March 22, 2007

Charles Abbate, Esq.
Vermont Protection & Advocacy, Inc.
141 Main Street, Suite 7
Montpelier, VT 05602

RE: Response to Report Concerning Emergency Department Treatment on August 6, 2006

Dear Mr. Abbate:

Fletcher Allen Healthcare ("Fletcher Allen") welcomes the opportunity to respond to the concerns that Vermont Protection & Advocacy ("VP & A") has raised in regard to the care provided to a patient in the Fletcher Allen Emergency Department ("ED") on August 6, 2006.

Fletcher Allen is committed to partnering with VP & A to achieve our common goal of ensuring that individuals who have been diagnosed with a mental illness are provided high quality, respectful care. We have reviewed this report in that spirit of collaboration and have carefully evaluated the findings and recommendations as part of our ongoing efforts to provide the best possible care for our patients.

At the outset, it is important to note that the actions of our staff in regard to the situation analyzed in this report were governed exclusively by a genuine concern for the safety of the patient and the other individuals (patients, visitors, and staff members) in the ED on August 6, 2006. The safety of the patient who is the subject of this report was the foremost concern of all of the staff members who interacted with the patient. All of their actions were taken in furtherance of their goal of ensuring that this seriously ill young man received appropriate care in a safe environment.

Because Fletcher Allen is committed to identifying opportunities for improvement in regard to treating and managing individuals who engage in dangerous and aggressive behavior, a formal review of the situation analyzed in this report occurred in a timely manner. This formal review involved face to face discussions with the individuals who had interacted with the patient in the ED, as well as an in-depth review of the medical records.

As part of our review, we also carefully reviewed the videotape which had captured many of our staff's interactions with the patient when he was in the ED. As you are aware, the usefulness of the videotape in regard to assessing the circumstances that are the subject of the report is limited by the lack of any audio recording. Due to the lack of any audio recording it is impossible to gain a full understanding of the verbal interactions that preceded the episodes that are described in the report and the totality of the circumstances cannot be discerned. An audio recording would have been very helpful in regard to responding to the patient's statements, documented in the report, in which he denied that

he had used loud, vulgar, or threatening language, especially in light of the reports of many others who were present that he did cause significant disruption by using that manner of speech.

The review also included the convening of a multidisciplinary peer review conference with participation by clinical experts, including clinical experts not employed by Fletcher Allen, who were not involved in the care of the patient. Fletcher Allen also notified Vermont Licensing & Protection of the circumstances that are analyzed in this report and invited this agency to conduct an external review.

As further evidence of Fletcher Allen's commitment to providing the best possible care for our patients, as VP & A noted in their report, Fletcher Allen demonstrated a genuine interest in collaborating with VP & A to review the situation that is the subject of this report. No restrictions were placed on VP & A in regard to being provided the information VP & A deemed relevant to complete the investigation. FAHC provided VP & A with all of the records and documents that were requested. FAHC also facilitated extensive interviews with every FAHC employee VP & A wished to interview. The references in the report to not being provided documentation are misleading as to FAHC's level of cooperation. If the requested documentation existed, it was provided to VP & A. If the requested document did not exist, VP & A was advised that no documentation relevant to their request could be located.

As a result of our intensive internal review, opportunities for improvement were identified.

While Fletcher Allen worked closely with the mental health advocacy community when designing our new ED to ensure that there was dedicated space carefully designed to provide safe and effective care in the ED to individuals who are seeking treatment for a mental illness, we agree with VP & A that the ED is not the most appropriate care setting for patients with acute mental illness. Although VP & A did not identify the length of time the patient spent in the ED as an issue and, in fact, recognized the good efforts made to admit the patient as soon as possible, we are striving to streamline the placement/admission process to ensure that patients are transferred from the ED to a more appropriate care setting as expeditiously as possible.

Fletcher Allen also agrees with VP & A that when circumstances will result in a delay in the placement/admission to another care setting that there should be enhanced communication among the members of the care team to ensure that appropriate clinical interventions are initiated in a timely manner.

Fletcher Allen also agrees with VP & A that when circumstances will result in a delay in the placement/admission that accurate, clinically relevant information should be carefully documented in the medical record to ensure a seamless transition to the next level of care.

Fletcher Allen also agrees with VP & A that a robust "peer review" process should be an essential component of our quality improvement program. Fletcher Allen is extremely

proud of our record of inviting individuals who have been diagnosed with a mental illness, and their advocates to play a key role in the planning, design, and constant evaluation of the mental health services we provide in furtherance of our goal of candidly assessing the quality of care we provide to psychiatric patients.

Fletcher Allen also agrees with VP & A that the training and education we provide to our staff to manage aggressive and threatening behavior should be constantly evaluated and revised as necessary to ensure that we are fulfilling our obligation to provide a safe environment for our patients, visitors, and staff.

Fletcher Allen also agrees with VP & A that our policies and procedures should be regularly evaluated and revised as necessary to ensure that we are providing our staff with appropriate guidance to provide safe and effective care.

Fletcher Allen has also adopted a new policy that will require our security officers to use alternatives to handcuffs in those rare situations where violent patients have to be contained by security officers for the safety of the patient or other individuals.

As part of our ongoing quality improvement program, efforts are underway to accomplish the objectives outlined above.

While Fletcher Allen, through its internal quality improvement process, has reached many of the same conclusions as VP & A in regard to actions that could be taken to improve the quality of the care we provide to patients with mental illness who present for treatment in the ED, Fletcher Allen strongly disagrees with the central premises of the VP & A Report. Specifically, Fletcher Allen disagrees with VP & A's assertion that FAHC disregarded our obligation allow patients full freedom of movement unless an emergency exists and less restrictive measures have been found to be ineffective. FAHC further disagrees with VP & A's assumption that the significant efforts to keep the patient in a safe environment, to prevent elopement, to facilitate family contact for de-escalation and to verbally de-escalate the patient were inadequate treatment efforts under the circumstances.

Fletcher Allen is extremely proud of the progress we have made over the past several years to reduce and hopefully eliminate the use of restraints in the provision of care to psychiatric patients. Fletcher Allen's commitment to the use of the least restrictive measures possible to manage aggressive or violent behavior is demonstrated by the fact that in this case, our staff went to extraordinary lengths to de-escalate the patient's violent and aggressive behavior through the skillful use of Management of Aggressive Behavior ("MOAB") techniques. The record also demonstrates that our staff prudently applied the least restrictive measures possible to protect the patient from harming himself or others when non-physical interventions, including offers of medication to control his behavior and extensive verbal interventions, were unsuccessful.

It is very unfortunate that the report focuses exclusively on the several brief episodes where our security officers, motivated by a genuine concern for the patient's safety, were

required to intervene as a last resort. A more comprehensive review of the videotape documentation would confirm that in the course of the eleven (11) hours the patient was in the ED that on numerous occasions our security officers did an exemplary job of employing non-physical techniques to successfully manage the patient's aggressive, threatening behavior.

Fletcher Allen strongly disagrees with VP & A's suggestion that the patient's behavior did not rise to a level that would justify any restriction on the patient's freedom of movement. VP & A's suggestion that the patient's behavior did not rise to a level that would justify any restriction would appear to be based on statements offered by the patient in which he denied that he had engaged in aggressive behavior, VP & A's retrospective review of the ED videotape, and selected quotes from the interviews they conducted with Fletcher Allen employees. Fletcher Allen would suggest that this analysis was flawed and ignores ample evidence supporting our position that our staff exercised good judgment on those few occasions when they were required to restrict the patient's freedom of movement.

It is undisputed that the patient met the stringent criteria established under Vermont law for involuntary hospitalization and treatment. Specifically, it had been determined that he suffered from a mental illness, ***that he posed a danger of harm to himself or others***, and that no less restrictive alternatives were available to treat his mental illness. As noted in the report, the patient had a long history of severe mental illness with multiple inpatient hospitalizations. It should be noted that while we recognize that past behavior may not necessarily be indicative of future behavior, during previous admissions to Fletcher Allen, the patient's course of treatment had been marked by multiple episodes of violent and aggressive behavior directed toward staff and other patients.

The report provides sufficient detail in regard to the patient's worsening mental health in the days immediately preceding his admission to the hospital. As noted in the report, in the days preceding his admission, the patient had been non-compliant in regard to the treatment plan that had been implemented to ensure his health and safety. On the date in question, the patient's parents were sufficiently concerned about their son's safety, based on statements he made to them that he intended to harm himself, that they contacted the Burlington Police Department to escort him to Fletcher Allen for an emergency evaluation.

When the patient arrived in the ED, the staff was well aware that the patient had a history of refusing treatment and eloping. Since the patient was clearly at high risk of self-harm, and in urgent need of treatment, the staff immediately implemented protective measures to ensure that the patient did not elope from the ED. Again, the record demonstrates that the protective measures were carefully designed with the goal of respecting the patient's rights in regard to using the least restrictive measures necessary to ensure his safety.

The VP & A report uses selective quotes to suggest that on those occasions when our security officers were required to intervene that their actions were unwarranted based on VP & A's retrospective conclusion that the patient's behavior was not sufficiently

"threatening" to warrant any intervention. The report ignores numerous statements offered to VP & A by Fletcher Allen employees that support Fletcher Allen's position that the patient's behavior did rise to the level of requiring our staff to restrict his freedom of movement.

For instance, the very experienced ED nurse primarily responsible for the patient's care, described the patient as "the second most manic patient" she had ever seen. She reported that the patient "was loud and threatening throughout the day, waving his arms, screaming, scaring small children." Other staff members confirmed that other patients/ visitors had expressed concern for their personal safety based on the patient's loud and aggressive behavior. She also noted that the patient was "confrontational" and had to be prevented from striking out at the security officers.

The nurse also defended the decision to forcibly confiscate the medications that the patient had in his possession. Since she was concerned that the patient might harm himself if he ingested the medications, she enlisted the patient's mother's assistance to persuade the patient to relinquish the medications. Their joint efforts employing verbal de-escalation techniques were unsuccessful and Security was forced to intervene when the patient "threw himself on the bag of meds" to prevent the staff from retrieving the medications. The nurse also noted that the patient's young age, tall stature, and excellent physical condition contributed to the difficulties the staff was experiencing managing his aggressive behavior.

Another ED nurse described the patient as "inflammatory and aggressive."

The psychiatry resident who evaluated the patient noted that the patient was verbally and physically abusive. The resident also stated that the staff understood that it was imperative that the patient not be allowed to leave the hospital since he was clearly at risk of serious harm if he eloped.

An Emergency Medical Technician ("EMT") in the ED described the patient as "very aggressive and threatening…ramped up…agitated." The EMT also confirmed the statements offered by other Fletcher Allen employees in regard to the fact that the patient made frequent threats and attempts to leave the hospital.

Under these very challenging circumstances, our staff showed great restraint and compassion when dealing with a young man who was obviously in a great deal of distress due to his mental illness. Our staff worked very closely with the patient's parents to minimize the stress and anxiety that the situation was causing them and their son. It is unfortunate that despite our best efforts to manage his aggressive and threatening behavior through non physical interventions, including offers of medication, on several occasions our security officers were required to briefly intervene to restrict his movement to protect the patient from harming himself, to prevent him from harming others, or to prevent him from placing himself at great risk by allowing him to leave the hospital.

We are pleased that the patient responded well to the treatment plan that was initiated when he was hospitalized and was discharged back into the care of our community mental health provider affiliates.

In closing, Fletcher Allen agrees with VP & A that any actions that restrict our patient's freedom of movement should be a safety intervention of last resort. Fletcher Allen also agrees with VP & A that the safety, dignity, and privacy of any patient whose freedom of movement is restricted, should be preserved to the greatest extent possible. We regret that VP & A has concluded that we were not successful at meeting the high standards we have established in regard to the provision of care to our psychiatric patients.

It should be noted that in an effort to foster a constructive dialogue with regard to these issues, FAHC has chosen to avoid legal argument in this responses. This does not indicate our agreement with VP & A's position as to what standards are applicable to FAHC or the manner in which VP & A applied the standards they assert are applicable.

As noted above, we agree with many of the recommendations offered in the report for our consideration and we are looking forward to continuing to work with VP & A to achieve our common goals. However, we respectfully disagree with the assertion that the actions of our staff failed to comport with the standards that have been established in regard to providing safe, effective, and respectful care to patients who have been diagnosed with a mental illness.

Sincerely,

John Brumsted, M.D.
Chief Quality Officer