

Correspondence

Irish Journal of Psychological Medicine, 40 (2023).
doi:10.1017/ipm.2020.17

Letter to the Editor

Is ‘medical clearance’ for acute general adult psychiatric presentations always necessary?

Dear Sir/Madam,

The Drogheda Department of Psychiatry is a stand-alone psychiatry unit based in Crosslanes, Drogheda serving the adult population of the counties Meath and Louth. The total number of assessments carried out from September to November 2019 was 523, with 11 (0.2%) of these requiring referral to the local Emergency Department (ED) for further medical workup after their psychiatric assessment.

A large number of psychiatric patients present to EDs around the country each day, with 11 000 people presenting with self-harm alone in 2016 (HSE, 2018). October 2019 saw the second-worst month for hospital overcrowding since records began, with an acknowledgement that the number of people attending EDs are rising and as a consequence 13,466 people over 75 years of age endure ED waits of more than 24 hours since the year began (HSE: Minister for Health, 2019).

Psychiatric patients have been shown to find the experience in EDs difficult, with particular dissatisfaction with wait times, lack of privacy and negative attitudes of general staff (Summers & Happell, 2003). An Australian report, which is likely to reflect the situation in Ireland, identified that psychiatric patients are more likely to have to wait longer than other patients with a similar severity of physical illness for assessment. This is due to a relatively lower number of psychiatric staff and lack of beds, which results in a longer period of treatment in the ED, with a higher risk of the patient leaving before completion of treatment (Australasian College for Emergency Medicine, 2018). This is in addition to the fact that a suitable, safe and available area in ED for psychiatric assessments is often lacking (21% of Basic Specialist Training (BST) trainees reporting deficiencies in 2017), putting the assessing doctor at risk (O’Donovan *et al.* 2017).

There is no doubt that certain presentations and cohorts require medical investigation before, after or in tandem with psychiatric assessment (such as older adults, older adults with cognitive impairment, those with significant comorbid medical illnesses or those presenting following self-harm or self-poisoning, intoxication, with neurological symptoms or not in a manner consistent with a psychiatric presentation). It

would be expected that in a stand-alone unit, these patients would be referred for appropriate medical assessment on the clinical judgement of the assessing psychiatric doctor, or indeed tests such as bloods or urine toxicology be performed on site. If the patient is referred by a GP or an ED, preferably any appropriate medical investigations would be completed before referral.

A paper published four decades ago struggled with identifying the origins of the term ‘medical clearance’. It was noted it may have the capacity to mislead rather to inform, as medical doctors may prematurely label a patient as medically clear due to an unfamiliarity with psychiatric conditions. Also that psychiatrists may ask for ‘medical clearance’ to hide their discomfort towards clinical medicine (Weissberg, 1979). An agreement on a protocol or algorithm for ‘medical clearance’ has not been widely accepted and this can lead to a process with inconsistencies and a lack of standardisation that can lead to further confusion with medical doctors (Zun *et al.* 2013).

Previous studies based in EDs have argued that the vast majority of medical problems, along with substance use, can be identified by vital signs, a basic history and physical examination (Olshaker *et al.* 1997). A retrospective investigation of 502 consecutive inpatient admissions to a psychiatric inpatient unit in the USA, contended only one patient’s laboratory results would have changed their initial management, had it been picked up in an ED originally and thus judged routine laboratory screening bloods to be unnecessary (Janiak & Atteberry, 2012). Another US retrospective review, based in a large ED over a five month period, noted that of the patients who presented with isolated psychiatric complaints and a past psychiatric history, none were subsequently shown to have positive laboratory or radiological results after ‘medical clearance’ (Korn *et al.* 2000).

There is no doubt that focused medical assessments are vital in the assessment and management of certain psychiatric presentations, but is a blanket ‘medical clearance’ taking up finite resources in EDs that are already overcrowded and which psychiatric patients find difficult? (HSE: Minister for Health, 2019; Summers & Happell, 2003). It is also to be considered that it is possibly leading to a reduction in the overall quality of care provided to psychiatric patients, due to long waiting times and the risk of absconson (Australasian College for Emergency Medicine, 2018). Models such as parallel medical and psychiatric assessments in EDs could mitigate some of these issues. However, if there is such a low medical referral rate

from an adult stand-alone unit (0.2% over 3 months), it seems reasonable to query if 'medical clearance' of all the patients assessed would have been beneficial.

Financial support

This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Conflict of interest

The authors have no conflicts of interest to declare.

Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008.

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