A Double Standard of Care for Mental and Physical Illness — The Story of Esmin Green

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In the common parlance of the Internet, the video of Esmin Green's dying hour “went viral” in a matter of days. Nearly 2 million viewers saw some version of it on YouTube alone, and countless others on CNN.com and other news sites.

The scene is a waiting room. A woman walks in and sits down in one of the chairs lining the wall. A few minutes later, she rolls off the chair and lands on the floor, face down. For the next 20 minutes, people walk in and out of the room or sit in chairs against the wall, taking no notice. A security guard walks in, looks at the figure on the floor, and walks out.

The woman writhes on the floor, makes vain efforts to stand, and falls back on her face, her head beneath the row of chairs against the wall. Finally, 35 minutes after she fell off the chair, she stops moving. A security guard rolls his chair into the room, looks at the body on the floor from across the room, and rolls back out of view.

More than hour later, a woman wearing a yellow jacket comes into the room and pokes the still form on the floor with her foot. She reaches down and prods the body with her hand, then walks away. Minutes later, she returns with a woman in white, who also reaches down and tries to turn the woman on the floor. Then the women leave, and the security guard rolls in on his chair for another look.

The woman in white returns. She is pulling a gurney and is accompanied by other medical personnel. They begin ministering to the fallen woman, working on her for the next half-hour.

All of the action was captured on security cameras in the waiting room of the psychiatric emergency department (ER) at Kings County Hospital Center in Brooklyn, NY. The woman, Esmin Green, had been admitted to the department at 6:50 am on June 18. She died on the waiting room floor 36 hours later while still waiting to be assigned a bed.

Nursing notes published after the release of the security videos recorded that Green was ambulatory and up and about at 6 pm, when the video showed her lying on the floor. According to the notes, she had gone to the bathroom. Twenty minutes later, the notes recorded vitals that appeared to be within normal ranges. The video does not show anyone checking Green’s blood pressure or respiration at the time indicated on the chart.

The coroner later found that Ms Green died of deep venous thrombosis brought on by an extended period of physical inactivity.

Officials of the New York City Health and Hospitals Corporation (HHC) did not respond to Psychiatric Times’ request for an interview for this story. But previously, they announced the suspension or termination of 6 hospital employees in connection with Green’s death. On July 1, they announced, “As a result of this tragic incident, we will put into place additional and significant reforms to help ensure that the care and safety of psychiatric patients under our care is not compromised.”

They also listed “recent and future reforms for Kings County Psychiatric Emergency Program.” These include additional staffing and training and a program aimed at reducing the waiting time for psychiatric beds.

A week later, HHC President Alan C. Aviles said, “We failed Esmin Green and believe her family deserves fair and just compensation. HHC referred this matter to criminal enforcement and regulatory authorities on June 20. We have been cooperating and will continue to support any and all investigations.”

Kings County Hospital Center has a troubled history. A lawsuit filed by the New York Civil Liberties Union (NYCLU) and 2 other patient advocacy groups in 2007 described the psychiatric ER and inpatient unit as “a chamber of filth, decay, indifference, and danger.” According to a press release
from NYCLU, “Patients are regularly ignored and those that dare advocate for themselves are punished with forcible injections of psychotropic drugs.”

Later that year, radio station WNYC reported that “Kings County has been the most sued hospital in the city’s public health system by a wide margin,” adding that HHC had paid “about $60 million for Kings County lawsuits over the last 2 years.” That figure represented one-third of the total amount paid for malpractice suits by the hospital system during that period.

As shocking as the Kings County story is, mental health professionals and advocates for the mentally ill worry that it overshadows a more fundamental problem: a double standard of care for mental and physical illness.

“It’s unlikely to imagine a person waiting for a cardiac bed for 24 hours and being ignored,” said Ken Duckworth, MD, who is medical director of the National Alliance on Mental Illness. “We as a society have to ask ourselves, how do we allow such a disparity in the quality of care for people with psychiatric illnesses? How can this happen for the people we serve in psychiatry?”

“Esmin Green was involuntarily committed and was waiting for admission to a psychiatric unit. She was, in the eyes of the world and the ER staff, a ‘mental patient.’ This is a status that no one should ever have. It’s a stigma that leads health professionals to lose interest in or to outright abuse the person,” blogged author and psychiatrist Peter Breggin, MD, on Huffingtonpost.com.

“As soon as a patient mentions he has a psychiatric illness, that comes first in the eyes of the ER staff,” added Tony Ng, MD, assistant professor of psychiatry in the Uniformed Services School of Medicine at George Washington School of Medicine, and president of the American Association for Emergency Psychiatry. “That’s one of the biggest concerns we have. Just because you’re a psychiatric patient, you can still have medical issues. They shouldn’t be minimized. In a lot of cases, staff assumes that just because he’s a psychiatric patient, he doesn’t know what he’s talking about. They do not do the same kind of workup they would do if he weren’t a psychiatric patient.”

Lisa Halpern, MPP, director of Vinfen Corporation’s Dorchester Bay Recovery Center, coauthored a chapter in the book Emergency Psychiatry with Dr Duckworth.1 She wrote about the experience of a psychiatric patient in the ER from a unique perspective: that of the patient.

“In 2006, at the recommendation of my general practitioner,” she wrote, “I entered the emergency room of a top-notch teaching hospital with a painful physical ailment. Although I have schizophrenia, I did not come to the ER for psychiatric complaints, only physical ones.”

However, when she mentioned her history of schizophrenia, the hospital staff ushered her into a locked room, took away her clothes, and brought in a sitter to stay with her. Halpern told Psychiatric Times that she waited 4 or 5 hours to be examined for her physical complaint. “I was just fortunate I did not have a life-threatening ailment at that time,” she said.

“From my own experience, there definitely is something systemically wrong that needs to be fixed in the emergency room,” she said. “ERs have a systemic need to classify people—this person to this group, that person goes over there. It’s difficult when someone presents who doesn’t fall into a particular category. They can fall through the cracks.”

She said her experience led her to conceal her psychiatric history on subsequent visits to the ER, with the potential risk of “sabotaging my own care. I didn’t fit into the schizophrenia category because I had a physical ailment, and didn’t fit into the physical category because I have schizophrenia. I took a lot of chances with my care. I was fortunate to get out okay.”

“Esmin Green’s story is tragic—a human life was lost. The macro view is that she’s not alone, and that’s tragic. It’s not just her story, it’s other people’s stories too. It just had the light of publicity on it. We need to shine the light on it, and be with it as painful as it is, and honor her memory as best we can.”

References:

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