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Changes at Psychiatric Emergency Service at Cambridge Hospital

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To the Members of the Cambridge City Council:

For the past fourteen years, I have worked as a staff psychiatrist at the Psychiatric Emergency Service (PES) at Cambridge Hospital. Two weeks ago, in response to the plan to move the PES to the Emergency Department (ED), I resigned, saying that the safety of patients, staff, trainees, and students would be jeopardized.

I have brought up many concerns with the administration. To summarize:

1. There is not an adequate plan in place for how all patients at risk of harming themselves or others will be kept under constant observation. PES staff currently provides this service. In the ED, Public Safety officers will be responsible. However, there are only five of them scheduled per shift, and they are frequently called to other parts of the hospital. I have been told that there will always be at least one officer in the ED, which, knowing how acute the service can become, is not a reassuring number.
2. The two rooms being set aside for highly agitated psychiatric patients are located right next to the ambulance bay, one of the busiest exits in the ED. They are not observable from the nursing station and not fitted with video monitors or panic buttons.
3. The reduction in staffing is drastic. Currently, five mental health clinicians are regularly scheduled for daytime shifts in the PES. In the ED, that number will be reduced to three and, quite frequently, two. The number of patients being seen will not be any less, so it is unclear how the work is going to be done.
4. A large percentage of the care delivered in the ED will be psychiatric. It would make sense for psychiatric nurses to be part of the team, but that will not be the case. Instead, all PES nurses, who up to this point have been the backbone of the service, will be laid off, taking with them years of experience.
5. It has been a common practice in the ED to put psychiatric patients in beds 5,6,7, and 8, which are all located in a single small room, separated only by curtains. When the PES moves to the ED, this will happen to an even greater extent, raising very concerning questions about privacy. The administration has said that any clinician wanting to move a patient from one of these beds to a private room will be

able to do so. But how that is actually going to happen when the ED is busy, with patients spilling into the hallways, is unclear.

6. The PES has always had its own phone line, with clinicians readily available to take calls 24 hours a day. It is frequently the first few minutes of contact with a patient in crisis that will determine the outcome of the case. On many occasions, the PES team has had to coordinate keeping a suicidal or homicidal patient on the line while tracing the call and contacting the police and EMTs, all so that person can be safely brought in from the community for evaluation. Under the proposed plan, all calls would go to a "behavioral communications center" staffed by just one person per shift, who would not have clinical training and would be responsible for many other administrative calls about insurance matters, etc. This person would be put in the position of deciding which calls would be forwarded and then locating a busy clinician located in the ED to take the call.

The "integration" of the PES and the ED is being put forward as a way to improve the quality of care. Based on my experience, however, I would instead predict:

1. An increase in the risk of patients harming themselves in the ED.
2. An increase in the risk of patients (most of whom are being assessed for suicidality and/or homicidality) eloping from the ED.
3. An increase in the use of chemical and physical restraints in the ED.
4. An increase in the risk of assaults in the ED. (Of note, the doors separating the pediatric and adult areas of the ED are always kept open.)

The problems with the proposed plan should be obvious. In fact, the administration has been informed of everything I have written above. So what is the justification for the move? Apart from the reduction in operating costs, the answer seems to be — this is how it is done everywhere else, "pretty much an industry best practice" as a Cambridge Health Alliance spokesman recently put it. That statement is highly debatable. First, there is growing awareness that treating psychiatric patients in traditional emergency rooms is very problematic. A December 25, 2013 article in *The New York Times* entitled "E.R. Costs for Mentally Ill Soar, and Hospitals Seek Better Way" attests to this. Second, though many hospitals use a consultation model for emergency psychiatry, the implementation is often far more sophisticated than what is being discussed here. Certainly, that is the case for teaching hospitals in the Boston area. For instance, at Beth Israel Deaconess Medical Center there is a specific zone of the emergency department designated for psychiatry, with specially designed rooms, psychiatric nursing staff, and readily available sitters to monitor patients. Cambridge Hospital might seem to be too small to require these sorts of resources, but the number of psychiatric emergency visits there is actually quite large, a total of 5000 per year when the PES and the ED are combined. Compare that to 6000 per year at Massachusetts General Hospital — which has a separate, well-staffed, state-of-the-art emergency psychiatry service — and one begins to see just how irresponsible the plan to move the PES to the ED really is.

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