# Request for a Non-partisan Investigation into the Current Status of Access to Emergency Care in Bermuda

After a number of recent experiences accompanying very elderly friends and acquaintances who required Emergency Department care and hospital admission at King Edward VII Memorial Hospital (KEMH), I feel that I can no longer maintain my silence on a topic that is very near and dear to my heart.

I believe that I may have a somewhat unique perspective concerning the unacceptable situation that now exists in terms of access to Emergency Care and hospitalization, as well as the overall process of "bed flow" at KEMH, having served for 30 years as Director, and then Chief of Emergency Services at KEMH (July 1, 1988 until July 1, 2018) as well as a six year appointment to the Bermuda Hospitals Board (BHB) from December 2018 to December 2024.

The post that I served in for so long, was actually created by a "Royal Commission of Inquiry into Emergency Care in Bermuda" that was held in 1983 after it was felt that a number of preventable deaths had occurred amongst patients who had attended the Emergency Department at KEMH. This commission came up with a total of 17 recommendations, one of which was that the BHB hire a board-certified Emergency Physician from North America to provide clinical oversight of the unit. Eventually all of the commission's recommendations were implemented resulting in a dramatic improvement in the quality of Emergency Care in this country.

I am now calling for a similar commission to investigate critical overcrowding in the Emergency Department and wards of KEMH which is placing every individual in this country at risk for an adverse medical outcome should they require Emergency Care or hospitalization.

In support of this intended goal, I will try to provide some background information as to "how we got here"; what the real risks are; how this could impact the very financial security of this country; and then offer some recognized plausible solutions for the problem. This a great country and we are better than accepting the current status quo. It is my firm belief that we can solve almost any problem in Bermuda if we work together collectively to achieve the end goal - especially when it's as important as this one.

Unfortunately, there is a tendency to politicize problems dealing with the delivery of health care. I would argue that one of the fundamental responsibilities of every democratically elected government is to provide access to high quality health care for all of its citizens. For many years, I have observed a lack of cooperation in this country between the Government of the day and the hospital, regardless of the party in power. This "them" versus "us" mentality must stop. We are now facing a crisis in access to Emergency Care which worsens by the day. There is only one Bermuda, one hospital, and one Emergency Department in this country. Everyone must work together to make this right. Simply put, Bermudians deserve better access to care. In my discussions with many people, their fear of long waits and bed gridlock results in significant delays in their presentation for emergency treatment – only going to the department when they are literally at "death's door". This is obviously a dangerous trend which may result in unnecessary tragedy.

There is also a very real risk here for the economic health and stability of Bermuda. If for no other reason, Government must ask itself what will happen if our overseas business community concludes that our health care delivery system is inadequate or unsafe. How long will they domicile their senior executive staff here when the next nearest hospital is over 690 miles away? There are many other attractive destinations in the world in which to conduct business in an electronically connected world. And whether you love – or loath - International Business, no one can argue that it is not the "lifeblood" of our economy constituting 80% of our gross economic product. The days of tourism fully subsidizing our country's financial well-being are long gone – and despite the best efforts of numerous governments - are unlikely to ever return again.

**How We Got Here**

The current bed situation at KEMH was all quite preventable. At the time when planning for the new "Acute Care Wing" began in 2010, there was very clear guidance from multiple international healthcare agencies that hospitals in "developed nations" should expand their total number of Emergency Department beds by 10 to as much as 20% - as well as their total number of inpatient beds by at least 10% - just to deal with their aging populations. These recommendations were based on a pretty simple premise – that the fastest growing segments of the population in these countries are the "elderly" (over 60) and especially the "Super elderly" (over 80); if you live long enough, you will become seriously ill at some point and require hospitalization. For Bermuda - where we now have one of the world's "oldest populations", with a huge burden of chronic diseases often managed sub-optimally, and an increasing number of residents being either uninsured or underinsured - this guidance couldn't be more applicable.

The largely expatriate Senior Management Team running the hospital over this period, elected to bring in overseas consultants who essentially completely disregarded these guidelines as well as the bulk of recommendations made by frontline KEMH clinical leaders such as myself. These same overseas consultants derided the Emergency Department at KEMH as a "walk in clinic on steroids" completely ignoring the fact that it is the only full-service provider of Emergency Care for our entire country – which is, of course, very isolated geographically from the rest of the world.

When I first viewed the construction plan options for the new Emergency Department I was appalled. *Instead of expanding the total number of Emergency Department beds by 10 - 20%, the total number was reduced by 27%. This meant that from the time that the new department opened there was nearly a 50% bed deficit of what would eventually be required*.

When the Emergency Department planning team raised serious concerns about the size of the new ED, we were assured that there wouldn't be a problem, because an entire ward of the Acute Care Wing (ACW) would be reserved for "unplanned (non-elective) admissions" and that patients in the ED would be transferred immediately to this ward once a 'decision to admit" had been made. During the final planning phase for construction of the new ACW, the "Unplanned Admission Unit" concept was abandoned – *but the allocation of bedspace for the ED was never modified accordingly.*

Not unexpectedly patients ended up being placed in the hallways from "day one" when the new Emergency Department was opened. To make matters worse, no "surge capacity" was designed into the unit, and the "fast track" area - for patients with minor medical complaints – was completely eliminated. This was compounded by the fact that *the new build actually*

*reduced the total number of inpatient beds instead of expanding them by 10 -20%*. When I complained that the design would be an absolute disaster, I was threatened with dismissal on numerous occasions by the Chief of Staff, Dr. Donald Thomas III who unceremoniously told me that " I could go work somewhere else if I didn't F---ing like it". This was my thanks after more than 20 years of loyal service to the hospital.

While the new "Acute Care Wing" (ACW) is beautiful to look at -especially from inside the building – it was never designed to meet the medical needs of the people of Bermuda in the 21st century. Less than 50 % of this building actually accommodates patient care. "We don't need atriums that you can park a 747 in – we just require sufficient inpatient beds for sick and critically ill patients."

**<u>The Risks Associated With Emergency Department Boarding</u>**

As a consequence of insufficient beds on the wards, patients who require admission to hospital must remain in the Emergency Department for extended periods of time until an inpatient bed becomes available. This is termed "*Emergency Department Boarding*". It is extremely dangerous for patients who are very ill. There is a large body of data based on numerous research studies which unequivocally demonstrates that ED Boarding:

1. **Leads to prolonged hospitalizations** due to delays in the implementation of inpatient care plans
2. **Reduces patient satisfaction**
3. **Increases medical malpractice claims** against the institution involved
4. **Leads to significant delays in actual patient assessment and care** (both for "Emergency" patients trying to access the unit as well as those "bedded" patients already admitted to hospital but remaining in the unit)
5. **Causes burnout, stress-related medical disorders and resignations in Emergency staff**
6. **Compromises the privacy of patients being boarded in hallways**
7. **Leads to dramatic increases in patients leaving the department prior to their initial medical assessment or final completion of their care**
8. ***<u>Most importantly, increases the mortality and morbidity rates for patients</u>*** (increases deaths and the worsening of a patient's medical condition / eventual outcome)

I served as Chief of Emergency Services for two years after the new Emergency Department in the Acute Care Wing was opened – and not surprisingly *documented several instances where I felt poor medical outcomes and even deaths could have been prevented had the unit not been seriously overcrowded while boarding numerous admitted patients*.

To put this all into perspective, lets look at some numbers. Earlier this week, there were 28 – 30 admitted patients being boarded in the Emergency department at KEMH at the start of the morning shift. There are now only 23 beds in the entire unit.

On an average day somewhere between 80 to 90 patients attend the Emergency Department at KEMH for care, of which 10 to15 – mostly the elderly - will be sick enough to require hospital admission. As you can clearly see – the numbers simply don't add up.

What this means is that the Emergency staff on duty must assess and provide treatment for 80 - 90 patients each day with essentially no beds. Ill patients are sometimes left in the waiting area for hours simply because there is no physical space available to place them.

At this point I would like to note that the current Emergency Doctors, Nurses, EMTs, and Chief of the Service, Dr. Dean Okereke, are all doing an absolutely stellar job in trying to manage what can only be described as a terrible situation which worsens by the day. None of this was their doing – and in my mind they are all some of Bermuda's greatest unsung heroes. One of the hardest things in the world for healthcare workers is to try to provide lifesaving treatment for really ill patients without the necessary resources (i.e. bedspace) to do the job. This current state of affairs has taken a dramatic toll on the morale within the department as physicians and nurses are asked to make compromises in patient's medical care on nearly a daily basis. And there are very real health consequences for the staff as well as the patients. Professional staff are dealing with a tremendous amount of stress. This can result in depression, "burn out", and a variety of stress-related medical disorders. From my own personal perspective, I developed diffuse psoriasis shortly after our move into the new unit. It all resolved within a week of my retirement. Nevertheless, 7 years after leaving the department, I still have nightmares nearly every night in which I'm working in the ED, can't move any of my admitted patients, or find beds for critically ill patients entering the department – surely a form of post-traumatic stress disorder (PTSD). I'm extremely concerned about my colleagues who are still employed in the Emergency Department at KEMH and have urged several to seek work elsewhere in the interest of their own health. I don't know how they continue do it.

**Solutions to the Problem**

It has always been my feeling that you shouldn't complain about a serious problem unless you are willing to provide serious solutions. We are fortunate in that the problem of Emergency Department boarding and overcrowding is far from unique to Bermuda. It is occurring in virtually all of the "developed nations" as a result of the changing demographics of their (aging) populations. Because of this, a great deal of research has been conducted in an attempt to find plausible, workable solutions for the problem. Unfortunately – like so many things in life – some of these solutions are not easy to implement and others require that we rethink our whole approach to hospital and community care. The good news here is that we "don't have to reinvent the wheel".

While KEMH has adopted some of these solutions in order to improve patient bed flow through the hospital, I believe that there is much more that can be done. While serving on the Bermuda Hospitals Board, I repeatedly heard that "it was all Government's fault because there aren't enough nursing home beds in this country and patient's who should be discharged from hospital following their successful treatment for an acute illness, remain in acute care beds for months (even years in some instances) effectively blocking those beds for patients requiring

admission." While there is certainly some truth in this, the bottom line is that at the end of the day, KEMH is solely responsible for managing its own bedspace effectively. The "blame game" does not serve the public's interest and only generates more excuses for further delays in what may be decisive, often difficult actions by hospital management that are required to fix the problem.

I served on the Medical Staff Committee of KEMH (comprising the Chief of Staff and Chiefs of all the respective departments at the hospital) from 1988 to 2018. Everyone recognized as early as the 1990's that the projections for the aging of our population would have a dramatic effect on our ability to provide medical care in this country – and that additional nursing home beds in the community were required. There was no real appetite by Government or the corporate / business sector to address this issue, and it was repeatedly "kicked down the road" by successive governments until now when we find ourselves in the current predicament.

So, what can we do to reduce overcrowding at the hospital and patient boarding in the Emergency Department?

I will offer my recommendations as follows, divided between those actions that KEMH must undertake immediately and those which I believe Government must adopt, but may require more time to implement.

**Actions required by KEMH**

1. **Board admitted patients on the wards or overflow units but not in the ED.**
   Numerous studies have demonstrated that it is far safer and outcomes are improved when admitted patients are boarded on the wards. If you think about this it only makes common sense. When these patients are on the wards, they are not blocking beds for the ever-increasing number of sick and elderly patients who are presenting to the Emergency Department for assessment and care. In effect, you reduce two strikes against the institution to one and almost immediately vastly improve the delivery of Emergency care in this country. The major barrier to implementation of this protocol is – and always has been – senior nursing managers on the wards who don't want to accommodate additional patients under their care. Their attitude has been that all is well as long as the Emergency staff have to deal with the problem. I would argue that *its not the Emergency Department's problem, it's the institution's problem (and for that matter, the entire country's problem*)! KEMH administrators need to act decisively on this issue, follow the science, and stop caving in to pressure from nursing administrators who do not always appear to have the patient's best interests at heart. The institution will likely have to hire additional nursing staff and purchase additional beds to accommodate this solution.

2. **Convert every available room and open space in the hospital to make it available for holding patients at times of peak capacity.**
   While this has been accomplished to some extent on the wards, there is still much more that needs to be done. This will also require the hiring of additional staff – but that "is the cost of doing business" in a safe and effective manner.

There are rooms in the "old hospital" that have "piped medical gases" for bedded patients requiring oxygen or suctioning – but are not being used clinically at present. Furthermore, there is ample space for bedding patients in the massive atriums of the ACW that are not being used at all – except for aesthetic purposes. *Do we want a functional hospital where there are sheltered areas utilized to full capacity to care for ill patients - or a non-functional hospital that is pretty to look at?* This is a "war" that we are currently losing and the hospital needs to approach this problem on a "wartime basis".

3. **Build additional inpatient bed space or partner with entrepreneurs in the community to provide "stepdown" beds to allow earlier discharge from acute care beds in the hospital for those patients requiring a continued - but much lower level - of care.**

   The looming necessity of constructing additional inpatient beds is an expensive option. I am aware of knowledgeable medical practitioners in the community who are more than willing to provide this type of service - but either of these options will require the full support and additional financial investment by the Government of Bermuda (see below).

4. **Create a patient discharge lounge and enforce a strict policy where patients medically fit for discharge must leave the hospital within 24 hours.**

   It is estimated that somewhere between a quarter to a third of the patients lying in beds on the acute care wards at KEMH on any given day do not actually require inpatient medical care. They simply remain there because there is either no place else for them to go – or there is a reluctance on the part of their family members to take them home. This number of patients is roughly equivalent – or even exceeds - the total number of patients being boarded each day in the Emergency Department.

   While the above is a well-proven solution to hospital overcrowding and the Emergency Department boarding that results, the difficulty and complexity of executing such a policy in our tight-knit and inter-related community cannot be underestimated.

**<u>Actions Required by the Government of Bermuda</u>**

**<u>1</u>, The Government of Bermuda must adjust their cap on financial support of KEMH to adequately reflect the true cost for the hospital to provide care to this community.**

The Government of Bermuda (not independent insurers) provides the overwhelming bulk of revenue required for the operation of KEMH. Since 2019, the Government capped funding significantly below what it costs to run the hospital and provide medical services for a community that has become more elderly and increasingly uninsured or under-insured. KEMH provides the medical safety net for this country. It is the "place of last resort" to access medical care for many Bermudians.

It is estimated that the Government may be currently underfunding the hospital by as much as 100 million dollars per year based on KEMH's true operating costs.

I served on the Bermuda Hospitals Board for much of the period since the funding cap was first introduced. We observed our cash reserves evaporate, and the hospital was forced into a position where it has to take out a 30-million-dollar loan from Clarion Bank just to pay staff salaries each month. In the absence of such a loan there remains a real risk that the institution could become insolvent. The additional consequences of this fiscal policy include deferred maintenance and required improvements to the physical plant of the hospital, freezes on staff salaries to compensate for inflation, and an inability to expand services to meet the community's increasing demand for medical care.

The limited ability of the organization to implement solutions to address hospital overcrowding and Emergency Department Boarding is just one more example of the consequences of the current cap on funding for KEMH.

With enhanced funding, the hospital would be better able to create the necessary additional bedspace (both temporary and permanent), purchase additional patient care equipment (beds), and hire additional nursing, physician, and support staff to deal with the overcrowding issue – which, once again, is only predicted to continue to worsen over the next decade based on our aging population.

It is truly fortunate that the Government of Bermuda will be collecting sizeable tax revenues from the International Business Community in the near term. It is essential that a significant portion of these funds be invested in the medical care of Bermudians in general, and Bermuda's only medical hospital in particular – in addition to the required investments in education, affordable housing, and infrastructure that are needed. *I would advocate that Bermuda's reputation as a desirable location for overseas companies to conduct International Business is at stake.*

**2. Government must create additional skilled and unskilled nursing home beds in the community to offload the country's only acute care hospital**

This could be achieved by building new, purpose-built facilities; converting older structures that are currently vacant or are under-utilized; or partnering with entrepreneurs in the community. No matter which solution is selected, there will be significant costs involved – not only for the physical structures needed, but for hiring the additional healthcare providers that will be required. Any comprehensive plan for managing our elderly population will have to be heavily subsidized by the Government as many of the individuals requiring these services are older pensioners completely lacking in the financial resources to pay for the care required. *Nevertheless, it is important to remember that any of the above solutions would be far more cost effective than leaving these individuals in an acute care bed at the hospita*l.

**<u>In Summary</u>**

**Bermuda is currently facing a healthcare crisis that is worsening by the day. It is primarily an "access to care" issue which potentially impacts the health concerns of every Bermudian, Guest Worker, and Visitor to these islands. Poor structural design of the island's only Acute Care Hospital and a decades-long failure to adequately plan and**

**properly invest in how to deal with the country's rapidly aging population has created a situation at the hospital where there is now overcrowding of inpatient beds on nearly a daily basis. As a consequence, many patients in the Emergency Department at KEMH are "boarded" for days before they are transferred to a hospital ward. This is dangerous as it places these patients at increased risk for serious delays in their care, an increased incidence of medical errors, adverse outcomes, and even death. Furthermore, significant delays in the initial assessment and care of critically ill patients presenting to the Emergency Department may occur – simply because "there is no place to put them".**

**Sadly, the Bermuda Hospitals Board and the Government of Bermuda have failed to effectively partner to resolve this untenable situation – which, as previously stated, impacts everyone living on these islands and could even threaten our country's economic livelihood. This is unfortunate as there are proven solutions that could have already been adopted to resolve the matter. These solutions, however, will require a deep social commitment as well as a significant financial investment from both of the major parties involved.**

**I am therefore requesting that an independent, non-partisan commission of inquiry be appointed to objectively review public access to Emergency care in Bermuda as well as hospitalization at KEMH and make recommendations as to how to remedy the present situation predicated on evidence-based solutions that have been found to be effective in many other communities throughout the "developed world". It is my firm belief that Bermuda clearly has the ability to fix this, if we simply unite in common cause for the good of all.**

**Respectfully submitted,**

**Edward A. Schultz MD FACEP**

**Diplomate American Board of Emergency Medicine, American Board of Internal Medicine, and Subspecialty Board of Undersea & Hyperbaric Medicine**