identified includes acronyms, words, and phrases representing biological conditions, clinical procedures, directions for treatment of a patient, laboratory results, and drug names. These are omnipresent in contemporary medical practice. Examples of this sort of jargon should be familiar to all readers and include: “CABG” (coronary artery bypass graft); “BUN” (blood urea nitrogen); “NPO” (nothing by mouth); “AMA” (against medical advice); “Po2” (partial pressure of oxygen); “PCN” (penicillin); and “ALS” (amyotrophic lateral sclerosis). In addition, intravenous pharmacologic agents are “pushed,” and patients are said to be “lined up” (having multiple intravenous lines, usually including a Swan- Ganz catheter); “bagged” (ventilation of the lungs by hand);<sup>10</sup> “coded” (in cardiac arrest); and “extubated” (removal of an intratracheal tube). The proliferation of this type of jargon has spurred one enterprising pharmacy professor to publish a book consisting of nothing but medical abbreviations and their meanings.<sup>14</sup> In its current edition, this book purports to contain 7000 abbreviations with 11000 possible meanings.<sup>14</sup>

Given the vast information required by modern clinical practice, such acronyms are useful in delivering information efficiently when time is scarce. The time saved by the use of

abbreviations for elaborate procedures might, in some cases, save a patient’s life. More routinely, jargon of this type communicates considerable information efficiently without lengthy explanations during physicians’ rounds and nurses’ shifts. It can be argued that this type of technical jargon is morally neutral when its focus is purely descriptive, and generally lacks negative social or psychological connotations.

However, such jargon can often be more complicated than the terms it is designed to replace. If patients are “alimeted” rather than fed, “ambulate” rather than walk, and have “upper and lower extremities,” instead of arms and legs, the purpose of jargon as a time-saving device may seem less clear.<sup>13</sup> Such jargon can be morally inappropriate in specific contexts if its function is to obscure the truth from those who have a right to be adequately informed (eg, “We will need to do an LP on your child due to her elevated WBC and questionable CT results.”). Thus it seems prudent to maintain a critical awareness of the ways in which such terms rule the lives of health professionals.

The second general type of jargon is the euphemism, which is defined as a word or phrase that is less expressive, but considered less distasteful, than another.<sup>15</sup> The use of “passed,” “going out,” and “expired” as synonyms for death—along with “ETD” (“estimated time until [or of] death”)—is quite common.

Since many physicians may consider the death of a patient to be a personal failure, euphemisms serve to deflect some of the emotional impact of such events. The literature on human responses to death is vast and beyond the scope of this article. However, the personal discomfort of health-care providers should not be minimized. Even though euphemisms regarding death are common in the general culture, it is possible that physicians use them more often due to their intense personal responsibility for the care of others and continual exposure to human suffering.

Use of terms such as “peed,” and “pooped,” for excretory functions is often encountered. Health-care providers are forced, by virtue of their professional roles, to witness private human functions, including sexual and excretory matters. Euphemisms may serve to reduce or enable the caregiver and patient to ignore potential embarrassment that would arise from similar experiences in other contexts. Thus, euphemisms appear not to be morally objectionable when used to defuse the natural tensions that arise in medical settings for patient and caregiver alike.

The third type of jargon that we identified includes initiatory terms and phrases—that is, language conveying a sense of affinity to the professional group. We acquired an extensive list of such terms, the highlights of which include the following: heparin (or other drugs) “onboard” or “loaded”; the patient “crashed and burned” (as in cases of septic shock); the patient was “found down” (discovered on the floor at home or other nonmedical environment); “turf (to transfer an unpleasant patient to another ward or unit); “train wreck” (in “SICU” [surgical intensive care unit]—a patient with massive trauma, or “MICU” [medical intensive care unit]—a patient with multisystem organ failure); “bone zone” (a bone marrow transplant unit); “Hotel California” (when patients check into, but not out of, an MICU or SICU); “hit” (a new admission); “getting hurt” (the result of multiple hits); “FLK” (“funny-looking kid”—a pediatric patient with a characteristic appearance, but an unidentified disorder); “OTD” (“out the door”—a patient soon to leave the floor or unit); “shrink” (a psychiatrist); “flea” (an internist—as fleas are the last to leave a dead dog, so too are internists the last to leave a dead or dying patient); and “house” (hospital). Jargon of this sort has also crept into usage in published articles.<sup>16</sup>

In addition to verbal jargon, visual symbols are employed to convey both positive and negative connotations. A favorite technique appears to be to describe patients, characteristics using symbolic images on the blackboards of critical care units that list the names of house staff and patients. One example of this practice was seen in the drawing of a rocket ready on a launch pad beside the name of a patient who was expected to leave a unit soon. These uses of language and visual imagery have the dual purpose of conveying a sense of belonging to the group of medical professionals and excluding strangers and observers from professional or other information deemed inappropriate for outside knowledge.

The moral status of initiatory terms, although somewhat vague, is probably neutral in many cases unless, as in the case of acronyms, they are used to obfuscate the truth from persons having moral claims on such knowledge, such as families of patients seeking prognostic information. Physicians should be aware of

the level of sophistication of patients and their families in regard to the type of language used to communicate necessary medical information. Unless clinicians remain aware of tendencies to use jargon indiscriminately, they may confuse lay persons to whom proper disclosure is owed. Moreover, in the daily fray of discussions with family members, clinicians may inadvertently use initiatory terms that may be interpreted by patients or family members as derogatory or demeaning. Such scenarios should be avoided by physicians through careful attention to the context and function of the initiatory term. To reiterate, the moral status of particular terms will depend on these conditions and, as we will discuss later, their overall effect on the character of the medical milieu.

One subset of initiatory terms may carry greater negative moral implications than those mentioned above. This subset includes judgmental phrases and statements with a conclusory tone and negative implications. Examples of this type of jargon include: “the patient was noncompliant with the prescribed treatment regimen” and “the patient denies drug or alcohol use.” Such conclusory phrases seem to convey a sense that the patient has somehow “failed” in the medical encounter, and that the clinician is recording this shortcoming. Such phrases could be construed to mean that any miscommunication between doctors and patients is necessarily the fault of the patient, or that patients are assumed to be untrustworthy until proven honest. Both of these assumptions seem morally suspect. Even if the individual physician does not intend to act improperly, such assumptions, if allowed to remain a part of the medical community, may have a negative impact on the overall view of doctor-patient relations. The moral implication of these assumptions could be that the profession inadvertently “judges” patients prematurely or by inappropriate standards. Thus, some initiatory language may have negative moral implications.

The fourth and final type of jargon we will discuss includes terms with common derogatory connotations. Examples of this type include the following: “GOMER” (get out of my emergency room); “found under a rock” (a homeless patient found down); “positive Q sign” (a dying patient whose tongue is hanging out); “dump” (to transfer an unpleasant patient to another ward or unit); “GMCU” (GOMER medical care unit); “GOTW” (GOMER of the week); “veggie,” “gork,” and “carrot” (patients in a persistent vegetative state; also “watering my vegetable patch”); “veterinary medicine” (treating gorks, carrots, veggies, or retarded persons); “crispy critters” (burned patients); “circling the drain” (a patient who is expected to die soon); “troll” (a difficult or unpleasant patient, commonly a drug addict or alcoholic); “land whale” (morbidly obese patients); “crock” and “turkey” (patients with multiple complaints, none of which can be physiologically explained); “rock” (an immobile, long-term patient);





and “pb<sup>3</sup>” (“pine box by bedside”—an imminently dying patient). The use of these and similar terms can be viewed as being morally inappropriate because they fail to reflect beneficent attitudes toward patients, and ostensibly demonstrate

a lack of compassion for human suffering. Despite their sometimes

helpful psychological attributes for medical staff, these terms indicate a lack of respect for humans as moral agents, and demonstrate a failure to appreciate the altruistic goals of medicine as a profession. Even the most humane caregivers occasionally are stretched beyond their limits by the demands of medical care, and the use of these terms may offer psychological solace of contemporary medical practice. Such occasional use of jargon may provide an essential coping mechanism for health professionals burdened by the incessant pressures. Even so, health professionals should be aware of the implications of discovery of such use by outsiders. This alone should serve to limit the use of derogatory jargon.

However, there is another compelling reason for avoiding such terms—their effect on the medical environment. Frequent use of derogatory jargon by individuals may have a subtle and indirect, yet pervasive, effect on the attitudes and practices of persons who provide care for patients. As recognized by May<sup>17</sup> and Coulehan,<sup>18</sup> being a “good” physician may have as much to do with who the person is, as with what the person does. Under such an analysis, the character of practitioners is an important part of caring for patients as a moral enterprise. Inappropriate use of medical slang could thus be viewed as having a corrosive effect on the character of the healthcare team as a whole. In such circumstances, use of inappropriate jargon could be said to have a morally diminishing effect on the practice and attitudes of physicians even if no direct harm occurs in a particular case.

## THE IMPORTANCE OF CONTEXT

Regardless of their moral status, terms and phrases from any of these categories can be morally improper when used inappropriately. For example, although initiatory phrases serve the important function of professional socialization, it would clearly be wrong for a physician to use phrases like “train wreck” or “crashed and burned” to describe a patient’s course to family members.

In some rare cases it might not be immoral for clinicians with extreme stress to apply derogatory slang to particularly vexing patients, when absolute privacy is assured. The pathos of clinical medicine can sometimes suspend traditional bounds of moral behavior, and it is reasonable to assume that many physicians who occasionally use derogatory jargon under great stress are otherwise excellent and caring doctors. Here, the operative words are “occasionally” and “great stress.” One physician has remarked that the “teacher who thinks that a resident who refers to a patient as an ‘alkie’ or ‘troll’ is practicing bad medicine is guilty of dreadful naivete.”<sup>11</sup> We do not suggest that it is necessary to avoid all disparaging jargon for clinicians to practice excellent medicine. Nor can it be assumed that the use of derogatory jargon in some

circumstances has no significant psychological benefit to the physician. However, any psychological benefit obtained by clinicians may be at the price of compromising the aggregate character of the medical enterprise. Therefore, psychological benefit does not morally justify the use of derogatory jargon. This situation should prompt observers to scrutinize the social, psychological, and physical conditions that have produced so much stress and discomfort among physicians. It does not bode well that the system of medical education and training is so structured that a major coping mechanism is the verbal disparagement of those persons for whom the physician professes to be caring. Although the causes and cures of physician stress are beyond the scope of this article, it is nonetheless important to consider the role of these issues in the problem of misuse of jargon.

The persistent use of derogatory remarks about patients without regard for their effect on observers may reflect negatively on both the character of individual physicians and on medicine as a whole. This is particularly apparent in hospital teaching settings where physicians (as attending clinicians in the wards, intensive care units, or primary-care ambulatory settings) are viewed not only as teachers of clinical skills but also as role models for physicians in training. Presumably physicians who train medical students and residents are also obliged to consistently exhibit the strength in character necessary for the humane practice of medicine as a moral vocation. If, as suggested by May,<sup>17</sup> professional virtues are “caught” as much as they are taught, it may be difficult to morally justify the frequent use of derogatory language by a physician who occupies the dual role of clinician and teacher. This discussion should make it clear that when assessing the moral status of jargon, its function and its individual and collective context are often more important than its content. Further, much jargon can clearly serve several of the identified functions and roles simultaneously.

Research has indicated that slang terms and phrases often mean different things to different persons even when they describe technical matters.<sup>8</sup> This can cause confusion in clinical settings and may have a negative impact on patient care, for example, in the use of emergency paging euphemisms. The term “code blue” could be interpreted to mean any one or more of the following clinical scenarios: hypoventilatory respiratory arrest followed by ventricular fibrillation; sudden-onset electrical-mechanical dissociation followed by agonal respiratory efforts; or upper-airway obstruction followed by asystole.<sup>8</sup> Important clinical distinctions could be lost, and valuable time spent interpreting jargon. Also, the use of jargon within earshot of a patient may induce fear, irrespective of whether the jargon is accurately comprehended by him or her.<sup>9</sup> Such jargon-induced fear, which can usually be avoided, may exacerbate the vulnerability of patients.

One possible objection to our characterizations of terms is that we have misplaced some of them into our self-defined categories. How is it that in this system, “crashed and burned” is classified as initiatory while “positive Q sign” is derogatory? Admittedly, this system of classification is not as precise as, for example, reading laboratory reports. However, we have attempted to discern subtle qualitative differences among terms to interpret how the patient might feel about them if he or she discovered their use. In general, the initiatory terms avoid singling out particularly unpleasant characteristics of patients or preying on physiologic manifestations that are not in the patient’s control. Thus, since “positive Q sign” focuses on the protruding tongue of the dying patient, it is viewed as a disparaging term.



Medical jargon from any of the four categories should be assessed from a perspective informed by a consideration of the functions served by the term, the context in which it is used, and its impact on the character of the medical profession. We prefer a case-based approach to analysis of the

moral aspects of medical jargon,

one that takes into account all the circumstances relevant to the use of particular terms. If health professionals pause before making derogatory remarks and consider the full implications of the terms they are about to use, perhaps less objectionable alternatives can be found while preserving their psychological benefit.

It is apparent that a moral analysis of medical jargon requires an understanding of the ways in which circumstances alter cases. Few slang terms are either inherently appropriate or inappropriate from a moral perspective. Even sensitive physicians may, under stress, apply derogatory terms to difficult patients. Nonetheless, if patterns of abuse of derogatory terms persist, clinicians' respect for the moral integrity of their patients, and of medicine in general, maybe compromised. We prefer an approach that balances the potential harm of derogatory jargon with the psychological benefits obtained by the staff. In many cases, however, a balancing of benefits and burdens will require physicians to limit their use of depreciative terms. Moral precedent clearly supports the position that physicians who respect their patients as persons should avoid clearly derogatory jargon when possible. We suggest that physicians should be more aware of the functions served by neologisms and confine their use to appropriate settings, while recognizing the potential impact of such jargon on the character of the medical profession. Above all, we seek to inculcate this awareness into daily practice where the use of medical slang abounds.

Accepted for publication October 6,1992.

We are grateful to the physicians and nurses who candidly related to us the jargon that they used or heard being used during their clinical experience.

## REFERENCES

1. Barkley K. Hospital talk. *Am Speech*. 1927;2: 312-314.
2. House DE. Hospital lingo. *Am Speech*. 1938;13: 227-229.
3. Wolf ZR. Learning the professional jargon of nursing during change of shift report. *Holistic Nurs Pract*. 1989;4:78-83.

4. Hussey HH. Medical jargon. *JAMA*.1976;235:1149.
5. Girone JA. Further elucidation of medical jargon. *N Engl J Med*. 1972;286:382.
6. Kolin PC. The language of nursing. *Am Speech*. 1973;48:192-210.
7. Zauder HL. Medical jargon--A few lines about lines? *Anesthesiology*. 1980;53:271.
8. Mogielnicki RP. Etymological evolution of emergency paging euphemisms. *Chest*. 1984;85:266-268.
9. Cosper B. How well do patients understand hospital jargon? *Am J Nurs*. 1977;77:1932-1934.
10. Eger El. A glossary of anesthetic jargon. *Anesth Analg*. 1989;68:740-743.
11. McCue JD. The effects of stress on physicians and their medical practice. *N Engl J Med*.1982; 306:458-463.
12. Smith DA. Medical jargon. *Pa Med*. 1988;91:6.
13. Rowland LP. Jargon. *JAMA*. 1968;205:468.
14. Davis NM. *Medical Abbreviations: 7000 Conveniences at the Expense of Communications and Safety*. 5th ed. Huntingdon Valley, Pa: Neil M. Davis Associates; 1990.
15. *Webster's New World Dictionary*. Cleveland, Ohio: World Publishing Co; 1966.
16. CoeJM, Soloway HB. Computer-assisted heparin monitoring. *Am J Clin Pathol*. 1979;72:74-76.
17. May WF. The virtues in a professional setting. *Soundings*. 1984;68:245-268.
18. Coulehan JL. Character and virtue in medical practice. *Pa Med*. 1989;92:58-61.



**“He basically really found his calling while he was in Jesuit training. Where other people might go some place quiet and do a lot of mediation, he went and lived with homeless people. Former students will write in about how just instrumental he was in shaping their careers, in helping them to stick up for their values. I think he would consider that the biggest honor. He'd be patient about us grieving, but then he would also say, okay now, you know what you need to do, so go do it.”**

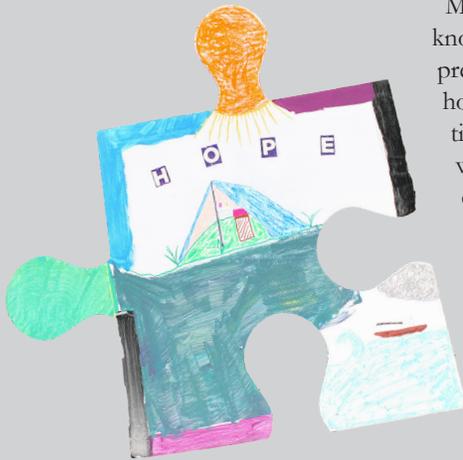
**-Dr. Regina Bussing, M.D., chair of University of Florida Department of Psychiatry**

## DISCHARGED TO THE STREETS: WHO CARES?

Christensen, R.C., Discharged to the streets: who cares? Pharos Alpha Omega Alpha Honor Med Soc, 2007. 70(4): p. 15-6.

“Recall the face of the poorest and the weakest man whom you may have seen, and ask yourself if the step you contemplate is going to be of any use to him. Will he gain anything by it? Will it restore him to a control over his own life and destiny?”

-Mohandas K. Gandhi<sup>1</sup>



Mr. Ruiz was well known to me from previous psychiatric hospitalizations. This time, however, he was only partially clothed and covered in feces. His rambling speech was so disjointed it was incoherent. The police had brought him to the emergency

department after coaxing him from a rain-soaked box

leaning against a dumpster behind an abandoned restaurant. In his early forties, Mr. Ruiz looked decades older.

From what I could gather, he had been living in his cardboard shell for nearly ten days following his release from a local inpatient psychiatric facility. When I spoke with the psychiatrist responsible for Mr. Ruiz's treatment and discharge, the doctor coolly reported that it really was not part of his “job” to find housing for people. Moreover, he quickly added, Mr. Ruiz “chose” to return to the streets rather than go to a local shelter for homeless persons.

Mr. Lancaster, on the other hand, was an elderly man bearing an uncanny resemblance to a mildly-confused Santa Claus. I met him on my weekly ride-along with a street outreach team attached to our city's homeless center. On these search-and-find excursions, two case managers and I scour the streets and surrounding woods to locate and engage homeless persons in need of medical and/or psychiatric care. We make arrangements for those with medical needs to be seen in our shelter-based psychiatric or primary care clinic. We always look for ways to bundle shelter and food with the medical services.

In the breaking dawn light of this particular day, we came across Mr. Lancaster lying in a dark, garbage-strewn alley that snaked behind a homeless shelter. His legs were crudely wrapped in dirt-caked gauze dressings

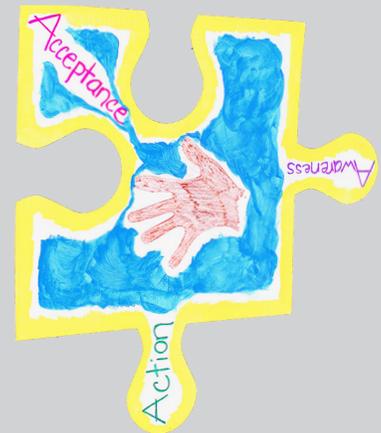
and soaked through with urine. On his wrist was the hospital identification band that recorded his name and birth date. He was seventy-seven years old. Prior to our encounter he had been admitted to a local hospital for several days, where he had received inpatient treatment for an angry, oozing cellulitis covering his lower legs. Upon discharge on a late Sunday evening, he had been given a cab voucher with instructions to the driver to take him to the nearest shelter.

After being dropped off by the cabbie, he realized he had missed the admission curfew. When we came upon him he had spent the previous twelve hours lying in the gravel of the alley, unable to stand, calling for help but unheard and unnoticed. Next to him was a large plastic bag filled with sterile gauze wrappings and rolls of medical tape. Before leaving the hospital the previous night, he had been given written instructions to change his bandages once a day, fill his antibiotic prescription, and be scrupulous about keeping his legs dry and elevated. Once we got him bathed and situated at the shelter, it became painfully obvious that dementia had robbed him of a trustworthy memory and a reliable set of problem-solving skills. The written instructions were not only useless but—tragically—

comical in light of his state of homelessness and confusion.

I would like to think that a homeless mentally-ill person being discharged from a hospital unit to a city street is an exception to the norm.

I would even like to believe that these particular adverse events are usually the result of administrative oversights that are always seen as serious and humanly painful mistakes. But as a psychiatrist who has worked with homeless persons for two decades, I know better. More times than I care to recount, the “choice” to return the person to the streets arises not with the homeless patient but rather with the treating physician.

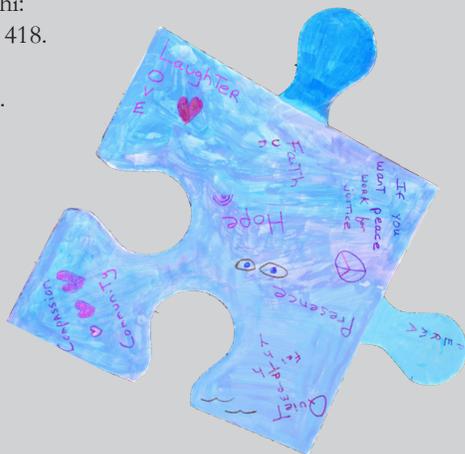


I believe we can do better. A covenant of care implies that our moral commitments and professional instincts are singularly “focused upon individualized and excellent care of the patient.”<sup>2</sup> Because our professional positions grant us visible moral standing in society and a clarion voice in medical institutions, we are uniquely privileged to be both the providers of medical care and advocates for needed compassionate services.

Homeless persons who enter the health care system with broken minds and damaged bodies invariably need more from their doctors than medical care alone. And physicians who find themselves in the position of caring for those who are “the poorest and the weakest” persons in our communities, may often struggle (as did William Osler) to “maintain an incessant watchfulness lest complacency beget indifference, or lest local interests should be permitted to narrow the influence of a trust.”<sup>3</sup> At the end of the day, however, the “choice” to care deeply, to prevent suffering and to never abandon a patient rests always with us.

## REFERENCES

1. Iyer R, editor. The Essential Writings of Mahatma Gandhi. New Delhi: Oxford University Press; 1990: 418.
2. Harris ED Jr. Professions, professionalism, and covenants. *Pharos* Summer 2006; 69; 1.
3. Silverman ME, Murray TJ, Bryan CS, editors. The Quotable Osler. Philadelphia: American College of Physicians; 2003: 7.



**“He slept in doorways, he begged for food, he tried to get showers in different shelters. I know, even one night, he was a little scared for his life, living on the street. And he really found God, for him, in the homeless people there. His wife, Kathy, worked for Habitat for Humanity, so they decided a few years back that the way they would celebrate their anniversary each year is to pick a different place and spend a week with Habitat for Humanity, building homes for the homeless. How you can affect so many people on a scholarly level, as a professor, as a researcher, as a doctor, but also as a man of the poor? How do you do all of that? I don’t know anybody else.”**

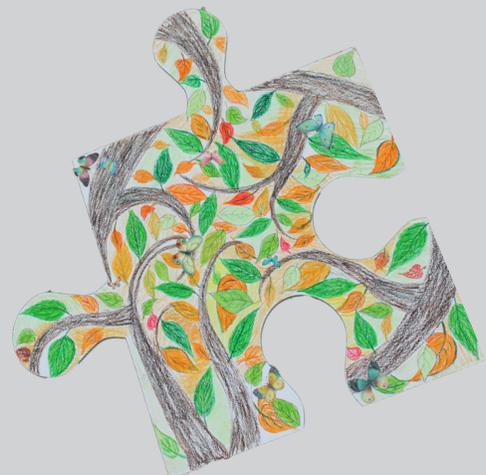
**-Rev. Ronald Anton, S.J.,  
Georgetown University, Fellow  
Seminarian**

**“I see you. I hear you. You are not invisible. That, to me, epitomizes my boss. The sweetest, kindest man I’ve ever known and the best doctor I ever had.”**

**-Sharon Griffith, Senior Counselor of Behavioral Health, Sulzbacher Beaches Clinic**

**“He could look past the disheveled clothing, the sunburn, the scars of living outdoors. He saw them as a patient who needed care. Many, many people loved Dr. C, and we miss him every day.”**

**-Audrey Moran, Senior VP for Social Responsibility and Community Advocacy, Baptist Health**



## A REFLECTION ON HOMELESSNESS AND SELF- NEGLECT

Christensen, R.C., Diogenes and Marcella. A reflection on homelessness and self-neglect. *Pharos Alpha Omega Alpha Honor Med Soc*, 2007. 70(2): p. 52-3.

“When . . . someone once called him a madman, Diogenes replied, ‘I am not mad; it is only that my head is different from yours.’” — Luis E. Navia<sup>1p85</sup>

The term “Diogenes Syndrome” has been applied at times to describe persons who exhibit “severe self-neglect, domestic squalor, social withdrawal, stubborn refusal of any well-meant help, and sometimes a tendency to hoard rubbish (sylllogomania).”<sup>2p571</sup> Although the literature documents the presence of an underlying mental illness in many of these individuals, there appears to be an equal number who exhibit no signs of an identifiable, neatly-defined psychiatric disorder.<sup>3p366</sup>

Why Diogenes of Sinope, a fourth-century BC Greek philosopher, has been chosen as the namesake for this unique syndrome is not exactly clear. What is known about this eccentric figure is based upon snippets of quotes and fragments of stories collected over the years. He apparently left no surviving corpus of original writings. Nevertheless, Diogenes is commonly recognized as the father of Cynicism, a branch of philosophy that questioned the core values of society and espoused the primacy of personal freedom, self-sufficiency, lack of shame, and a pervasive indifference to social judgment. Stories abound of Diogenes’ contempt of civil authority and his indifference to social norms. His “home” was a makeshift earthenware barrel that he lugged around as he slept on the streets and the public spaces of whatever Greek city he was living in at the time. He has been described as a “homeless and wandering man, who recognized no country as his own, who paid no homage to the authorities or the laws, who chose a life of hardship and penury, who spoke with unequaled freedom, who rejected and often broke laws and conventions, and yet a man who claimed to have attained happiness and who remained at peace amid the turmoil of his surrounding world.”<sup>1p44</sup>

That description reminds me of Marcella. Marcella is a middle-aged homeless woman I’ve worked with over the years in my role as a community psychiatrist. She lives on our city’s urban streets and is invariably outfitted in multiple layers of soiled clothing. For four years I’ve been making weekly visits to her as part of our psychiatric outreach to homeless persons who live outside shelter walls. Finding her is easy because her “buggy”—a converted grocery cart exploding with plastic bottles, rain-soaked newspapers, paper cups (used), broken umbrellas, shreds of plastic tarp, fractured toys salvaged from dumpsters, and grease-stained paper bags—serves as her identifiable marker on the urban landscape. For four years I’ve been trying to understand why Marcella hoards rubbish, remains socially isolated, and refuses all offers of shelter and medical care. After four years I still have no answers.

Our conversations follow the same script each week:

“Any new problems, Marcella?”

No.

“Any physical complaints?”

No.

“How have your mood, appetite, and energy been this past week?”

Fine.

“Anybody bothering or harassing you?”

Just the police, but they know I have rights.

“Can I get you a shelter bed for the night?”

No.

“Will you at least agree to come to the clinic for a check-up?”

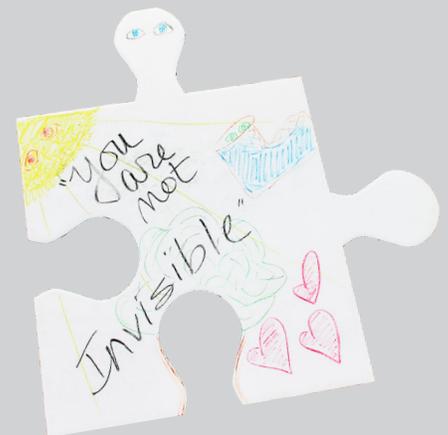
No.

We chat further about the weather, the availability of food and water (always precarious contingencies for homeless persons living on the streets), and safety issues, but I always know our “session” is over when Marcella says, “I’m not crazy, doc, and I’m fine just where I am.”

I have a very difficult time accepting that Marcella is “just fine” living as she does. Her state of extreme poverty and isolation pain me beyond words. But I also know that her self-neglect troubles me far more than it does her. Moreover, as a physician, I have no diagnosis to adequately understand her behavior or her motives.

The “medical model” as a construct of explanation fails miserably in Marcella’s case. She does not appear to have a mood disorder. She is most definitely not psychotic. Her symptoms of anxiety regarding her life and living situation are clearly less severe than my own. Although one might assume she meets diagnostic criteria for obsessive-compulsive disorder based upon her hoarding, even this is questionable. She has never drunk alcohol and even laughs with a certain amount of derision whenever I ask about her use of other drugs.

Although Diogenes Syndrome may be helpful in describing Marcella’s situation, it falls hopelessly short in explaining Marcella’s behavior. In my twenty-five years of working with homeless persons, I hold firm to the conviction that those who slug out a brutish existence on the streets are there not because of personal choice, but as a result of a serious mental illness or an addiction. Marcella exhibits signs of neither. She is as different and enigmatic as Diogenes was in his day.



I long for the moment that Marcella accepts my offer of shelter and safety. Until then, the weekly street visits that signal a human commitment to care and a physician's obligation not to abandon seem to be the right thing to do and the only thing I can offer. In the meantime, I'll continue to try, and to better understand Marcella outside the narrow and limited boundaries of a medical model. Perhaps I'll even learn to accept that Marcella, like Diogenes, is most certainly not mad, it's only that her head is different from mine.

**REFERENCES**

1. Navia LE. Diogenes the Cynic. Amherst (NY): Humanity Books; 2005.
2. Esposito D, Rouillon F, Limosin F. Diogenes Syndrome in a pair of siblings. Can J Psychiatry 2003; 48: 571-72.
3. Clark AN, Manikar GD, Gray I. Diogenes Syndrome: A clinical study of gross neglect in old age. Lancet 1975; 1: 366-68.

**“He was a professor at the University of Florida, so we contracted for his services. He was a nationally renown expert on street psychiatry, recognized all over the country. We’re making him out to be a saint, and he was a saint, but he did have a pretty dry and wicked sense of humor. [After his death], everyone in the shelter came out -- it was staff, it was patients, it was residents -- and in the middle of the circle, right there at the shelter, we memorialized him at the place that he loved and at the place that loved him.”**

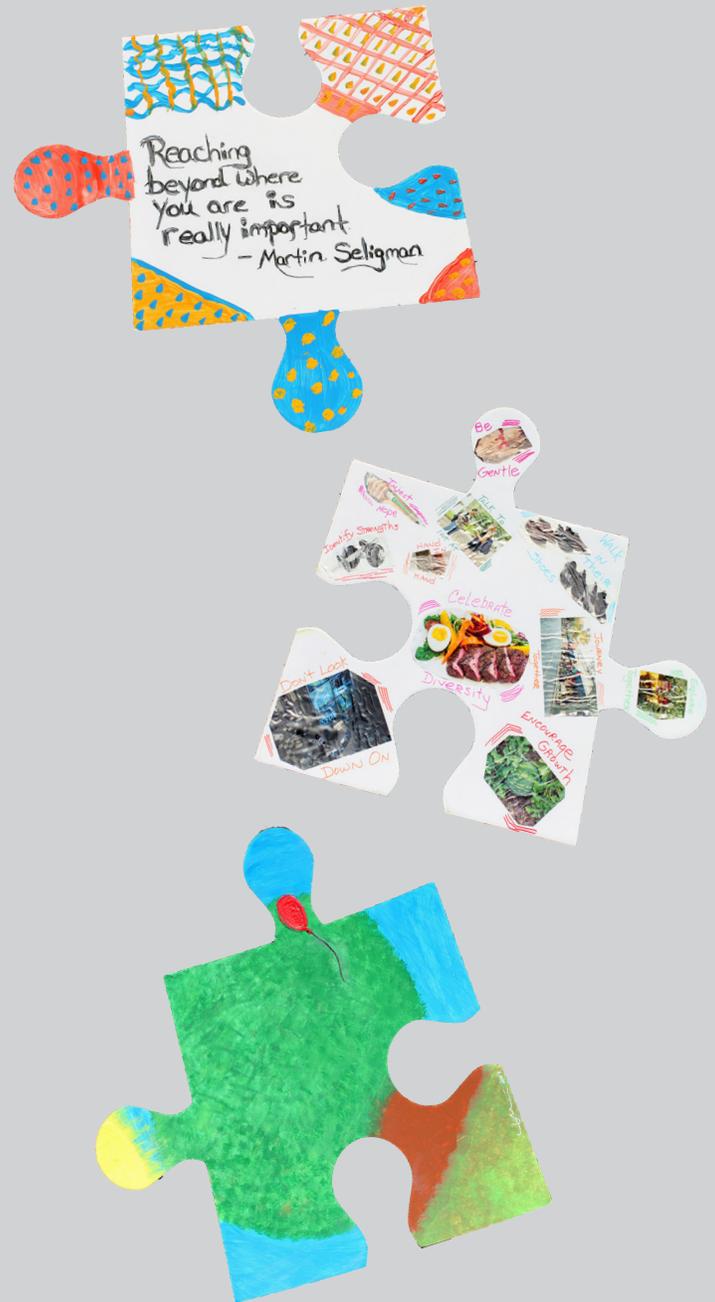
**-Cindy Funkhouser, President and CEO, Sulzbacher Center**

**“One of the first things he used to ask people was ‘Is there anything I can do for you?’ And that was how he kind of opened the door. He was a friend, he was a mentor, he was my therapist, because lord knows I need it at times. He was an all-around good guy.”**

**-James Christopher, Homeless Outreach Specialist, Sulzbacher Beaches HOPE Team**

**“I was suicidal and had a lot of mental issues. And he saw me as a patient. Just looking at him, you could just see that he cared.”**

**-Lisa, former patient of Dr. Christensen**



## THE LANGUAGE OF CARE. TAKING PSYCHIATRY TO THE STREETS.

Christensen, R.C., The language of care. Taking psychiatry to the streets. The Pharos of Alpha Omega Alpha-Honor Medical Society. Alpha Omega Alpha, 2009. 72(3): p. 36-9.

“The language of care is greater than the act of speaking. It is a language of sensitivity, patient presence, and gentle approach; a language of concern and mutual respect. It does not depend on our particular roles or the labels the world gives us. Healing words flow from our common humanness, our feel for a person’s life condition, and our compassion for someone else’s suffering.”

modified to store medical supplies that could be used to transport the team. Through our academic department’s community psychiatry program, I signed on as the “street” psychiatrist.

Most of my patients live in the urban niches provided by parking garages, or in scooped-out sand dunes alongside the beach walkways, or in the corners of a seldom-used bus stop shelter. Much of my clinical work over these years has been carried out, literally, on the street. My “office” is portable and my “patient follow-up” schedule varies dramatically depending upon who our outreach team can locate on any day. Most of the time we find the usual persons in the usual places, but tropical storms, relentless heat, or unannounced police sweeps of public spaces can wreak havoc on our search-and-find efforts.

Of course, our outreach team is always on the lookout for that new person navigating the street who has recently been released from jail, or discharged from the hospital without safe shelter, or cast out of an apartment by a rent- jilted landlord. Many times the outward signs of severe mental illness are obvious, but not always. As we roll up in our medical outreach van and introduce ourselves, I almost always experience that gnawing reluctance to reveal my professional identity. From experience, I know well that persons with chronic mental disorders living on the street seldom have images and memories of psychiatrists framed in comical Freudian stereotypes. For most, interactions with the public mental health care system—overcrowded crisis units, detoxification facilities, forensic hospitals and jails—have left them with painful recollections of involuntary hospitalizations, coercive treatment and less than compassionate recovery- oriented care. Rarely does the person say, “Wow, am I glad to see you, Doc!” In fact, after introducing myself, the usual reactions are shot through with a glaring suspiciousness: “Why do you think I need to see you?” or “Ya gonna lock me up?” Hostility and flat-out rejection occasionally occur: “I don’t want nothin’ from you!”

I have over the years learned to take nothing personally during those initial encounters because I now have a different perspective. When I first began doing street outreach my approach was still shaped by my experience of interacting with patients who willingly came to my clinic: patients came for treatment and I provided it. That is not the case when conducting street outreach. On one of our team’s initial forays years ago I made contact with a woman living on the street who was floridly psychotic, malodorous, filthy from head to toe, and fairly agitated.

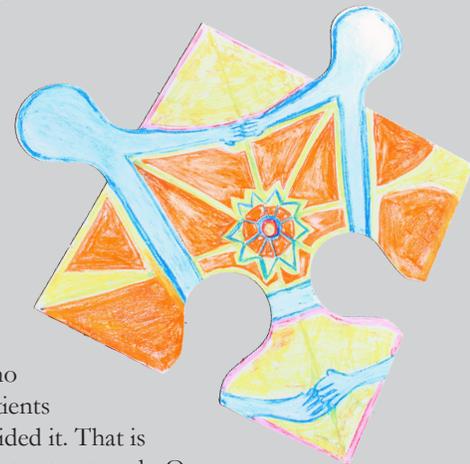


—Craig Rennebohm <sup>1p182</sup>

Over the years I have become increasingly reluctant to tell others that I am a psychiatrist. While getting my haircut, or on a long- distance flight, the inevitable question arises, “And what do you do?” When I finally come out with it, I just know my acquaintance has begun to mentally conjure those cartoon images from The New Yorker of the bearded, cigar- smoking psychiatrist, scribbling on a pad while “analyzing” the patient lying on a couch. I know those cartoons are playing a role in the questioning because I usually start fielding a string of queries about dream interpretation and long- smoldering conflicts with mother figures. In my most therapeutic way, I usually respond with, “Well, I don’t actually practice that type of psychiatry.”

I then talk about my work with the mentally-ill homeless. Individuals who suffer from serious and persistent mental illnesses comprise nearly one-third of the homeless population in this country.<sup>2p2</sup>The most vulnerable are those who are both mentally ill and chronically unsheltered, who differ in a number of respects from homeless persons who are temporarily domiciled within a shelter system or service agency. The mentally ill who are chronically unsheltered are more functionally and socially impaired than their shelter-based counterparts and are less likely to pursue or accept basic services (e.g., food, shelter, appropriate clothing), case management assistance, and medical care.

Nearly a decade ago, Jacksonville’s civic leaders and mental health advocates recognized the need to engage the segment of the homeless population in our city that appeared to be in greatest need for basic human services. These were the persons, it was argued, who were most difficult to engage because many cycled through the hospital emergency departments, jails, and psychiatric crisis units only to wind up back where they started: on the street. The city provided funding of several hundred thousand dollars per year, renewed annually for the past nine years, to implement a medical street outreach team comprised of two case managers, a nurse, and a part-time psychiatrist. A local car dealership donated a van



After telling her who I was and what I did, she totally and completely ignored me. Staring off into the distance, she pressed on with a monologue that made sense only to her. I was flustered because I was unable to interrupt or otherwise get her attention. Looking for any hook to engage her, I said something along the lines of, “You know, Ms. Virginia, I could give you medications that would make you feel better.” At that moment, she stopped her psychotic soliloquy in mid- sentence, looked me full in the eyes, and replied, “Hmmm . . . Ya think? Well, I think giving me medication would make you feel better, but it sure as hell won’t make me feel better!”

Since that time I have come to more fully recognize that meaningful psychiatric street outreach is not based on developing a diagnosis, formulating a treatment plan, or dispensing medication. Although our street outreach efforts yield over 120 contacts per month, providing shelter and/or medical care to approximately fifty percent of this population, our work is not only about producing measurable clinical outcomes. Rather, it is all about cultivating relationships. Those “first meetings” are given to making sure at least two things happen: first, I acknowledge the essential worth and dignity of the person, and second, I ensure that he or she is willing to see me again. Nothing else matters. Indeed, no truly meaningful medical treatment can begin until some semblance of a healing partnership has been established.

Four years after the initial encounter with Ms. Virginia, and after many, many street “appointments” during which medications were never mentioned again, she agreed to move into safe housing. Today she fully participates in her recovery from devastating mental illness and actively directs her own care.

In reaching out to those who endure harrowing, isolated existences on our city streets because of confused minds and crushing fear, compassionate acts of human recognition and deep listening carry far greater transformative power than do initial offers of medication and treatment. If nothing else, my work on the streets as a psychiatrist has taught me that the slow dance of healing always begins with a “language of care” that speaks of presence rather than analysis, invitation instead of interpretation.

## REFERENCES

1. Rennebohm C (with Paul D). *Souls in the Hands of a Tender God: Stories of the Search for Home and Healing on the Streets*. Boston: Beacon Press; 2008.
2. McQuiston HL, Gillig PM *Mental Illness and Homelessness: An Introduction*. In: Gillig PM, McQuiston HL, editors. *Clinical Guide to the Treatment of the Mentally Ill Homeless Person*. Washington (DC): American Psychiatric Publishing; 2006: 1–8.
3. Lam JA, Rosenheck R. Street outreach for homeless persons with serious mental illness: Is it effective? *Med Care* 1999; 37: 894–907.

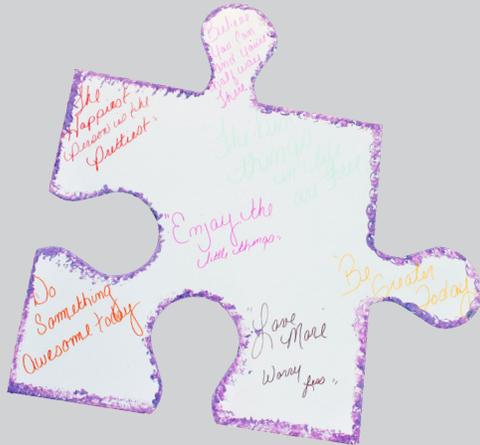


**“Sometimes he would make sarcastic comments just to throw you off guard, and you would say, ‘Can I laugh at that?’ I get to hear from the patients themselves what he meant to them and how he effected their lives. They just think the world of him. Some of them said, when I lost him, it was like losing my own father. He taught so many people that all lives matter.”**  
**-Dr. Ana Turner MD, Adjunct Professor of Psychiatry, University of Florida College of Medicine**

# ROLE OF AN AUSTRALIAN HOMELESS HEALTH OUTREACH TEAM: COMMENTARY

Christensen, R.C. and J.C. Byrd, Role of an Australian Homeless Health Outreach Team: Commentary. *International journal of therapy and rehabilitation*, 2010. 17(7): p. 383.

Developing and adapting effective models of health care delivery



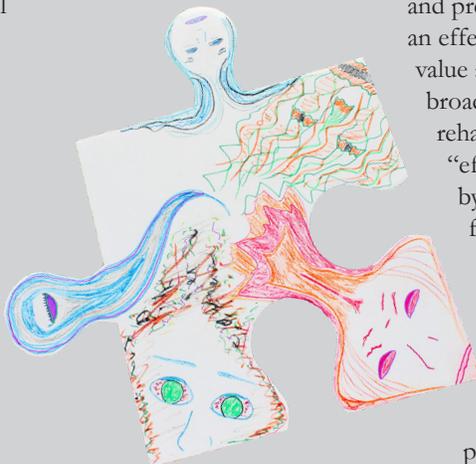
for homeless persons is not without significant challenges. As the authors of this descriptive article rightly point out, the causes of homelessness in developed countries are multiple and complex. Indeed, the population itself is

diverse and heterogenous.

Tragically, the individuals who literally live on our streets, yet remain largely hidden in the shadows of society, suffer disproportionately from the effects of serious mental illness, substance use disorders and life-threatening medical conditions.

The life expectancy for those who are chronically unsheltered and contending with the 'tri-morbidity' of addictions, mental disorders and physical illness is nearly 25 years less than it is for those in the general population (O'Connell, 2005). Yet those who suffer the most, comprising that segment of the homeless population that has been continuously unsheltered for 1 year or longer, are also the least likely to accept services and offers of assistance by health care outreach workers (Lam and Rosenheck, 1997).

recent study identified the most common reasons for declining services by those who are considered 'chronically' homeless involved a pervasive mistrust of the outreach workers and a lack of confidence that the services would be of personal benefit (Kryda and Compton, 2009).



## MEASURING SUCCESS

This article provides a description of a mental health outreach initiative that seeks to engage homeless persons who battle the devastating effects of psychiatric illness. The composition of

the Homeless Health Outreach Team (HHOT) is multidisciplinary in nature and the 'duties' of the staff are delineated by professional training (e.g. social work, psychology, occupational therapy, mental health nursing and psychiatry). The key elements of the work are broadly categorized as engagement, outreach, assessment and the development of a recovery plan.

In this particular article there is a clear emphasis on detailing the model's components and much less of a focus on measuring the efficacy of the work. And therein lies the challenge for all of us who participate in providing rehabilitation-oriented health care services to homeless persons: do transdisciplinary street outreach models that are designed to engage the most vulnerable, marginalized members of our communities actually 'work'? If so, how is the value measured and which clinical model is most effective? Indeed, can we point to one particular type of assertive outreach initiative as constituting a 'best practices' model and recommend future street outreach upstarts replicate it in design and implementation? These are complex questions that do not have readily available answers based upon the current literature.

## A RADICAL APPROACH

What we do know with certainty is that working with persons who are mentally ill and chronically homeless requires a radical revising of our traditional approaches to health care delivery, and presses us to think pragmatically about what constitutes an effective clinical practice. Hence, we would suggest that the value and worth of assertive street outreach teams be measured broadly and also include those 'human' dimensions of care and rehabilitation that are not easily quantified. In our view, the full "efficacy" of outreach initiatives should not be measured solely by the more obvious parameters such as numbers referred for service linkage, medication management and addiction services. Rather, when assessing the value of this work that strives to promote recovery and rehabilitation, there needs to be a recognition of the most important initial goals sought by this unique health care approach: the fostering of human connection and relationship. In so many ways, and for a wide range of reasons, chronically homeless persons have become untethered to the web of relationships that define not only a social community but, more important, a community of caring. Health care outreach teams such as HHOT have enormous value through their unique capacity to forge human relationships with chronically marginalized persons, reconnecting homeless individuals to a social community and promoting a model of recovery where the person begins to shed their former identity of being labeled 'homeless', 'mentally ill', and 'addicted'.

## CONCLUSIONS

Indeed, do street outreach models like HHOT 'work'? We would argue that they do, primarily because the road that leads from a state of homelessness to rehabilitation and recovery is built

upon first cultivating trusting relationships and fostering social reconnection. Only through outreach initiatives like HHOT can those who slug out a brutish existence defined by homelessness and social isolation be located, be recognized and begin the human work of establishing relationship and reconnection. Indeed, without that initial foray into the shadows by specialized outreach teams there truly can be no other meaningful rehabilitation outcomes to measure.

2010).  
 2. Lam JA, Rosenheck R (1997) Street outreach for homeless persons with serious mental illness: is 11 effective? *Medical Care* 37(9):894-907  
 3. Kryda AD, Compton MT (2009) Mistrust of outreach workers and lack of confidence in available services among individuals who are chronically homeless. *Community Ment Health J* 45(2): 144-50

**REFERENCES**

1. O’Connell J (2005) Pre mature mortality in homeless populations: a review of the literature. Online. <http://tinyurl.com/26h5koa> (accessed 24 June



**“He really started our street outreach, called the HOPE Team, and he would go out with them and find individuals living in the woods, under bridges, on the beach, in campsites.”**  
**-Tory Wilcox, Mental Health Counselor, Sulzbacher Center**

**“He really created the definition of a street psychiatrist, working with the homeless population. He really created that. That didn’t exist before Dr. C.”**

**-Denise Marzullo, President and CEO, Mental Health America of Northeast Florida**



## CARING FOR THE INVISIBLE AND FORGOTTEN

Christensen, R.C., Caring for the invisible and the forgotten. The Pharos of Alpha Omega Alpha-Honor Medical Society. Alpha Omega Alpha, 2014. 78(4): p. 48-50.

Illness isolates; the isolated become invisible; the invisible become forgotten.

—Elisabeth Tova Bailey <sup>1p132</sup>

I was recently asked to speak to the class of graduating medical students on the topic of humanistic care in medicine. Always after receiving those sorts of invitations I start fretting about what I can possibly say that will be meaningful, memorable, and maybe even a bit profound. On my morning runs, at night lying awake, and on my drives to and from the clinic, I propose, formulate, and discard potential topics based on what I think would be of interest to the group in attendance. This time I had the good sense to ask one of the student organizers what she thought would be of value to upper level medical students who were just a few months shy of starting their residency training. “Just talk,” she suggested, “about your own work in medicine and what we might learn about patient care.” Following her advice, I began to think in a more deliberate way about my patients, and their struggles, and what they have taught me over the past several decades. I focused upon trying to describe what I have learned as a physician about patient care from persons whose illnesses have frequently driven them into the shadows of our society and, oftentimes, outside the web of human relationships.

For twenty-five years I have been providing care to patients whose illnesses contribute to the most devastating form of suffering: human and social isolation. Through my work as an academic community psychiatrist I have been given the somewhat unique opportunity, and privilege, to dedicate my full professional energies to caring for mentally ill persons experiencing homelessness. My patients are those who, for the most part, have received the bulk of their health care through safety net clinics, emergency departments, public crisis units, jails, and prisons. They have been treated by a myriad of different unfamiliar providers, most commonly under rushed and less-than-caring circumstances. Over the years I have come to fully appreciate that they shoulder burdens most of us cannot begin to fathom. And they have taught me everything about the grinding pain that arises from human isolation and aloneness.

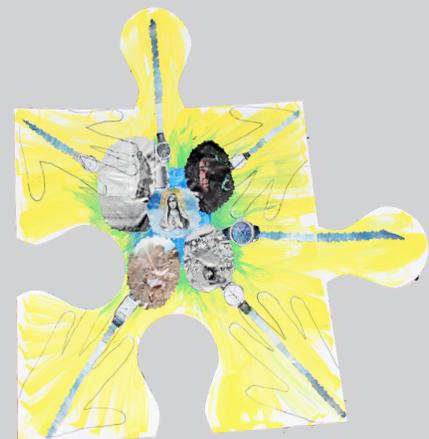
My inner-city clinic welcomes those who spend most of their days in solitary wanderings through our city streets, oftentimes wholly preoccupied with bizarre ruminations or engaged in conversations that only they can hear. Even though we have a medical street outreach team that tries to engage individuals experiencing chronic homelessness, most remain unseen and unnoticed, invisible to the many who pass by on their morning

treks to work or on their way to grab a quick sandwich at the noon hour. For the vast majority of my patients, the clinic appointment is the one opportunity they have to be heard, to receive attention, and to know that their lives matter and have meaning. In those clinic encounters, or during the fleeting stop-and-greet meetings on the street, discussions about medications, treatment plans, and lab results are put on hold. Because the most common shared experience for most of my patients is one shaped by human

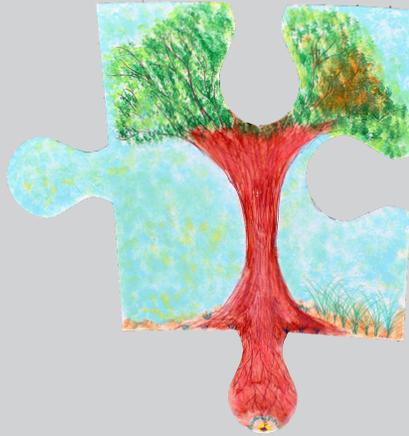
loneliness and deprivation, my initial treatment intervention is nothing more than undivided attention and empathic listening. I fully believe my most important role as a physician is to show up and, by my presence say, very clearly, “I see you. I hear you.” It is always the first step to coaxing persons out of the shadows and back into the human community where many have come to believe they are unwanted and unwelcome. In fact, some have come to the conclusion they do not exist at all.<sup>2</sup>

A few months ago I was called to the front of the clinic to see a young woman who had wandered in from the streets where she had been living for several years.

She was disheveled, malodorous, and seemingly oblivious to the efforts of our staff to gather the usual intake information. She was not one of our regular patients and no one in our clinic had ever seen her before this unexpected appearance. When I introduced myself and asked how I should address her, she reluctantly and guardedly gave her name: “Dead Girl.”



I invited her back to my office and sat with her. She began a long, detailed account of her nihilistic belief that her internal organs had rotted away and she had died many years ago following the suicide of her boyfriend. She had lived mostly on the streets over the years, but had become a “ghost” who was invisible to others.



“No one can see my face,” she explained, “since I’m dead.”

As I often do during that tenuous slow dance of building trust, I worked hard to speak little and to listen much. I later learned that her name was Robin and she had experienced at a young age the sorts of horrifying trauma that can wound persons beyond repair. As a child she saw herself as being invisible to the family who was supposed to care for her and, later, to the agencies that were supposed to protect her. Now, many years later, her illness made her invisible to those who walked by her everyday. Instead of interpreting the chronic social ostracism as human rejection, she had developed the delusional belief that she was no longer a living being who could be seen. Obviously, it was much more acceptable for her to believe that she was invisible rather than ignored and forgotten.

Then there is Willie, a middle-aged gentleman who suffers from the ravages of rheumatoid arthritis and schizophrenia, who we seek out every couple of days through our medical street outreach team. Gaunt and drawn from years of being battered on the beach by the sun and wind, he hides beneath layers of blankets and tarps. Several trash bags filled with his personal belongings surround his living space and stand like sentinels that silently warn others away. Each time we make contact with Willie it takes many minutes before he peeks out from beneath what he perceives to be his cloak of invisibility. He almost always acts surprised that we have been able to find him because he fully believes that he is unseen underneath his makeshift cover. And in many ways he is “invisible” since he is surrounded each day by a crowded beach teeming with swimmers and surfers, bikers and walkers, who seemingly are incapable of “seeing” the mentally ill person who is sharing their public space. The contact with our medical outreach team appears to be the only tether to the human community Willie has remaining to remind him he is not invisible and he is not forgotten.

The fundamental acts of relationship and human connection in medicine can be healing and restorative, as underscored by the physician Richard Gunderman, MD, when he eloquently describes what patients most need from the doctors who care for them:

They need us to be genuinely curious about them and take a sincere interest in their lives, not just with a view to arriving at a diagnosis or prescribing a therapy, but simply to share their experience. Everyone will get sick. Everyone will die, even the doctor. Medicine may turn the tide for a time, offering a reprieve of months, years, or even decades of life. But the end is always the same, and every human being, even a doctor, needs someone with whom to share it. There are times when our patients need us to be human beings first and experts second.

My patients who struggle with chronic homelessness have been exemplary teachers when it comes to understanding the therapeutic value in medicine of an empathic presence, other-directed attention, and human recognition in the slow work of healing. They have taught me that physicians must always be willing to recognize those patients who, because of the depth of their illness and suffering, are isolated and alone, unseen and forgotten, whether they are living on the streets of our cities, occupying an ICU bed within a teaching hospital, or sitting alone on the edge of a bed in a skilled nursing facility. And, as physicians, I would hope the initial impulse and response that begins the process of healing will always be, “I see you. I hear you. You are not invisible.”

## REFERENCES

1. Bailey ET. *The Sound of a Wild Snail Eating*. Chapel Hill (NC): Algonquin Books of Chapel Hill; 2010.
2. Christensen RC. Dead men walking: Reflections on Cotard’s syndrome and homelessness. *The Pharos* 2005 Winter; 68: 33–34.
3. Gunderman RB. Success, professionalism, and the medical student. *The Pharos* 2012 Spring; 75: 6–8.

**“In fact, the joke was, the way to not attract Dr. Christensen would be to give him a nice, air-conditioned office with a nice big window and a really pretty desk, because his most favorite place to work was behind the dumpster, up in the woods, on the doorstep, next to the garbage can, wherever you would find someone who was homeless and very sick and desperate, that is where he would be. I think his legacy should be and is doing whatever it takes. If that is delivering medical care behind the dumpster, then of course that’s where it has to happen. That’s what he taught everybody.”**

**-Linda Lanier, Former President and CEO, Suzlbacher Center (1997-2003)**

# INVOLUNTARY PSYCHIATRIC HOSPITALIZATION AND RISK MANAGEMENT: ETHICAL CONSIDERATIONS

Christensen, R.C., *Invol.Psych.Hosp.Risk.Mgmt.Ethical.Considerat.* Jefferson Journal of Psychiatry, 1993: p. 42-47.

## ABSTRACT

During an era where physicians go to great lengths to limit personal risk and ensure self-protection from lawsuits, psychiatrists may be inclined to err on the side of involuntarily hospitalizing patients who have been briefly evaluated in the emergency room or clinic setting. However, conscientious treatment decisions, particularly those pertaining to involuntary psychiatric hospitalization, need to address at least two fundamental ethical concerns: the patient's best interests and the clinician's motives. This article discusses the moral components involved in clinical decision making and presents a case example which highlights the ethical implications of involuntary psychiatric hospitalizations.

Several years ago, a colleague in the field of medical ethics reminded me that every treatment decision possesses three facets which must be examined by the decisionmaker: the clinical, the legal and the ethical. In other words, one must be prepared to evaluate every treatment choice for its medical appropriateness, its legal defensibility and its ethical soundness. I believe physicians, in general, are cognizant of the clinical concerns driving treatment choices and are becoming increasingly more aware of their legal responsibilities based upon principles of prudent risk management. However, I have frequently wondered how attuned psychiatrists are to identifying and addressing the ethical tension created by moral principles and values which threaten at times to come into sharp conflict in the clinical setting. Nowhere has this become more evident than in the hospital emergency room where I have often been compelled to hospitalize persons against their wishes, to "break" confidentiality for the purpose of protecting the patient, and even deny people access to the most appropriate health care services because of their inability to pay. To reduce these treatment decisions to only their clinical and legal foundations is to perilously ignore their moral dimensions. I understand this to be no trivial oversight since it is the moral aspect of a decision which reminds physicians that the patient before them is first and foremost a person, someone who is owed, as Paul Ramsey writes, a "moral quality of action and attitude" by the physician who steps into a relationship with them.<sup>1</sup>

At two a.m., in the rush of a busy emergency room, it may be too much to expect a harried on-call psychiatrist to assume the role of a moral philosopher. But one does not need to be a philosopher-physician to identify, consider and reason about the ethical concerns involved in one of the most frequently encountered psychiatric emergency situations confronted by the consult-liaison psychiatrist: the decision to hospitalize a patient against his/her wishes.

Theoretically, commitment laws are based on the presumption that the patient is not only mentally ill, but also suffers from a severe impairment related to the underlying mental illness which renders them dangerous to themselves or others, or neglectful of their basic human needs. Most states provide

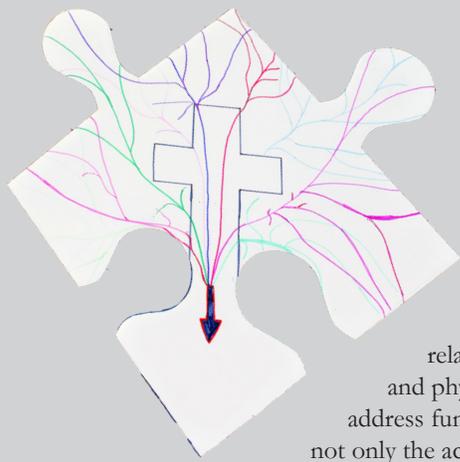
for a period of commitment which is relatively brief (e.g., 48 to 72 hours), and designed primarily for crisis intervention and observation. It is this type of involuntary hospitalization which is commonly initiated by the emergency room psychiatrist. The frequency of this clinical occurrence is well-documented in a 1986 Client/Patient Sample Survey sponsored by NIMH which found that noncriminal involuntary admissions to both public and private psychiatric hospitals accounted for 27 percent or all inpatient admissions.<sup>2</sup>

From an ethical perspective, the dilemma is usually framed as a tension between society's obligation to protect its members by providing care and safety to those debilitated by the ravages of mental illness versus the individual's right to be a self-determining, autonomous agent who is responsible for his/her own life choices. Figured into this matrix, is the physician's obligation to promote the good of the patient and not to inflict harm, duties based squarely on the ethical principles of beneficence and nonmaleficence, respectively.<sup>3</sup>

Concretely, however, there is great disagreement at times over how suicidal, dangerous or helpless a person must be to justify overriding their wishes and hospitalizing them.<sup>4</sup> To involuntarily commit a person is to deny them the most fundamental of all human rights, their right to liberty and self-determination. Whether the abridgement of these rights is justified on the basis of an appeal to paternalism (i.e., protection of the patient), or grounded in an obligation to protect innocent third parties, it is a step which ought never be taken hastily and without consideration of the moral components or the decision.

Although this may appear to be a rather obvious observation, at times there appears to be a certain nonreflective ease with which clinicians involuntarily commit patients for short-term psychiatric hospitalizations after brief evaluations in the emergency room. During post-call conferences, as well as informal discussions with other psychiatrists, our justifications frequently appear to be reduced to primarily clinical and /or legal concerns. This implies that either ethical concerns are playing no role in our decision making processes or they are remaining unaddressed, buried beneath the more prominent clinical indications and, at times, legal risks impelling the decision to admit a person against his/her wishes.

It can be argued that morally conscientious treatment decisions, particularly those pertaining to involuntary psychiatric hospitalization, need to address at least two critically relevant ethical concerns: assessment of the patient's best interest and evaluation of the clinician's motives. Although there are numerous other moral considerations associated with this specific clinical situation, the intention in this brief paper is not to posit an exhaustive list of ethical concerns which must be examined by the psychiatrist whenever the situation of involuntary commitment arises.



Rather, the attempt here is to provide a starting point where practical ethical reasoning can become integrated into the clinical decision making process. Attending to questions related to the patient's best interest, and physician motives, serves to address fundamental moral concerns about not only the act, but the agent as well.

### CONSIDERING THE PATIENT'S BEST INTEREST

Assessing the patient's best interest strikes at the very core of the involuntary hospitalization dilemma since the psychiatrist is faced with the prospect of interfering with someone's personal liberty based on the duty to protect or promote the good of those who cannot adequately take care of themselves. Although most physicians unarguably would acknowledge a moral duty to act in the patient's best interests, the assessment of what that entails in particular clinical situations is frequently ambiguous and uncertain.

What constitutes a patient's best interests traditionally has been viewed rather narrowly within the Hippocratic tradition as the physician calculating medical benefits and harms for the patient. Robert Veatch has suggested, however, that if physicians are to honestly attempt to assess what is "in the interest" of the patient, they need to consider what the patient's concept of their personal welfare entails, even if the patient's notion is broader and more expansive than immediate medical concerns alone.<sup>5</sup> Clearly, facilitating access to the mental health care system may be of supreme benefit to one patient, while for another, the loss of an already limited personal autonomy or the burden associated with the stigma of being labeled "mentally ill" which might result from an involuntary hospitalization, could represent devastating harm.

From an ethical perspective, the decision to involuntarily admit an individual must be justified on the grounds that the overall good of the person is being advanced by the clinician's actions. At the very least, this will require a minimal understanding on the part of the psychiatrist of what it is that the patient believes, values and holds to be his/her best interest, not an easy task considering the time and informational constraints encountered in an emergency room or clinical setting. Nonetheless, in every instance where the possibility of an involuntary hospitalization arises, the psychiatrist needs to honestly evaluate what would best serve the interest of the patient before them, taking into consideration the particular circumstances of the clinical situation, the treatment objectives of the commitment, and the patient's own understanding of his/her personal good. To do anything less is to engage in clinical decision making which has not adequately engaged a moral point of view.

### CONSIDERING THE CLINICIAN'S MOTIVES

As already noted, a clinical decision to admit a patient against his/her wishes should be based squarely upon a concern for the patient's welfare. As Alan Dyer notes, "Taken as a whole, the central tenet of the Hippocratic Oath and tradition is the benefit of the patient. The physician must subsume self-interest to what is good for the patient"<sup>6</sup>. Unfortunately, in many emergency situations

where disposition decisions frequently are made quickly, with incomplete knowledge and information about the patient, it cannot be assumed that involuntary hospitalization decisions are always intended to benefit only the patient.

As noted by one clinician addressing the topic of risk management, promoting the patient's welfare is usually only part of the clinical picture. The author writes, "... Practicing medicine in modern day America requires familiarity with the scope of legal responsibilities imposed upon the physician as well as having the resources to develop tools to minimize and avoid legal liability. Caring for patients is only part of the business that medicine, for better or worse, has become".<sup>7</sup>

During an era where physicians go to great lengths to limit personal liability and ensure self-protection from lawsuits, psychiatrists will not infrequently err on the safe side because of the belief that there is not enough time, information or capability to consider alternatives consensually with the patient.<sup>8</sup> Paul Appelbaum has referred to the practice of involuntary psychiatric hospitalization based on self-protecting motives as "preventive detention," and describes it as "ways in which clinicians feel compelled by the threat of liability to detain in persons who would not otherwise be considered appropriate subjects for psychiatric hospitalizations".<sup>9</sup>

The obvious ethical concern here is a clinician's proclivity to sacrifice what may be in the patient's best interests for reasons which are primarily self-serving and self-protective in nature. Although this is clearly unacceptable from a moral standpoint, I have listened on more than one occasion during post-call conferences as clinicians justify their involuntary admission decisions based on concerns of legal risks alone. This is not to say that liability considerations are of no importance because, unquestionably, they are. However, they need to be viewed as just one component of the clinical decision and should not be allowed to overshadow, and certainly not replace, the pressing moral concerns which are at stake whenever psychiatrists make treatment choices which impact so profoundly upon the lives of others. As a consequence, if we are to honestly assess the moral nature of involuntary hospitalization decisions, greater attention needs to be focused up on identifying the motives which impel our treatment choices.

The following case example illustrates the prominent ethical concerns which ought to be addressed whenever a clinician is faced with the possibility of involuntarily hospitalizing a patient.

### CASE STUDY

D.W. was a 30+ year-old, single female with no previous psychiatric history, who was sent to the emergency room of a large teaching hospital under an involuntary detention act initiated by the patient's psychologist. According to the details included in the accompanying paperwork, the patient had reported a depressed mood for the past several weeks and, on that particular morning, had experienced thoughts of killing herself. She denied having a plan but, upon questioning, admitted that she had a gun in her home.

When contacted by telephone, the outside psychologist stated she initiated the involuntary detention (which authorizes the hospitalization of a person for three days, but which can be



rescinded prior to that time by a treating psychiatrist) because she did not know the patient well. She stated she was unsure the patient would present to the emergency room on her own volition. The patient was, therefore, transported to the emergency room by the local police for further evaluation of suicidality.

When the consulting psychiatrist arrived in the emergency room, he found the completed involuntary commitment forms attached to the patient's chart. The emergency room triage physician had written on the chart's facesheet that the patient was suicidal and ordered a psychiatry consult.

On subsequent examination by the psychiatrist, the patient related a history of worsening depression with mild sleep and appetite disturbances over the course of the past several weeks. She identified numerous stressors, most related to her new small business and her unfamiliar role as a manager of other employees. Although she admitted to having fleeting suicidal ideations during this time period, she stated, "I never seriously considered it," and denied the formulation of a plan. Concerns about her depressed mood, as well as the emergence of transient self-destructive thoughts, had impelled her to see a psychologist. On this particular day, she arrived at her psychologist's office at an unscheduled time and requested an appointment because, "I was having thoughts of hurting myself on and off this morning." She added, "I think she (the psychologist) just freaked out when I told her what I had been thinking about, even though I made it clear that I had no intention of hurting myself. Now I'm in this horrible mess."

The psychiatrist discussed with the patient the option of a voluntary admission, but the patient stated she could not afford to be absent from work since her business depended upon her direct involvement. Moreover, she believed her depression would best be treated on an outpatient basis with the option of a voluntary admission at a later date if symptoms did not improve. She was willing to follow-up with her current psychologist the next day. When asked if she felt "safe" returning home, the patient responded, "Yeah, I think so." When pressed further, she stated, "Well, none of us ever know how we're going to be in a day or two, but I don't think I would ever hurt myself." On further questioning, it was learned that the patient lived by herself. She felt she could not ask a friend to spend the night "and watch over me" because she believed it was unnecessary and too embarrassing to tell others about the recent events leading to her current situation.

The psychiatrist decided not to rescind the involuntary hold and transferred the patient to the local crisis stabilization unit, mindful of the fact that she was unlikely to receive treatment for her depression in that facility. He acknowledged her low suicide risk, but he felt the potential for personal liability was quite high in light of the documented circumstances surrounding the patient's presentation in the emergency room. The patient was transported to the crisis unit and the involuntary hospitalization act was rescinded the following day by that facility's psychiatrist.

## DISCUSSION

Although there is some degree of uncertainty associated with both the clinical and practical issues raised by the case study presented in this paper, it clearly represents an instance in which the practice of defensive psychiatry contributed to the involuntary admission decision. The decision to involuntarily hospitalize this patient was primarily based up on the clinician's self-interest in avoiding possible litigation in the event of a suicide, rather than being grounded in a thoughtful assessment of the patient's best interest.

Concerns derived from the principles of beneficence (e.g., harms accrued from the loss of work, the stigma of being labeled mentally ill in a person with no previous psychiatric history, possible rupture of a therapist-patient relationship, and, perhaps most importantly, the low therapeutic potential of an involuntary hospitalization), as well as autonomy (e.g., detaining a person against her wishes, overriding a person's preferences regarding both the timing and the type of further treatment, etc.), should have served as powerful ethical checks to a decision making process primarily driven by self-protective motives. Clearly, it is difficult to ethically justify this hospitalization as an act which advanced the patient's overall good.

## SUMMARY

In summary, I have argued that all clinical decision making must be evaluated for its medical appropriateness, legal defensibility and ethical soundness. Nowhere is this more needed than in the emergency room where decisions regarding the involuntary hospitalization of a person are frequently made under the severe limitations of insufficient time and inadequate information. In this brief paper, I have proposed two ethical considerations, the patient's best interests and the clinician's motives, which might serve as starting points for examining the ethical acceptability of involuntary commitment decisions. This habit of assuming the moral point of view in the clinical setting is designed to not only encourage the practice of ethical reflection but, perhaps more important, to foster the ethical practice of involuntary psychiatric hospitalization in an era of prudent medical risk management. Patients, as persons, have a right to expect nothing less.

## REFERENCES

1. Ramsey P: *The Patient as Person*. New Haven: Yale University Press, 1975.
2. National Institute of Mental Health. *Client / Patient Sample Survey of Inpatient, Outpatient, and Partial Care Programs*. Unpublished data. Rockville, Md.: the Institute, 1986.
3. Jonsen A, Siegler 11, Winslade W: *Clinical Ethics*. New York: Macmillan Publishing Co., 1986.
4. Levenson .1: "Psychiatric Commitment and Involuntary Hospitalization: An Ethical Perspective." *Psychiatric Quarterly*, 1986; 58(2): 106-112.
5. Veatch R: *A Theory of Medical Ethics*. New York: Basic Books, 1981.
6. Dyer A: *Ethics and Psychiatry: Toward Professional Definition*. Washington, D.C.: American Psychiatric Association Press, 1988.
7. Harter-Golder B: "Risk Management for Individual Practices." *Journal of Florida Medical Association*, 1992; 79(2) :409-4 10.
8. Levenson.1: op ci t;p.1 IO-111.
9. Appelbaum P: "The New Preventive Detention: Psychiatry's Problematic Responsibility for the Control of Violence." *American Journal of Psychiatry*, 1988; 145(7):779-785.



## THE MENTALLY ILL NEED US ALL

Grace, G.D. and R. Christensen, The Mentally Ill Need Us All. *Clinical Psychiatry News*, 2003. 31(10): p. 14.

Over the past decade, mental health clinicians and researchers have played an important role in promoting awareness of mental health issues in general health care settings. In response, primary care providers have assumed an ever-increasing level of responsibility for first-line diagnosis, treatment, and referral of patients with emotional problems. That change represents a substantial improvement in the quality of health care afforded to primary care patients.

But mental health advocacy efforts have largely ignored the critical role medical specialists can play in accessing mental health care for their patients. That's unfortunate, because large numbers of patients with unrecognized psychological disorders are seen in specialty care practices.

Medical specialists--such as cardiologists, endocrinologists, and pulmonologists--have a great deal of face-to-face contact with their patients, often treating those with chronic diseases for years. In many cases, they are in a better position to recognize psychiatric symptoms in their patients than the primary care clinician who originally made the referral. But the limited research related to this topic suggests that medical specialists seldom refer their patients for mental health care (*Psychosomatics* 38[2]:109-12, 1997).

There are several possible reasons why many specialty care physicians do not refer. First, they have never been expected to take on this responsibility. Most research, writing, and professional education addressing the issue has focused almost exclusively on primary care providers. And the education of medical specialists places comparatively little emphasis on recognizing psychiatric disorders.

Second, in an era dictated by managed care arrangements, primary care providers have been assigned the exclusive role of "gatekeeper" to specialty health care. Therefore, medical specialists seldom view it as their role or responsibility to deal with mental health issues--this area falls outside their defined field of expertise. Nonetheless, the identification of mental health problems is not the sole responsibility of primary care clinicians but should be shared by all professionals who provide health care to the patient. World Health Organization recommendations from the 2001 World Health Report, for instance, support the development of mental health referral links between primary, secondary, and tertiary providers. The dermatologist and gastroenterologist, for example, should be expected and able to recognize psychological problems in their patients and should refer them for care.

Our colleagues who practice in specialty settings have a unique opportunity to help alleviate the suffering and pain that burdens those who endure the effects of clinically unrecognized mental illness. Promoting research and educational efforts to help

them achieve that end should be the responsibility of all of us who work in the overlapping fields of mental health care and medicine. Indeed, our success in healing those afflicted by untreated mental disorders might well depend upon that collaboration.

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**"But what made me so proud is that there were always students with him, and it was an almost infectious learning about the humanistic qualities of a great physician. One thing I am pleased with is that his work will continue. It will continue to be a fabric of our medical school."**

**-Dr. Michael Good, M.D., Dean, University of Florida College of Medicine**





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1. Maggie Hannon overseeing the art workshop in Jacksonville. 2. Dr. Christensen's family at the Wilmot Garden's ceremony. 3. Psychiatry Resident Kathleen Burns at the Gainesville art workshop. 4. Musicians Sofia Sirocchi and John Wiegand from the UF Arts in Medicine program performing at the Gainesville art workshop. 5. Memorial in Wilmot Gardens. 6. Counselor Tory Wilcox at the Jacksonville art workshop. 7. Administrative Assistant Priscilla Spence at the Gainesville art workshop.

This book is a teaching tool produced by the University of Florida Department of Psychiatry. The members of the editorial board are Dr. Regina Bussing, Priscilla Spence, Dr. Jacqueline Hobbs, Dr. Dawn-Christi Bruijnzeel, Dr. Ana Thomas Turner, Dr. Josepha Cheong, Dr. Cara Yergen, Dr. Robert Averbuch, Kathy Christensen, Dr. Louis Solomon, and Tory Wilcox. Caroline Nickerson acted as editorial assistant for the project. The photo on the cover was taken by Ingrid Damiani. Special thanks to Maggie Hannon for leading two puzzle piece art workshops, one in Jacksonville and one in Gainesville, with Dr. Christensen's former colleagues, friends, and family. The photos on the back cover were taken at these workshops by Caroline Nickerson. Quotations are transcribed from the Florida Blue Sapphire 2016 Finalist Video. Thank you to all journals cited for granting reprinting rights.

