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THE LEARNER'S VOICE

Commitment Issues: Ambivalence over Involuntary Hospitalization

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The cuts on his forearm were superficial, with multiple stages of healing. "Do you know which part of the emergency room this is?" I tried to get a sense of how much David understood about why he was in the psychiatric emergency room. He nodded his head and explained, "It started with me admitting that I cut myself, and now I am here." What began as a standard visit to the emergency room for an unrelated injury became a full psychiatric evaluation for suicidal ideation and chronic self-harm. Immediately after witnessing the team restrain another patient and administer emergency medication, David timidly answered my questions about his mood and his life, with his eyes looking down toward the floor. It seemed like the most unideal of circumstances to build a therapeutic alliance. I hoped that despite being a complete stranger, I could be trusted with David's honest feelings about his mental state. I worried, though, that he would naturally be guarded, holding back from me in this frightening hallway.

After gathering collateral information, speaking to his outpatient team, and performing a comprehensive risk assessment, I had hoped that our team would agree to discharge him. David reported chronic ideation, without a method identified and without a plan or intent to act on his ideation. He was not without risk of suicide, but David's protective factors, the chronicity of his symptoms, and the strength of his outpatient care reassured me. The decision was ultimately made to hold him for the night and reassess.

That evening, I left the emergency room with a nagging feeling that something was wrong. I knew that the possibility of hospitalization was there to protect David. It ensured that he would not be discharged to the community inappropriately with a high risk of suicide. I wondered, however, would we also be hurting David by hospitalizing him, keeping him in paper scrubs, taking his possessions away, and restricting him to a hallway with a disorganized patient down the hall? Would we reward his honesty about his chronic suicidality with the possibility of involuntary commitment, taking away his freedoms, albeit for a short period? Would we prevent him from being honest with physicians in the future? But then again, suicide is notoriously difficult to predict, and prematurely discharging David could lead to his death. Perhaps as an inexperienced resident with an underdeveloped intuition, I underestimated his risk of suicide. Perhaps, too, a fear of his reaction to hearing that he would be hospitalized and my need to be perceived (and to think of myself) as a caring, helping physician colored my judgment. I trusted that the attending saw something that I did not, that perhaps David was at higher risk of suicide than my intuition led me to believe, and that comforted me for the evening. David was eventually discharged the next day, and I was relieved.

I witnessed several other complicated cases in the emergency room. There were some clear instances of patients requiring hospitalization and some other clear instances of safe discharges. But many fell in between, with differing opinions by attendings on the same cases. I spent my time in the emergency room trying to develop an intuition of whether to discharge patients, involuntarily hospitalize, or encourage voluntary admission. I asked attendings to explain their thought processes to help build my intuition, and I watched them balance patients' safety with their autonomy. In the process, I learned that a significant proportion of admissions were judgment calls, not always clear from the outset. But what that also meant was that some patients would be involuntarily hospitalized, subjected to a loss of freedom that might be avoidable, and others may be discharged less safely than others, at relatively high risk to themselves or others. Reasonable attending psychiatrists may err on one side or the other.

Functioning as trainees and physicians simultaneously, residents can potentially find themselves in a difficult position in the emergency room. As trainees, we practice under the supervision of senior physicians, functioning with a degree of autonomy but also with the expectation to carry

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out the management decisions of attendings. However, in the process of hospitalizing patients involuntarily, two physicians are empowered and relied upon to sign a certificate testifying legally that we *independently* believe a particular patient needs to be hospitalized against their will. We are asked to testify to our professional opinion, despite our status as novices. The dual role as trainee and physician raises a major potential conflict: What happens when a resident's intuition or assessment differs from an attending's decision that a patient meets criteria to be involuntarily hospitalized? In an ideal environment, a resident is able to raise this concern to senior physicians, elicit attendings' reasoning, and express his or her own reasoning. Ideally, residents would balance their humility, arising from their lesser experience in hospitalizing patients, with their confidence to voice an alternate position. However, what if disagreement still exists after discussion, and the trainee is relied upon to sign the certificate for involuntary hospitalization? In those cases, residents may be caught in an awkward power dynamic within a training structure and may be expected to sign documents they may not agree with. Fear of retaliation or simply not being liked by senior physicians may sway them inappropriately, ultimately affecting patients.

I have felt lucky to find attendings who have welcomed conversations about my hesitations in hospitalizing particular patients. One quipped, "Sounds like you have commitment issues," and continuously empowered me to approach her and other attending psychiatrists when these conflicts arise. As I move through residency, I hope that I remember the value of balancing patients' safety with their autonomy when deciding on involuntarily hospitalization and approach attendings with a mix of confidence, humility, and inquisitiveness when my assessment initially differs from theirs. I hope, too, that psychiatry residencies continue to foster environments where trainees feel comfortable raising their hesitations with humility, particularly when it involves legally attesting to their evaluation and assessments of patients.

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Declarations

Ethics Approval and Consent to Participate Please note that names were changed and no identifiable patient information was used in this piece, in order to protect the identity of the patient.

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