

RESIDENT'S COLUMN

by Jeffrey Junig, M.D., Ph.D.

Psychiatry in Crisis



I signed my name across from the next patient on the list and walked to the crowded waiting area. Our psychiatric crisis center is often at capacity.

Most of the people on emergency detention in our city pass through its doors, as well as a number of voluntary patients. The county system has been strained for a number of years, but has been under tremendous pressure more recently since the closure of some of the city's private psychiatric units. Apparently, it is difficult to make a profit on the uninsured, particularly when they have not filled out forms for coverage by the state Medicaid system. After working a few shifts at county, one realizes—to borrow a phrase—that something's gotta give.

I looked over the twisted human forms scattered throughout the room. Some were unmoving and covered head to toe with blankets, having been assigned the treatment plan of TOT, or "tincture of time," before their eventual discharge back to the street. A well-dressed couple huddled in the corner with their teen-age daughter, who was brought in by the police after telling a responsible friend that she wished she were dead. The looks on their faces made clear that their cocoon of suburban innocence had been irrevocably stripped away. Meanwhile, the "frequent flyers" in the room didn't stir as the manic patient yelled for help from the isolation room with a frightening force that would stop traffic even in New York City. And against the wall was my patient, a petite woman in her early 20s, sitting quietly with tears on her face.

I asked her to an interview room, silently predicting her history as I noted the fresh bandages on her forearm. "I don't know what happened," she began, trying to speak as her body shook with sobs. "I picked up the knife because I wanted to show him how mad I was, and then I cut myself ... I've been under a lot of stress lately ... I can't sleep ... I'm so embarrassed."

And of course every patient has a different story to tell, and in the difference lies one of the primary decisions in the crisis service—whether to keep or to let go. It has taken time for me to become immune to pleas for release, as I have learned that promises in the crisis service mean little to a truly suicidal patient. When in doubt, the patient stays—and I decided fairly quickly that this distraught patient was not going

home to her empty apartment tonight. After making that decision my mind already began moving ahead, as there were many names on the list, and the busiest part of the night was yet to come.

I asked the question that would make or break my ability to resolve her situation quickly and allow me to move to the next patient: "Do you have insurance?"

In the county system, beds are in short supply and reserved for the uninsured. I secretly hoped that she had no coverage, as that would allow a simple admission to the observation unit, where one bed sat empty. But I dropped that hope as she told me that she was covered by her mother's policy. I mentally pictured the complicated flowchart in the back room that showed "where patients should go" depending on their status as detained versus voluntary, detox versus primary psych, children versus adult, and, most importantly, the nature of their insurance. Certain HMO patients go here, others there. This hospital is in this preferred provider organization, this one isn't. This one takes voluntary only, this one Medicaid HMO, this one straight Medicaid. As an aside, when I attended medical school in the 1980s nobody considered Medicaid as "insurance." Now, in the days of the uninsured, state coverage is seen as a good deal for the hospital.

The flowchart is often a big help. "What kind of insurance do you have?"

"I don't know. I'm on my mom's policy, because I'm in school ... but she can't know about any of this!"

I quickly realized the dilemma ahead. She was covered by insurance, but without specific information that verified coverage, I knew that no hospital would accept her. But if she stayed at county she would be billed over \$2,000, even for just one night in the observation unit. She explained that a bill like that would use up her tuition for the semester and that she would have to ignore the bill or leave school. She was obviously entitled to confidentiality, but how much was her confidentiality worth to her, or to the taxpayers of the county?

On a whim, I decided to contact a private hospital, explain the situation, and allow their mercy to intervene. I had only one choice of hospital—the only private hospital that accepted patients on detention—because by now, the young woman had decided that she would be best off at her apartment. Since I knew the admitting staff from prior rotations at the hospital, I tried a friendly, personal approach.

"Hey Mary, how are things over there? ... Good, good ... Oh, not much,

but I really need a favor ... Well, I have a person here who could really use your help ... a great teaching case ... No, I mean yes, I mean ... she sort of has insurance. Her mom does. But I don't know the company or the policy number ... I do know the mother's name, though."

After a pause (I imagined stifled laughter), she explained that she would like to help, but she needed to know a great deal of information, including whether they were "in network," and whether she had mental health days left. She understood the problem, but hospital fiscal policy trumped whatever mercy I had drummed up in the admitting office.

After hanging up the telephone, I had an idea. I would call the hospital that had treated her laceration and ask if they had her insurance information. I called that

When in doubt, the patient stays—this distraught patient was not going home.

emergency department, but my hopes were quickly dashed. The nature of her injury and amount of bleeding had opened an end run around the fiscal people, and allowed treatment before full information was obtained. After her treatment she had reported only "self-pay."

I returned to the patient, who had become more aware of her surroundings and more adamant that she should be allowed to leave. Again, she emphatically stated that her mother could not be involved. After explaining my fruitless efforts, she came up with an idea of her own. "I was treated at a different hospital last year, and used my mom's insurance. They should have it." I walked back to the phone, aware that during the past 30 minutes two more names had been added to the list.

"I do have some information here ... but I can't give it to you—it's confidential ... Yes, I understand your problem ... No, nobody else is here at this time of night ... Well, OK, I guess I could tell you the insurer, but no, not the group number—that is confidential."

The HIPAA-hyperaware person at this second hospital gave me the company name—a sequence of four initials that I was not familiar with. I had another idea and called the suturing hospital again. "I'm still working on this," I said. "Could you check if she has any other admissions?"

Sure enough, she had been there before. And on that face sheet she had the same four initials ... and a group number! I thanked her for her apparent breach of confidentiality, and called the psychiatric hospital again.

"You have the group number—great! What is the customer service number for the insurer, so I can verify coverage?"

They didn't have a customer service number at the other hospital. And no, the psychiatric hospital didn't have a

list of insurers, and no, she had never heard of this company.

After hanging up, I turned to the source of all information, the Internet. After a brief search I found the company, but there was only one number, and I was told by a pleasant recording that the corporate offices closed at 5 p.m. Other links contained the same four initials, but after 30 minutes and about 20 links, my only remaining possible resource was a site that promised names, agents and customer service numbers (!) of every insurer for paid subscribers. But then I noticed the offer buried in small print—a one-week free trial!

At about midnight, I received my e-mail with my subscription number. Five minutes later I had the insurer company service number. Ten minutes later I was promised a call back by the

merciful lady at the psychiatric hospital. Thirty minutes later she called back, and said that she "couldn't verify it for sure, but that they would go ahead and take her." Another 20 minutes waiting for the "doc-to-doc," then the nursing report, then a wait for transport—and finally, five hours after my decision to admit, and seven hours after her injury, she was on her way to a bed—and I continued my way down the list. I was proud of my tenacious efforts, even if the woman with the bandaged arm cursed me for the result.

Several hours later I squinted at the bright sunlight as I emerged from the facility, my memory of the college student displaced by memories of other equally desperate people. The end of my shift reminded me, admittedly disdainfully, of the film *Night of the Living Dead* (1968), in which residents of a besieged town are saved by the light of day. I was grateful for my ability to leave. Behind me, the struggle and darkness remained for the people whose destiny involved many more visits.

I love working with acute patients in the crisis service. The concentration of exposure for psychiatrist-in-training is unique and will prepare me well for my career. But for good or bad, the experience also makes me painfully aware of the problems inherent to treating those whose illness often coincides with limited means in an age of financial incentives and limited resources. I have no idea what the future holds for psychiatry or for health care in general. But to borrow a phrase—something's gotta give.

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