AUTHOR'S NOTE

The New York City jail system, with its hub on Rikers Island, manages approximately 1,000 people with serious mental illnesses on any given day, more than in all of the inpatient psychiatric units in the NYC public hospital system combined. While the volume is staggering and the implications for our society immense, the individual stories of these incarcerated men—who have been central to my experiences as a psychiatrist—are at once incredibly humbling, terrifying, and inspiring. Through them, I learned about survival and hope.

Like most jails, Rikers Island is primarily a detention center, a place originally intended to hold people charged with—not convicted of—crimes and considered too dangerous to be living in the community. For the eighty percent of detainees who are not serving a short misdemeanor sentence, the jail should be a quick stopover on the way from a judge's decision to retain them in custody to the decision to either release or transfer to prison. However, since the closure of many state psychiatric hospitals in the wake of the 1963 Community Mental Health Act and the escalation of the "war on drugs" in the 1980s, mental illness has been increasingly represented in the criminal justice system. The courts in New York City are overwhelmed, with long delays in case processing times. Rikers Island has become a jail where detainees stay for months, sometimes even years.

I wasn't aware of much of this when I began my internship at Bellevue Hospital in 2000 and had never given much thought to the island jail hidden in Flushing Bay. When I elected to do a month-long clinical rotation on Bellevue's 19th floor—a maximum-security hospital ward and the inpatient psychiatric unit for men at Rikers Island—I was quickly introduced to a world that was unlike any other. In only a few weeks, it was clear that being a doctor there was hard and confusing. One of my first patients, a cocaine addict with bipolar disorder, had "F.T.B." tattooed in scraggly block letters across his neck and scars all over his arms. I cringed when he proudly deciphered his neck for me as "Fuck the Bitch" and then melted when he showed me the cigarette burns from his mother and the self-inflicted razor cuts to his wrists from a recent suicide attempt. The many layers of complicated emotion underneath his violent body scars were both intriguing and scary.

This story describes my complicated and painful, yet sometimes incredibly joyful, journey into the world of psychiatry in jail. The seeds of this book began in 2007, in the eighth month of my second pregnancy, only days after I left my position as a psychiatrist on the Bellevue Hospital Prison Ward to start early maternity leave. At the time, my doctor had advised me to take it easy, not so much because of a specific physical risk but because my mental state was suffering. I was not sleeping well and I was constantly anxious and fearful. I started to write about my troubled thoughts and chaotic emotions as a way to download them from my brain—an attempt to get rid of them and, I hoped, make them less scary. The decision to publish some of those thoughts and stories was not made lightly. I am still deeply embedded in this work and have no interest in jeopardizing relationships or placing blame. I wish only to show this world through my own eyes, and in doing so, bring it a little more into the light.

For most doctors, working behind bars with patients whom others see as criminals, inmates, even "bodies," is not very appealing. The barriers to relieving suffering can be overwhelming and the rewards can

seem few and far between. Yet, while the challenge has tested my spirit, my relationships with family and friends, and even my health, I feel lucky to have been given—and taken—the opportunity to learn and grow in an environment that brings out the best and the worst. I have come to see my success as a doctor not by how well I treat mental illness but by how well I respect and honor my patients' humanity, no matter where they are or what they have done.

The worlds described in this book—both the hospital and the jail it serves—are heartbreaking at times, infuriating at others, and always compelling. These worlds can easily shape the lives of patients, staff, or officers into hardened, angry, and traumatized versions of themselves. The characters in this book, including me, have all been exposed and transformed in various ways. While some of the stories involve behavior by clinical staff and officers that may seem callous, even cruel, every action and word should be seen in the context of the whole system—a complicated tangle of courts, jails, laws, unions, bureaucracy, and public opinion—that struggles to support the men and women tasked with caring for and keeping safe a population that many would like to forget. The simpler, sometimes inevitable, path for the staff is to absorb the chaos and culture, to decide that nothing can be done. The harder road is to fight, every day, to resist that transformation and find inspiration and hope in even the most dire situations.

The events described in this book take place from the year 2000 through 2014. I witnessed much progress during those years—progress that has more recently escalated at a rapid pace—at Bellevue, at Rikers Island, and in the city. However, many of the episodes that I recount here relate to complicated personal and professional situations that, from another's perspective, could be viewed differently. They are as I remember them and not the opinions of Bellevue Hospital, the City of New York Department of Correction, or any other agency or individual. I believe that the lives and health of the patients in this system will be diminished if their stories remain hidden.

To balance these considerations, and because my guiding principle as a physician is to "do no harm," I have changed the names of all of the characters except myself, and in many instances, I have changed physical features and other potentially identifying characteristics as well. Some individual staff members and patients depicted are actually composites of a few people who shared the same experiences. Conversations and dialogue are primarily reconstructed from memory, with only a few exceptions, and so are susceptible to the limits of my ability to recall those details. At the end of the day, I hope that I have succeeded in presenting these compelling narratives while also respecting my colleagues and, above all, my patients.

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THE BODY BAG

At first, I don't realize that the rusty, unmarked metal gate on the corner of Twenty-sixth Street and First Avenue is the entryway to Bellevue, which looms over the East River on one side and the city's Poison Control Center on the other. Maybe the steady stream of people—amped-up, white-coated surgeons in scrubs, weary caregivers pushing invalids in wheelchairs, stumbling men who smell like alcohol and urine—should clue me in.

Since 1736, New York City has funded and supported Bellevue Hospital's mission of caring for anyone who walks in the door. It is the oldest public hospital in the country. Originally called a "Publick Workhouse and House of Correction," the modern-day hospital still treats patients who are mostly poor, uninsured, and homeless. Many are undocumented immigrants who speak no English. Some are under arrest. On the top floors sit the most famous psychiatric wards in the world. I know I am going to get to them someday, but first I have to learn to be a doctor.

Inside the gate, there is a decrepit garden with dying plants and dried-out fountains. A few weathered and lonely benches are scattered around. Perhaps this had once been a place of peace where you could quietly sit with a loved one, but now it is mostly a meet-up for drug

dealers and their clients—and me. During the six months I spend working as an intern in medicine and neurology, I eat lunch on those benches, occasionally chatting with the addicts.

On my first day as a psychiatry intern, I happily join the rush of doctors and patients flowing into Bellevue. My fancy white coat with "NYU School of Medicine" stitched in purple cursive over the breast pocket is back at my apartment, hanging in a closet. Instead, I'm wearing my version of a fierce outfit—knee-high black boots with heels that bring me close to six feet tall, black tights, a short black skirt, a black sweater, and a thrift-store leather jacket that was a hand-me-up from my younger brother. The only clue that I'm a doctor is the stethoscope wrapped around my messenger bag. I am starting in the psychiatric emergency room to learn all about schizophrenia, antipsychotic medication, and how to commit someone to a hospital against his will.

Four narrow doors funnel people from the garden into a cavernous foyer with a set of brightly painted murals called "Materials for Relaxation," created in 1941 and newly restored. I push through the door on the far right to circumvent the bottleneck of people streaming into the "F" link, the central thoroughfare that leads from one end of the hospital complex to the other. I swerve to avoid a young woman pushing a stroller and pulling her crying toddler, only to bump into an elderly, inebriated black man stumbling over stained and torn pants that drag on the floor. The masses of people around us merely shift their path.

"I'm so sorry," I say, reaching to help steady the man. He grumbles incoherently and moves on.

The walls in the massive "F" link hallway are dull and white, decorated only by a handful of posters advertising insurance plans for low-income families and an upcoming Fourth of July garden picnic for the Bellevue staff.

I flash my NYU School of Medicine ID at the security guard manning the checkpoint for the hospital. I have just a few minutes before morning rounds start. I shove open a set of unmarked double doors on the ground

floor, and I'm in the area of the hospital that only the really sick patients see: the back entrance to the ER, the emergency radiology suite, and the service elevators that move patients—including tiny, intubated preemie babies—up to the ICUs and inpatient suites. I know this world well from my medicine months, when I took care of people with heart attacks and diabetic comas. It is quieter back here than in the "F" link. The only people talking are the doctors and nurses; the patients and the transport techs who push their stretchers or wheelchairs are mostly silent.

I turn a corner, just before the hallway of X-ray rooms with their flashing red lights that signal radiation in progress, and look for the sign for CPEP, the Comprehensive Psychiatric Emergency Program.

"It's just past the station where the cops unload their weapons," Eileen, one of my co-residents, had told me on the phone the night before.

I see the sign, but from around another corner, I hear tense voices approaching.

"Hold him," one says. "It's just over there," says another.

I stop just in time to avoid the stretcher careening toward the CPEP. One EMS paramedic steers from the back while another stabilizes in front. Two NYPD cops walk on either side. They each have a hand on the body bag wiggling around on the stretcher.

"Hold still," one of the cops mutters to the bag. He looks across at his partner. "This ain't gonna be pretty."

Sounds of protest come from inside the bag—a muffled man's voice, deep and disturbed. He sounds like he's crying. The paramedics maneuver the stretcher into the doorway, jostling their passenger as they bump into a desk on the way in. I follow at a safe distance.

"Hold up," says a hospital police officer, holding his hand in front of my face. "You got to wait."

"But I work here," I protest, holding up my ID.

"Don't matter. You have to stay outside until this gets settled down." He closes the door in my face.

I try not to panic about being late for rounds on my first day and slump against the wall. I remember the first body bag I ever saw, the one that got me to medical school. I had been visiting Samantha, a close friend from high school and now a second-year medical student. One afternoon, she snuck me into the anatomy lab. The body bag was hidden inside one of many shiny dissection tables laid out in neat rows in the windowless, gymnasium-size room. I felt like I was in a stainless steel graveyard.

"You sure you want to see this?" Samantha asked. "It can be pretty gross if you're not used to it."

I wasn't sure. I gave her a quick nod anyway.

She went over to one of the covered tables and grabbed the handles on top of the hood. She struggled a bit to open it, but eventually the hood broke in two, each side hanging over the edge of the table. On the exposed flat surface lay a black body bag, zipped tight.

"Um . . . can we take a break?" I asked, starting to sweat.

"Sure, oh yeah, of course," she said as she laughed. "This was really hard for me the first time. Luckily, the students just started so they haven't dissected much. They've probably just cut into his back."

I turned away and dry-heaved.

"OK, I'm ready," I said, returning to the carcass and feeling both sick and exhilarated. Samantha slowly unzipped the bag. A waft of formalin and something kind of sweet hit me in the face. The top of a dead man's head came into view. I closed my eyes for a second and felt a little woozy. He was lying face down on the table. I assume he was a man, but in fact I saw nothing in this posterior view of an older, shriveled body to tell me for sure. His skin was pasty and a little yellow. He didn't have much hair covering his scalp, and folds of extra skin crowded around the back of his neck.

Samantha unzipped a bit more, and the cadaver's shoulders and upper back came into view. Flaps of skin from postmortem incisions had been restored as close to their original positions as possible. At some

point soon, Samantha told me, the entire backside of this man—all of his muscles, nerves, blood vessels, and bones—would be inspected and dissected. He would then be flipped over, and the same would be done to his front side. Everything stayed inside the body bag, she explained, even the extra fat and skin that would need to be removed to dissect the internal organs. After the dissections were complete, the anatomy professors made sure that each body—likely to be cremated—contained all of the same stuff with which it started.

"Can you believe we get to do this?" Samantha asked.

"No," I answered quietly. I couldn't look away. He was not beautiful or warm, but he was inviting. My fingers were itching to pick up the scalpel lying by his side and cut into the flesh. I wanted desperately to understand what was going on inside his body. I wanted to know everything about this dead man.

"We should go," Samantha said.

She zipped the bag up and closed the steel hood. We scurried out of the room and into the cool, fresh hallway just as the security guard walked by.

"I have never seen anything like that," I said, awed by the power of that body. Surprising even myself, I whispered, "I think I'm going to medical school."

Now, seven years later and fifteen minutes after my arrival at the CPEP, the door opens up again and the officer ushers me in.

"Thanks," I say, quickly walking in and passing the EMS workers, one of whom has an empty body bag over his shoulder. I enter into an open space that has ten chairs bolted to the floor and borders a large windowed panel defining three separate sections of the CPEP. The first section, closest to the entrance and the hospital police officer, is where patients check in. Names and birthdates are confirmed, medical record numbers are assigned, and each new patient is logged into a giant ledger.

The next section is the triage room, which has 270-degree visibility. It's where a nurse does a preliminary interview and assesses whether

a patient is stable enough to sit in the bolted chairs outside, or is so dangerous that he or she has to be locked in behind the door in the third section. Once inside this last area, no patient can get out without a doctor's order. For these patients, shoelaces and belts are removed to prevent hanging attempts, all property is taken and stored, and any illegal drugs are confiscated and flushed down the toilet.

There is a man handcuffed to a stretcher next to the triage room, asleep. He has a few bruises on his face, and his clothes are torn and dirty. His twisted body and sprawled legs give him the unnatural appearance of someone who has been medically induced into sleep. The cops I saw in the hallway are sitting in the chairs watching him. They look uneasy.

One of the nurses lets me in through a locked door into the triage room, grumbling about how "those interns really need to get their own keys." I scoot past her and head to where the doctors, medical students, and social workers are already gathered and talking about their patients.

"Sorry," I whisper as I sit down in the last available folding chair.

"Nice of you to join us," the attending psychiatrist, Dr. Leon, says to me.

"I was stuck in the hallway for about fifteen minutes," I say defensively. "The officer wouldn't let me in."

"Oh yeah," says Dr. Leon, softening. "That was the NYPD case. Spitting and fighting. We had to 5 and 2 him." Although I am new to psychiatry I've already heard these numbers on the medicine and neurology wards referring to 5 mg of Haldol and 2 mg of Ativan, a typical cocktail of intramuscular medications given to patients who are aggressively agitated. "Should be awake in a few hours, and then we can get him out of here."

I am too new and too afraid to ask what I am thinking: *What if he needs to be in the hospital?* I listen to the rest of the report and notice that Dr. Leon assigns himself the NYPD case; the patient's name is James. Patients like James get brought in for all kinds of reasons—from

requesting Ritalin to trying to hang themselves in the precinct house. The cops know that they could be sued—or fired—if someone in their custody is denied medical or psychiatric care, even if the request is for a pill that the "perp" hasn't taken for 20 years. Most of the doctors don't want to assess the NYPD patients; there are so many of them, thousands per year, and only a very small percentage get admitted to the hospital. Dr. Leon is trying to keep his psychiatrists happy by picking up the case. I ask if I can tag along.

Hours later, close to the end of the shift, we go to see James. He is still groggy from the medication but alert enough to answer questions. He's been charged with second-degree assault, the cops say, because he punched a stranger on the subway. I listen to Dr. Leon ask James a rapid-fire set of standard questions.

"How come the cops brought you to the hospital?"

"Don't ask me," James replies gruffly.

"Do you take psych meds?"

"Someone gave me some of those once, but I don't take 'em. Don't need 'em."

"Ever been in the hospital before?"

"Check the record, man. I been here a hundred times before."

"Are you suicidal?"

"No."

"Do you want to hurt anyone else?"

"Just those cops who roughed me up."

"Are you hearing voices?"

James laughs. "Just yours."

A few other basic questions follow, and Dr. Leon and I return to the doctors' area. We don't have James's medical record to see if he's been admitted or evaluated here before—this was in the days before computerized medical records.

"This is the form you have to fill out to give to the cops for arraignment," says Dr. Leon. I have no idea what "arraignment" means, so Dr.

Leon gives me a doctor's explanation: it is the hearing where James sees a judge for the first time and gets an attorney. The form says that James has been "psychiatrically cleared for arraignment" and doesn't need to be admitted to the hospital.

"How do you decide if he's OK for arraignment?" I ask.

"It's a really low threshold—basically, whether he can stand up in front of the judge and whether he can keep from hurting himself or anyone else in the courtroom."

I am too naive to know that this is just a CPEP definition that evolved because there is no legal definition of "stable for arraignment." I watch as Dr. Leon hands the paperwork to the cops, tells them James can go, and heads to the next patient on the list. I think about the way James presented—arrested for a stranger attack—and the need for a body bag and heavy tranquilizers to calm him down, the short, clipped answers about medication and hospitalizations. There is more happening with James than the quick assessment revealed. But after he heads out the CPEP door to the waiting NYPD squad car, I never see him again.