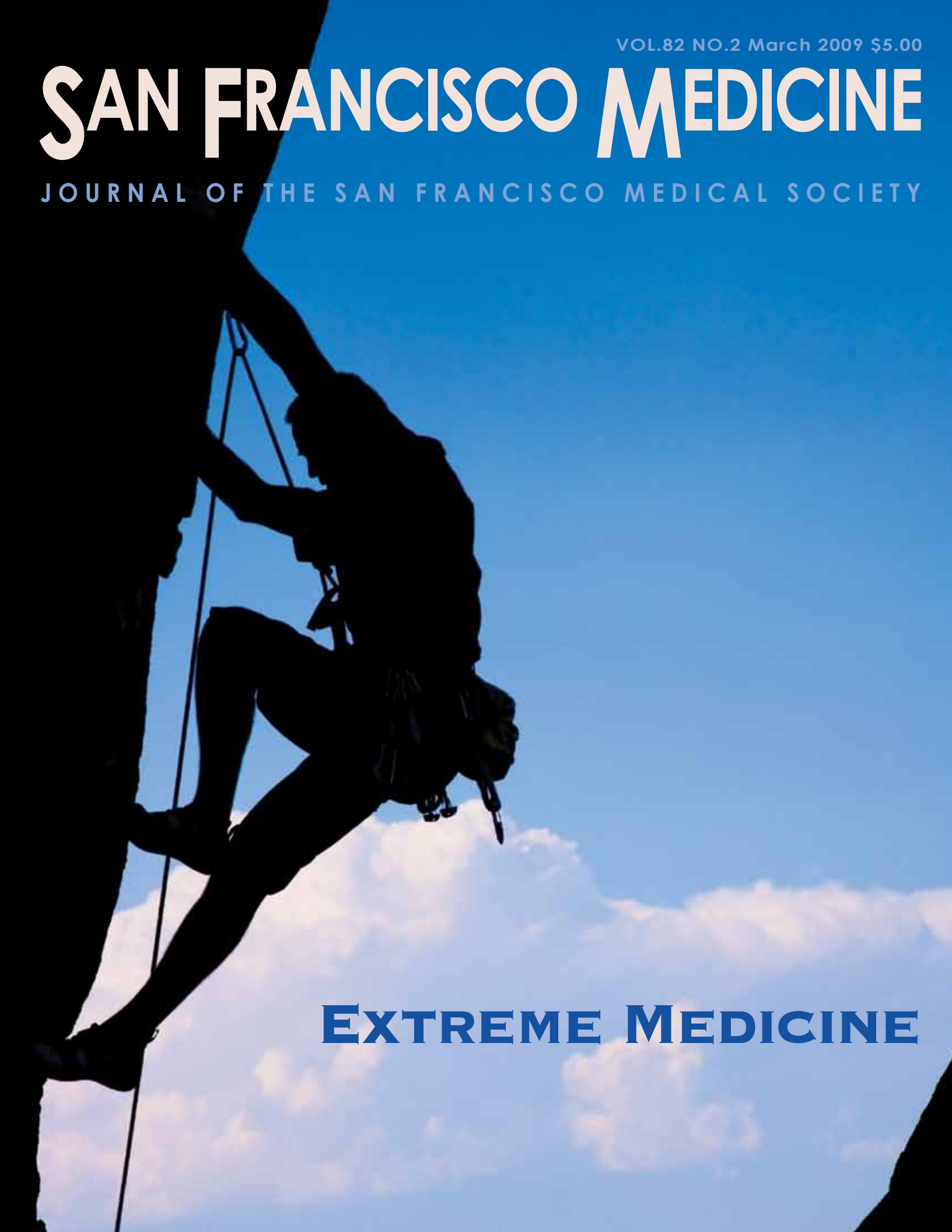
VOL.82 NO.2 March 2009 $5.00

SAN FRANCISCO MEDICINE

JOURNAL OF THE SAN FRANCISCO MEDICAL SOCIETY



Extreme Medicine

SAN FRANCISCO MEDICINE *March 2009 Volume 82, Number 2*
Extreme Medicine

FEATURE ARTICLES

10 After Shock
Mark Renneker, MD

12 In the Hurricane's Trail
Toni Brayer, MD

14 The Real ER
Malini K. Singh, MD, MPH

15 Superbowl Surgery
Daniel Marelli, MD, and David Bona, PhD

17 A Day in the Life of PES
David Elkin, MD; Paul R. Linde, MD; and Eric Woodward, MD

20 Straight from the Emergency Department
Brian McBeth, MD

21 Relative Risk
Robert Liner, MD

23 Mavericks, Missionaries, and Misfits
David K. Becker, MD

25 Rock Medicine
David Smith, MD, and Glenn "Raz" Raswyck, EMT

27 Rodeo Medicine
Dale J. Butterwick, CAT(C), and Mark A. Brandenburg, MD

29 Medicine and the Indy 500
Geoffrey L. Billows, MD, FACEP

31 Space Medicine
Karen Miller

33 Expedition Inspiration
Kathleen Grant, MD

35 Confessions of an Extreme Athlete
Daniel Bikle, MD, PhD

MONTHLY COLUMNS

4 On Your Behalf

7 President's Message
Charles Wibbelsman, MD

9 Editorial
Mike Denney, MD, PhD

43 Hospital News

46 Classified Ads

46 In Memoriam
Nancy Thomson, MD

SPECIAL SECTION

40 SFMS 2009 Annual Dinner

Editorial and Advertising Offices
1003 A O'Reilly
San Francisco, CA 94129
Phone: 415.561.0850 ext.261
Fax: 415.561.0833
Email: adenz@sfms.org
Web: www.sfms.org

Subscriptions:
$45 per year; $5 per issue
Advertising information is available on our website, www.sfms.org, or can be sent upon request.

Printing:
Sundance Press
P.O. Box 26605
Tuscon, AZ 85726-6605

A Day in the Life of PES

Twenty-Four Hours at the Psychiatric Emergency Services Department of San Francisco General Hospital

David Elkin, MD; Paul R. Linde, MD; and Eric Woodward, MD

It's 7:00 a.m., and a group of a dozen men and women—psychiatrists, social workers, nurses, and other mental health personnel—are gathered around a desk in the staff room, performing the daily ritual of the morning report in the Psychiatric Emergency Service (PES) at San Francisco General Hospital. A glowing LCD screen—one of few high-tech devices in an otherwise outdated and unadorned space—displays patients' names, diagnoses, and lengths of stay. Almost all of the twenty patients (an average case load) are in PES on an involuntary basis.

The State of California's Welfare and Institutions Code 5150 provides the legal justification for a person to be involuntarily taken into custody for up to seventy-two hours for an evaluation on the basis of being a danger to self, danger to others, and/or gravely disabled on the basis of a psychiatric illness. The PES at San Francisco General is open for business 24 hours a day, 7 days a week, 365 days a year. It is the only designated receiving facility in the city for people placed on 5150 psychiatric holds.

Often, working in PES can be compared to diving into the swirl of a cyclone and hanging on for dear life. The staff adjusts to the velocity and spin enough to manage as many as four equally compelling tasks at the same time. It helps to come equipped with an unusual combination of keen diagnostic skills, a sense of humor, tolerance for ambiguity, and the ability to react quickly to changing circumstances.

The environment in PES is custom-designed to manage psychiatric emergencies. Generally, two nurses sit behind the triage desk, a crescent-shaped structure facing toward four seclusion rooms, each with a heavy metal locking door and each containing a steel bed equipped with four restraints, one per extremity. To the right of the desk is the triage area, which is accessible from the outside corridor by set of double locked doors. This is where the police and paramedics enter to bring in patients from the streets. To the left of the desk is the sprawling "day room," which should really be called the "24/7" room, in which patients sit and sleep on pull-out chairs. Behind the desk, separated by a wall with two doors, is a cramped staff room.

"The PES at San Francisco General is open for business 24 hours a day, 7 days a week, 365 days a year. It is the only designated receiving facility in the city for people placed on 5150 psychiatric holds."

Some of the patients who were asleep in the day room are waking now, interrupting the report as they come to the desk to ask for medication or other requests. But the staff is busy discussing the clinical condition and disposition plans for each patient, some of whom were admitted over the night shift. This space is not secure within a Plexiglas "fishbowl" like many psychiatric units but is instead open to the patients, except for a modest counter and half-door about four feet high. Patients do wander in from time to time, and at least two have been known to jump the wall in a single bound—once a patient punched a nurse, and another was able to escape out of a slightly ajar first-story window. The staff is alert to signs of agitation as patients approach the nurses' station. Unlike other psych ERs, PES has no full-time security guards. Instead, police officers detailed to the medical ER and the hospital must be summoned for emergencies.

The staff is keenly focused on the task when there is a loud interruption: the arrival of a new patient. The front entrance to PES requires a key to get in and out, unless you are buzzed through a double set of doors. Before police officers enter, they check their guns into a small locker—similar to a bank safety-deposit box—built into the wall outside the front door. This time, the charge nurse pushes the buttons to admit two uniformed SFPD officers. They enter through the double doors, struggling with an agitated young man in handcuffs. The man, who has multiple piercings and tattoos, strives to slam his head against the wall. He is emaciated and his teeth are jagged lumps, his pupils are saucer-sized, his brow moist, his eyes darting up into corners and then off into space, his left antecubetal region bruised and swollen.

He mutters and smiles oddly, pausing only to take momentary stock, assumes a vigilant stance and then begins shouting again with renewed vigor.

Continued on the following page ...

"Try to calm down," says the psychiatrist from a few feet away, deferring eye contact, speaking softly. "No one is going to hurt you here. This is a safe place. How about taking some medication to take the edge off? You seem pretty wound up."

"No—you're going to poison me!"

The man begins screaming and flailing again, attempting to head-butt one of the officers.

"He's going to have to be in points, and I'll write for emergent meds," says the psychiatrist, above the din.

After the handcuffs are removed, the young man is restrained supine on a clean white sheet, his four extremities secured to Velcro/polyester restraints tied to a metal bed bolted to the seclusion room floor. He is given an IM injection of antipsychotics and benzodiazepines—California law specifies that patients can refuse medication, pending a hearing, but emergent medication is permissible when patients present an imminent threat to themselves or others. His toxicology screen later comes back positive for methamphetamine. His left arm findings suggest an intravenous route of administration.

There's no time for the staff to debrief about the incident; there's work to be done. Patients need to be evaluated to see whether they can be discharged or need admission. Paperwork needs to be completed on each patient. The computer database in PES keeps things organized, with information easily accessible, but entering the information on each patient is a time-consuming task for the staff.

Disposition is critical; PES is a small space, and patients must be either released for outpatient follow-up or admitted to an inpatient psychiatric unit within twenty-four hours. Some 500 to 700 patients are seen in PES each month, more than 7,000 patients in a given year. This does not include the significant number of patients who self-present and are turned away, or the hundreds of consults to the medical ER each year. Psychiatrically acute patients who are suicidal or psychotic and have MediCal, MediCare, or private insurance can be transferred for admission at other hospitals.

The disposition of acute patients without insurance is more problematic. Budget cuts to SFGH have reduced the number of inpatient psychiatry beds from approximately eighty to forty. It is no longer possible to admit all patients who might need admission; the staff members, who have also been affected by budget cuts, are left to place patients in whatever outpatient resources are available. It is like playing musical chairs with fewer chairs.

By noon, a half-dozen patients are discharged, but still new patients fill their places. Among the new patients are a man brought from the Golden Gate Bridge, stopped by police before he could jump off; an HIV-positive patient who was stopped by roommates before he took an overdose of medication; a man with schizophrenia who was threatening his parents. The staff needs to quickly assess each patient's clinical condition and treat them. Many of the patients have medical problems as well: diabetes, hepatitis B or C, and other illnesses. Psychiatric diagnoses do not confer immunity to medical problems, and it is up to the PES psychiatrists to treat these too. Sometimes patients are not medically stable and need to be transferred to the medical ER.

But now the medical ER is calling for a consult: a patient with borderline personality disorder is receiving stitches for self-inflicted lacerations to his wrists. A PES psychiatrist evaluates him for suicidality; he is given a referral and allowed to leave, but another patient who has been medically cleared after an acetaminophen overdose is still suicidal and is transferred to PES. The methamphetamine-intoxicated man who was brought in earlier is now out of restraints, groggy but able to be interviewed. Now, at 7:00 p.m., the mix of patients include those who were "new" twelve hours ago along with those who have just arrived, the new "new" patients.

PES is a noisy place. Staff who work there become habituated to a certain dose of cacophony. PES is licensed by the state to hold and observe patients for up to twenty-four hours and not to exceed a maximum capacity of eighteen patients. Sometimes, however, patients are confined for two or three days as they wait for inpatient beds, and the census can jump into the mid-twenties. What else can be done with psychiatrically unstable patients who are not safe to leave and have nowhere else to go? There is a diversion policy of sorts, referred to as Condition Red, when police bring involuntarily detained patients to private hospital emergency rooms in the city. But this system can result in a backup of patients at other hospitals.

Psychiatrists who work at PES occasionally situate themselves in front of the nursing station—insinuated between the shift's charge nurse and the doors of our four seclusion rooms. They are one-part psychiatrist, one-part primary care doctor, one-part traffic cop, one-part stand-up comedian, and one-part maître d'. The role strain can be challenging; fewer than half of the doctors who work here make this their full-time job, and fewer still work here for more than ten years.

By 10:00 p.m., things appear manageable again. Many of the patients are settling in for the night or are asleep. But an hour later, the police bring in an agitated man who was running naked in the street, yelling at cars. He is clearly intoxicated—the staff is guessing alcohol plus cocaine. He is medicated and placed in the last of the empty seclusion rooms. Another half-dozen patients arrive by 3:00 a.m., and the charge nurse decides to call an official red alert. During the rest of the night, the new patients are worked up and several become stable enough for transfer to private hospitals. Another patient is lethargic, with a low 02 saturation, and is transferred to the medical ER. The staff continues its work, and before long the frosted windows in the staff room brighten to a light grey.

It's 7:00 a.m. once again, and the staff gathers to perform the ritual of the morning report. This time there are no interruptions, and another day officially begins smoothly. The staff knows that it won't be long before the pace increases again, but for now it's nice to have a quiet start. sfm