Personal Paper

Suicide in San Francisco

S G POTTS

As I had always had a long-felt desire to visit San Francisco, I applied for an elective there in "clinical suicidology" offered by the University of California's department of psychiatry. Once accepted, I prepared to fly out, not knowing quite what to expect. "Psychiatry? In California?" people asked, in voices tinged with scorn, conjuring images of pandering to the egos of rich neurotic divorcees. Then, eyes narrowed ever so slightly in suspicion, they queried further: "And why San Francisco?" alluding to the city's reputation as a centre for generations of outcasts, from the Beat Poets of the '50s, through the hippies of the '60s, to its current invasion by America's more exuberant homosexuals.

I arrived with an open mind, leaving time to explore and find a home before starting work. The medical school stands between the wooded hilltop which forms the city's high point and the broad green gash of the Golden Gate Park. It is reached by way of the Haight, where dishevelled remnants of hippy Mecca days lead dogs past boutique windows and tramp-owned night-time doorways. In the park nearby hordes of lunchtime joggers model sportswear on the grass, while serious runners pant eucalyptus air downhill to the roaring surf of Ocean Beach. I found a room in the Sunset, a quiet cocoon surrounding the medical centre and home to many of its workers. Even here, amid the vegetarian restaurants and alternative bookshops, the smell of street fear at night is strong: by the General Hospital, far on the other side of town in the poor Spanish heart of the Mission District, it is overpowering, with the hospital a haven from the clamour and violence around it. It was here that I worked, often with the victims of that violence and sometimes with its perpetrators.

Liaison psychiatry

Initially, I accompanied the various members of the liaison psychiatry team, including doctors, psychologists, nurse specialists, and social workers, to observe their interviews with medical and surgical patients referred to them for psychiatric attention and advice. The problems encountered were many and varied, although suicide attempts were the commonest and constituted the only routine reason for referral. I was almost disappointed to find that the service rarely, if ever, dealt with those making attempts at the Golden Gate Bridge because they rarely, if ever, survived. Their determination astounded me: to look over the guardrail to the jagged rocks and swift tides far below prompts a chill terror, yet many were the tortured souls who hurled themselves hence, fighting, if need be, to evade the Samaritan grasp of concerned passers-by. In contrast to this awful certainty the smaller Bay Bridge presented a grim type of Russian roulette,

for fewer attempts were made here but more survived. One such survivor came to the General Hospital's renowned trauma unit, horribly injured, but alive, to become spoken of as "the Bay Bridge jumper." For in San Francisco "jumpers" are not just woollen garments; and "jumping" is a career, dramatic but short. We had Bay Bridge jumpers, seven-storey jumpers, plate glass window jumpers, and more. They lay multiply splinted, intubated, and monitored amid the victims of car crashes and stabbings. I am still haunted by the frightened psychotic eyes of one girl who, although immobilised and incapable of speech, managed to scratch a note saying she still wanted to kill herself.

There were other methods of self-destruction; from the bizarre invitation to immolate him that a tramp extended to some passing youths—not to mention their even more bizarre acceptance—to the now sadly routine overdoses seen in all general hospitals. Each case told a story, and together they formed a dispiriting odyssey of modern city life. More practically the accumulated experience helped explode several myths about suicide still current in the lay and medical worlds—the most important being that one can do little to help. One can. Inevitably there are those who will leave hospital to take another, more serious, overdose, or make a second and fatal leap: but there are many, many more who, with the right psychiatric help and social support, can build a little hope in their lives.

More responsibility

As time went by I became involved in a wider range of problems and was given more responsibility to deal with them. The first interview I performed, albeit under supervision, was with a proud black grandmother, the matriarch of her block. She had been a professional singer in Las Vegas and still rejoiced in impressing her local church by the power and range of her voice. One month previously, she had had an emergency tracheostomy tube inserted for acute laryngeal obstruction of uncertain cause; since when she had steadfastly disavowed its existence and tearfully refused to care for it. She was referred because, although otherwise well, she could not go home until she gave the apparatus the attention it needed. I fumbled my way through a long and involved interview, made technically difficult by her hoarse telegraphic speech, and I left dissatisfied. The next day, however, she had volunteered to clean out the tube herself for the first time, and she was soon ready to leave. I chanced to meet her some weeks later, smiling, lively, and in every way improved. Modesty tells me this change was purely coincidental with my interview, and largely engineered by persistent nursing attention—but I couldn't suppress a slight flush of gratification.

Not all our cases turned out so well. I recall an elderly widow who was still as depressed, withdrawn, and apathetic when I left for home as she had been when first seen a month before. She had suffered what was to her a devastating and unsought mutilation in the form of a colostomy and proctectomy for a rectal tumour. Three weeks after surgery she lay whimpering in her room, refusing to look at her stoma, and vomiting every time it was

dressed. Combined intensive visits by her family, medical and nursing staff, social workers, and the liaison psychiatry team produced precious little change in the patient and a general accumulation of frustration and feelings of impotence in those around her.

In this case, as in many others, depression relating to chronic illness was a major presenting complaint. Equally common were difficulties in compliance with the treatment of such illness. Young diabetics figured prominently in this group: one teenager I saw was admitted almost monthly in diabetic comas after neglecting her insulin injections. She seemed to be chasing a personal record for severity of acidosis, and smiled with pride when told her pH had dropped to 6.96 this time: "Lowest yet" she beamed at me. Dependence on, and damage by, both alcohol and an astonishing variety of drugs were other frequent reasons for referral. Less common, but more diagnostically challenging, were the psychiatric manifestations of underlying physical disease—and vice versa—and the differentiation of psychiatric from neurological disorders.

I think my attachment exposed me to a large part of the territory liaison psychiatry is coming to claim. As psychiatry develops a firmer scientific footing, and as medicine recognises the importance of social and psychological variables in disease hitherto considered purely physical, this border territory is destined to expand. It is important, however, to set some rough limits at this stage. Liaison psychiatry is not glorified social work; nor is it the simple tabulation of emotional response to physical illness. It has elements of these, but its essence entails seeing the patient as a unitary being not to be categorised and subdivided into separate aspects considered apart—seeing him, first and foremost, as a person.

Psychiatric emergency service

Liaison psychiatry was not my only experience of American medicine. Once a week I spent the night on the psychiatric

emergency service. Set in a cramped corner of the casualty department, it received anyone who sought psychiatric attention, and also dealt with the sharp end of forensic psychiatry, seeing many people brought in against their will by the police. The air was heavy with menace. All patients were searched for weapons, some were handcuffed, and a few were strapped down by wrists and ankles: nevertheless, assaults on staff were not rare. The atmosphere of violence also pervaded the hospital's top floor: here were housed the forensic, forensic psychiatry, and jail wards. Their orange-suited inmates were led in ankle chains around the corridors past my office by wary uniformed guards. It was all very alien to a mild-mannered Limey used to mild-mannered police without guns at their belts.

I discovered much about the complicated workings of the American medical system. The General Hospital took many patients on the MediCal and MediCare insurance programmes for the poor and elderly and others with limited or non-existent means of payment. It contrasted sharply with the plush carpeted interior of the city's many private hospitals, two of which I came to visit regularly, having contributed inadvertently to my landlady's stay there. My faith in the National Health Service as an instrument of social justice was considerably strengthened.

In all I thoroughly enjoyed my time in America. San Francisco is a beautiful, vibrant city, then riding a growing wave of football fever as the 49ers disposed of the best opposition in the land to carry off the Superbowl amid scenes of unparalleled jubilation. I grew to love the rickety hurtling progress of the old cable cars as I rode their footplate to dinner in Chinatown. I took bracing ferry passages to the sleepy beauty of Angel Island and the grim halls of Alcatraz. On weekends I toured Marin County, climbing Mt Tamalpais or strolling the stately redwood groves and sweeping sunset beaches. My stay finished with a weekend's cross-country ski-camping amid the glories of Yosemite, where my tent was raided by raccoons while I marvelled at the immense granite monoliths dusted with snow.

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Certain women's magazines have recently carried articles describing a "morning after" oral contraceptive procedure. The woman takes two tablets of a combined "pill" such as Eugynon 50 the morning after unprotected intercourse and a further two tablets 12 hours later. How reliable is this technique and if despite it pregnancy results will the risk of fetal abnormality be increased? Furthermore, would the risk be so substantial as to warrant therapeutic abortion, and what would be the legal position of a gynaecologist refusing termination of pregnancy in such circumstances if an abnormal infant in fact resulted?

This method—using a total of 200 µg ethinylestradiol and 2 mg dl-norgestrol—was first tested in 608 women aged 17-34 (mean age 21), of whom 464 had regular cycles.¹ Coitus occurred at mid-cycle in 152, and treatment was started within 72 hours of intercourse. Only one pregnancy occurred among the 608 cases, and this is the basis of the quoted "failure rate" of 0.16%. Later reports, however, are less favourable, and one centre has reported four pregnancies in under 300 patients.² The risk of fetal abnormality among these failures is unknown; oral contraceptives taken in normal dosage after conception seem to be safe, but sex hormones in higher dosage have been suspected of causing fetal abnormalities.³ Patients should therefore be told that if the method fails there may be a possible risk of non-fatal fetal abnormality, but that this risk—if present—is low. In my opinion therapeutic abortion is not necessary on this ground alone, but of course the patient—for example, a victim of rape—may have other grounds. The legal position of an abnormal infant is not clear. If a gynaecologist had refused termination the mother was free to seek a second opinion, and according to a recent decision a child has no right to sue for its own birth.⁴ Presumably the mother might sue the gynaecologist or the prescriber of the drugs: this has not been tested, but because of the scientific uncertainties outlined above I think that her case would not be very

strong.—JAMES OWEN DRIFE, lecturer in obstetrics and gynaecology, Bristol.

¹ Yuzpe AA, Lancee WJ. Ethinylestradiol and dl-norgestrol as a postcoital contraceptive. *Fertil Steril* 1977;28:932-6.

² Ambani LM, Joshi NJ, Vaidya RA, Devi PK. Are hormonal contraceptives teratogenic? *Fertil Steril* 1977;28:791-7.

³ Tully B. Postcoital contraception. *British Journal of Family Planning* 1981;7:53.

⁴ Law report. *The Times* 1982 Feb 20:21.

Is there any advantage in performing intradermal skin testing before intramuscular injection of long-acting penicillin?

Skin testing is of some value in predicting acute allergic reactions to penicillin. The initial test should always be a prick or scratch test with a concentration of the drug of 50 000 IU/ml or less, and only if the result of this test is negative should an intradermal test be done. The smallest volume of the drug should be used to produce a minimally raised skin bleb. A volume of 0.01 to 0.02 ml of 1000 IU/ml penicillin concentration is usually recommended.¹ Levine and Zolov² showed that if skin testing is negative there is a low risk that the patient will have an acute allergic reaction—that is, anaphylaxis, urticaria, or asthma—but it does not exclude the possibility of other allergic manifestations. In contrast, positive skin testing had a high probability of an acute allergic reaction. Although penicillin allergy is fairly common, it is unnecessary to skin test every person receiving penicillin. It must be done, however, whenever there is doubt, and particularly if there is a family or personal history of an allergic diathesis or of penicillin allergy.—GILLIAN SANDERS, senior registrar in clinical pharmacology, Newcastle upon Tyne.

¹ Feinberg SM. Allergy from therapeutic products. Incidence, importance, recognition and prevention. *JAMA* 1961;178:815-8.

² Levine BB, Zolov DM. Prediction of penicillin allergy by immunological tests. *J Allergy* 1969;43:231-44.