Emergency!! Or is it?

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1:00 A.M.; May 21st

Psychologist Dr. Mason had had a long day. It was around 1:00 a.m. and she had finally returned home. There was the usual work she did on a day to day basis; grading papers, helping at the university’s psychiatric clinic, reading psychology articles; but on this particular Tuesday Dr. Mason had dealt with even more. Dr. Mason had just returned from the Emergency Department at her local hospital, Middle Point. She had been there to support a patient of hers, Cameron. Dr. Mason sat at her kitchen table, drinking a cup of tea, and she thought back on the experience she had just encountered at the hospital. Dr. Mason and her colleague Dr. Lambert had taken a patient to the Emergency Department (ED) because of suicidal ideations. Their patient had been treated with disdain by the ED staff, inadvertently given tips on how to commit suicide, and kept waiting for over six hours before being admitted in the psychiatric wing of Middle Point Hospital. Dr. Mason thought to herself, if the treatment of a mentally unstable patient was like this in Middle Point Hospital’s ED, could it be like this in similar healthcare facilities?

5:00 p.m.; May 20th

It is a brisk fall afternoon when Joshua, a clinical psychology graduate student at Hamilton Jones University (HJU), received a phone call from Cameron, a distraught patient. Joshua worked in the university’s psychiatric clinic as part of his graduate training, which included helping treat patients with mental instabilities including but not limited to depression, anxiety, and stress. Cameron called him describing what Joshua diagnosed as suicidal behavior. The patient’s voice sounded distraught. Cameron had shown signs of suicidal ideations before in therapy sessions and had attempted suicide once before becoming a patient at this clinic. Cameron was being treated using psychotherapy methods such as therapy sessions for depression and anxiety at HJU’s clinic. Joshua never dealt with a suicidal patient and reached out to one of his supervisors Dr. Lambert for help treating this patient, which was the appropriate action to take.

A Broken Contract for Safety

Every new patient at the clinic completes a BDI (Beck Depression Inventory) that measures the patient’s depression levels. One item on this test indicated the level of suicidal risk on a scale of
0 (none) to 2 (high risk) and Cameron who had taken the BDI on multiple occasions consistently rated suicidal ideations as a 2. Suicidal ideation is the medical term for thoughts of ending one’s life and can vary between passing thoughts to thorough planning or attempts. Suicidal behaviors or thoughts, which are closely connected to suicidal ideations, are most often associated with depression as well as other psychiatric disorders. The clinic at Hamilton Jones University did not have a set protocol for suicidal patients because each patient was different and must be treated as so, which is appropriate, but in most suicidal cases a “Contract for Safety” would be set up. A Contract for Safety is a list of ways patients can seek help if there are any thoughts of suicide and it can include calling a 24 hour suicidal hotline, practicing relaxation methods, or talking to a trusted friend. Cameron was in a bad state of mind and when Cameron called Joshua, Cameron told the graduate student that the contract for safety would be broken if there was no immediate help.

Joshua called in one of his supervisors, Dr. Lambert, to ask for help because he felt that this situation was beyond his scope of practice. Dr. Lambert talked to Cameron and was able to get the patient to agree to meet at the nearest emergency department (ED) at Middle Point Hospital. Since one of the means of harm for Cameron was to purposely get in a car accident, Dr. Lambert asked Cameron’s roommate to drive to Middle Point Hospital. In her experience Dr. Lambert knew that having an ambulance pick up the patient would be stressful and could hinder the treatment process. As Dr. Lambert packed up to leave the clinic she ran into Dr. Mason, a fellow colleague in the psychology department at Hamilton Jones University. Dr. Mason asked Dr. Lambert if it would be okay if she came as well thinking it would be best for there to be two supporters with Cameron. Dr. Mason told Dr. Lambert that the emergency visit would take a long time, much longer than Dr. Lambert suspected, and that Cameron would need a support system at all times. Dr. Lambert had just recently visited the emergency department at Middle Point Hospital with chest pain and had been admitted in less than ten minutes since it was such a high risk emergency (see treatment protocol in Appendix A), so she though the same would be done with Cameron. Even though Dr. Lambert thought that since Cameron’s situation was a high risk emergency and the patient would be admitted almost immediately, she accepted Dr. Mason’s help. They left for Middle Point Hospital and arrived at the ED at around 6:00 pm that Tuesday evening.

6:00 P.M.; May 20th Middle Point Hospital

Dr. Lambert and Dr. Mason met Cameron at the emergency department and got the patient checked in. Dr. Lambert told the ED staff that Cameron was actively suicidal and needs to be hospitalized. Thirty minutes pass and Cameron was given a private waiting room. Both Dr. Lambert and Dr. Mason knew that separation gave Cameron anxiety so they stayed in the room as well. They were in the room for about 2 hours without being seen by any member of the medical staff. Outside the room sat a young volunteer, probably high school age, whose job seems to resemble that of a hall monitor. She sat outside the room just in case the patient tried to leave and then the volunteer would intervene, not with physical force but by talking to the patient. The volunteer pulled Dr. Mason aside during their wait and tells her that it was really helpful to have them there. Dr. Mason and Dr. Lambert try to keep Cameron engaged during the long wait by chatting and playing games such as tic-tac-toe and hangman. It is evident that Cameron was becoming frustrated at around 7:00. Cameron looked at Dr. Mason and asked
“Why did I even come here? No one has come to see me yet, can I just go home now?” Dr. Mason persuaded Cameron to stay for a little while longer.

After the two-hour wait Cameron was taken into an exam room with a physician and a nurse. Cameron asked if Dr. Lambert and Dr. Mason could come with them and the physician obliged. The physician and nurse are a part of the emergency department staff and will screen Cameron for suicidal behavior. The questions the physician ask were appropriate but the manner in which they are given was very harsh and direct. For example, the physician started the conversation with the question “Oh, so you’re thinking of killing yourself?” When asked how Cameron wanted to commit suicide the patient told them that overdosing on prescription medications may be an option. “Do you have those medications?” the physician asked, seeing if Cameron had easy access to means of suicide. The questions were asked in a hurry and Dr. Mason thought that the physician and nurse seemed to be in a rush and that maybe they believed there are more important patients waiting. Nonetheless, after the rushed assessment, the physician called for a psychiatry consult.

8:00 P.M. May 20th

While Dr. Mason waited, she recalled a recent article she read. This article included three best practices a medical facility should exercise when treating patients with mental conditions (see Appendix B). The three practices Dr. Mason remembered were decreasing the amount of time these patients spent waiting, have an appropriate screening process for these patients, and having proper follow-up care.

After another hours’ wait a pharmacist entered the exam room to talk to Cameron. She asked Cameron what medications Cameron had been taking and from what pharmacies the medications were coming from. “I get my medications from different pharmacies.” Cameron told the pharmacist. This baffled the pharmacist and worried her. “You should start getting your medications at the same facility, Cameron. You never know what kind of interactions the drugs can have with each other. Something could go wrong and you could die!” Cameron looked at Dr. Mason with a smirk. Dr. Lambert and Dr. Mason wondered if the pharmacist knew why Cameron was there in the first place. Hopefully a staff member of an ED would not have said that to a patient if they knew the patient was there for suicidal ideations. Nonetheless, the pharmacist unintentionally supplied Cameron with another way to commit suicide.

9:00 P.M. May 20th

Dr. Mason believed that the admission process of a patient, or patient flow, could have been improved at Middle Point Hospital. She believed that the entire premise of effective patient flow in a healthcare facility, especially one as hectic as an ED, is that the patient’s received quality care in a timely manner and the staff could effectively work as a team, one that spread past the ED and encompassed the hospital as a whole. Dr. Mason did not see effective patient flow in Cameron’s case; the patient had already waited for what most believed to be a long time and the staff did not seem to be working as a team seen by the pharmacist’s remarks and not being knowledgeable of Cameron’s chief complaint.
Two hours after the pharmacist questioned Cameron, a psychiatric resident finally entered the room. She asked Dr. Mason politely to wait outside the door while she and Cameron talk. The resident called Dr. Mason back into the room later and told her and Cameron that she, the resident, thought it would be highly beneficial for Cameron to be admitted into the psychiatric wing to become stabilized. The resident’s tone and demeanor was appropriate and warm. It was visible that Cameron felt more comfortable around the resident compared to the physician or pharmacist. Cameron was admitted to the hospital; Dr. Mason left the Emergency Department around midnight, after more than six hours.

**Major Issues**

Looking back at the experience that night, Dr. Mason was troubled with the thought that Cameron’s case was not an exception, but that many mentally unstable ED patients are treated this way. Dr. Mason assumed from this experience that members of an ED staff are not familiar with mental instability cases such as Cameron’s. The questions that keep bothering Dr. Mason are why were they not familiar with such emergencies? Could patient flow have been improved in this experience? Was Cameron treated ethically during her visit? Shouldn’t there have been a set protocol for patients like Cameron? This bothered Dr. Mason and even the calming tea she drank could not help her fall asleep that night.
Appendix A

Chest Pain Protocol in the Emergency Department

The standard “Door-to-Balloon” time (or arrival to angioplasty time) in the emergency department for patients presenting with chest pain or heart attack is 90 minutes. The driving force behind this protocol is to save as many lives as possible. This protocol is only successful when it is a team effort between a multitude of staff members including physicians, nurses, EMS, medical technicians, laboratory technicians, pharmacists, and even administration.

A patient who arrives in the emergency department (ED) with chest pain must undergo a number of items within ten minutes after arrival. Within the first ten minutes the patient must:

- Be triaged
- Have history taken
  - Focus on pain duration and past history of heart disease risk factors
  - Some patients may present with atypical symptoms
- Receive aspirin and nitroglycerin
- Have an IV line established
- Have blood obtained for lab work
- Start EKG monitoring
  - Results should be immediately shown to the ED physician
- Be given oxygen therapy
Suicide is a prevalent issue in today’s society. Every year in the U.S. around 800,000 people attempt suicide and about 30,000 attempts result in death, calculating to one suicide every sixteen minutes (Giordano & Stichler, 2009). In 2009, death from suicide surpassed the number of deaths from car crashes (Centers for Disease Control [CDC], 2010). Suicide is the eighth leading cause of death in the United States and is the third leading cause of death for people aged 15-24 years old (Giordano & Stichler, 2009; Perhats & Valdez, 2008). These numbers continue to increase each year.

This is a huge concern for general acute care hospitals because most commonly patients who attempt or contemplate suicide have been treated in the emergency department prior to their fatal attempt (Knesper, 2011). Some patients seek treatment in the emergency department (ED) for injuries rather than mental health services while others seek mental health treatment by coming to the ED. The concern is that not every patient is screened properly for suicidal thought and intent and many tend to leave without being seen by a mental health professional; some who are contemplating suicide might subsequently attempt it.

In 2002, 438,000 ED visits were for self-harm injuries and 116,639 of these visits were confirmed suicide attempts (Perhats & Valdez, 2008). ED staff should treat the physical damage but must also follow up with a psych consult or referral, but not all staff are trained in suicide assessment and prevention, and may not be familiar with the signs and symptoms of a suicidal patient. The emergency department is a prime location for suicide prevention because it serves as a primary care provider for the uninsured (Giordano & Stichler, 2009). This is relevant because there is a positive correlation between suicide attempts and financial difficulties. These departments are also an important location for early identification of suicide risks because the staff encounters many people with mental illness who are looking for referrals for treatment and they go to the ED. It has been estimated that 90% of those who attempt suicide have a mental illness (Perhats & Valdez, 2008).

Emergency departments have a great number of patients who are also being treated for injuries resulting from self-harm. It is important to follow up with these patients to ensure that they receive the help they need. A study found that within 5 years of a suicide attempt and visit to the E.D. 37% of patients made another attempt, and 7% died in result to self-harm (Knesper, 2011). Although death by suicide captures our attention, emergency department staff needs to focus on the actions leading up to a suicide death, then they can learn the risk factors and signs of a person contemplating self-harm. There are many missed opportunities in suicide prevention that could be taken during an emergency room visit (Perhats & Valdez, 2008). Patients who attempt suicide and are not successful do not usually get the follow up care they need, and are at an increased risk for completing suicide in the future.

It has been concluded that the emergency department is a key place to divert more people from suicidal actions. The most effective intervention the ED can use in the prevention of suicide are means restriction, follow up care, education, appropriate screening for suicidal intent, and an active referral to a mental health professional in a short time frame. If used properly, the education and active care a patient and his or her family receive can save lives.
References


Knesper, D. J., American Association of Suidiology, & Suicide Prevention Resource Center. (2010) Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. Newton, MA: Education Development Center, Inc.