'The patient is medically cleared'

It is standard practice for psychiatric nurses and junior doctors working in emergency departments to ask that patients be 'medically cleared' before psychiatric admission or even assessment. However, there is a lack of agreement over what this process should entail.

'Medically cleared' is a term of uncertain meaning and no mutual understanding (Weissberg, 1979; Zun, 2005; Reeves et al, 2010). It is a bone of contention between psychiatric staff, who may feel they should not be asked to see a patient until all possible pathology other than 'functional' psychiatric illness has been excluded, and general hospital staff, who may feel it is not their role to investigate patients who are 'clearly psychiatric'. It may be treated as the starting gun for psychiatric involvement, with a reluctance for psychiatry to become involved ahead of this. Patients often breach the 4-hour wait in the emergency department as a result of delayed or lengthy psychiatric involvement (Henderson et al, 2003; Dutta et al, 2004), which is sometimes clinically necessary. Disagreements between emergency department and psychiatric clinicians have become magnified by issues of stigma, differing priorities, limited postgraduate experience, and separated mental health and acute trusts.

In the authors' experience, junior psychiatrists and psychiatric nurses are often uncertain what it is that they are really requesting when they ask for a patient to be medically cleared. Likewise, emergency department staff do not have a universal understanding of the request for medical clearance; they may assume this requires only a cursory physical examination or sometimes just a set of basic observations. What psychiatric staff are often asking when they ask if a patient is medically cleared is whether the patient is medically safe to be on a psychiatric ward, which should be seen as roughly equivalent to whether or not the patient would be be medically safe to be at home. There is also the need to exclude potential physical pathology (*Table 1*) behind symptoms of mental illness.

What do mental health professionals want from emergency department staff?

Vignette 1: A patient who is known to be HIV positive presents with new-onset psychosis. It is not possible to exclude all possible organic causes in the emergency department, and a decision must be made about who will take over the inpatient management of the patient while further investigations are carried out.

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Before immediately assuming that a patient requires an instant transfer to psychiatry, it is helpful to bear in mind the range of possibilities when someone presents with psychiatric symptomatology; there may be an 'organic' basis that is immediately treatable (*Table 1*). Many cases are not so simple that one disease process can immediately be singled out, and it must be borne in mind that people with psychiatric disorders have high rates of comorbid physical illness, as well as being more likely to receive substandard medical care (De Hert et al, 2011a,b).

Psychiatrists will be worried about whether the patient has physical problems that might not be spotted or appropriately managed on a psychiatric ward. Psychiatric wards do not have the facility to manage patients on intravenous fluids or oxygen, for example, and, because of the separation of mental health and acute trusts, often do not have access to the same computer system as the general hospital, making it difficult to obtain test results. Mental health nurses may have limited medical experience. Psychiatric wards are often on a different site to the general hospital, and psychiatrists have to consider the fact that they can not get an urgent medical review for a inpatient, or even call a crash team if necessary; for many psychiatric wards, the only option for a patient who has deteriorated medically is to be taken to the emergency department by ambulance.

Of course, nobody can ever be fully medically cleared. We can never exclude every single possible condition in every single person, and investigation often continues beyond the emergency department. If the patient is medically stable, a psychiatric ward might be the most appropriate place to admit him/her, but it should not

Table 1. Conditions which may lead to psychiatric symptoms

Infection (systemic, e.g. urinary tract infection, or intracranial, e.g. encephalitis)
Intracranial lesion
Head injury
Other neurological disorders, e.g. epilepsy, multiple sclerosis
Alcohol intoxication or withdrawal
Prescribed or illicit drugs, including withdrawal syndromes
Metabolic and endocrine disorders, i.e. hypoglycaemia
Hypoxia

mean that medical support is withdrawn altogether. Local resources need to be taken into account when making such decisions.

Emergency department staff need to have an understanding of why there could be a need to delay psychiatric assessment. The classic example is that of the intoxicated patient. When someone is intoxicated, his/her mental state will fluctuate significantly over a few hours. While straightforward intoxication might not be considered a reason to medically admit a patient, a couple of hours of 'sobering up' (with an agreed timetable for observations) can make all the difference in terms of whether a psychiatrist can make a reliable assessment of the underlying mental state and what can subsequently be done to help. It may be desirable to rid the department of people who are drunk and challenging in their behaviour, but if a psychiatric assessment has been requested, clinicians must appreciate the reasons for delaying this. Apparently suicidal patients might feel differently when sober, and decisions about use of the Mental Health Act cannot be made when alcohol or drugs are clouding the clinical picture. Especially important will be cognitive assessment in terms of associated head injury and other causes of alcohol-related cognitive dysfunction such as Wernicke's encephalopathy.

Owing to the nature of psychiatric assessment, there may still be barriers to this even after a patient has been declared medically fit to leave the emergency department. A patient post-overdose might be toxicologically and biochemically 'clear' but still exhibit physical or behavioural symptoms preventing psychiatric assessment for a few hours (e.g. drowsiness, vomiting, agitation).

Vignette 2: A patient who had taken a massive overdose of fluoxetine and was very agitated and pacing was referred to the psychiatric team as 'medically cleared'. Her extreme agitation, assumed to be a product of mental illness, necessitated restraint and parenteral benzodiazepines. The presence of myoclonic jerks with severe agitation and confusion indicated likely serotonin toxicity. After 24 hours of sedation with benzodiazepines and supportive management, the serotonin syndrome fully resolved and she was able to give a coherent account of herself.

Joint working: how psychiatrists can make life easier in the emergency department

Vignette 3: A patient is referred to the psychiatric team following a paracetamol overdose. She is on a Parvolex infusion and will not be medically fit for discharge for at least 12 hours. However, she is not suffering severe physical symptoms and is calm and coherent.

Overdose or other form of self-harm is a common reason for psychiatric referral in the emergency department. A patient who has self-harmed may not need to be medically cleared before psychiatric assessment. If the patient is awake, able to speak and willing to talk, early assessment is good practice. Once patients are medically fit for discharge they will often be keen to leave the hospital as soon as possible and may be less tolerant of psychiatric assessment if it prolongs their stay in the emergency department. Follow-up of self-harm patients is poor and it is therefore prudent to make as comprehensive an assessment as possible while in the emergency department.

Mental health professionals need to consider what they mean when asking the emergency department to medically clear a patient. Is there a specific question that needs to be answered?

If a general physical examination is needed, is there any reason for the psychiatrist not to do it him-/herself? Is there something specific that needs to be investigated for? If so, it is completely reasonable to give the emergency department some guidance on what to look for in a focused examination and investigations. If, after the assessment, the psychiatrist has cause to suspect that there is an organic basis for the patient's presentation, e.g. because a cognitive examination suggests acute confusion, he/she should explain the rationale for specific investigations.

Some barriers to effective joint working may be down to issues of confidence and perceived competence. Junior psychiatrists working in the emergency department sometimes fall into the trap of thinking that they do not have the ability to physically examine patients or carry out investigations. A core trainee in psychiatry may well have more experience than an emergency department foundation doctor or core trainee, so should not expect that the doctor assigned to 'clear' the patient will know more about medicine. Nothing should be automatically assumed simply because someone has written 'medically cleared' in the notes. It is reasonable to check exactly what has been done. A satisfactory medical clearance should not ever mean that the psychiatrist ignores the patient's physical health or fails to continue to consider the possibility of a missed diagnosis.

While a patient might need medical investigation or management before being fit for discharge home or transfer to a psychiatric ward, it may be appropriate to begin psychiatric assessment at the same time. Joint management improves working relationships between teams and lessens the chance of 4-hour wait breaches. There are some contraindications to psychiatric assessment (*Table 2*) but these are always relative, and if psychiatrists are in any doubt, a brief end-of-the-bed review will clarify;

Table 2. Relative contraindications to psychiatric assessment

Reduced Glasgow Coma Scale
Intoxication
Obvious primary pathology needing immediate investigation or treatment (e.g. trauma, myocardial infarction)
Refusal by patient

outright refusal to see a patient is very rarely reasonable. This will enable the psychiatrist to explain his/her reasons for not immediately carrying out a full assessment, instead of merely appearing obstructive. Even if the patient will be being admitted to a medical ward, there is still a role for psychiatry in advising on symptom management and obtaining a collateral history from other sources. Of course, there is no reason why a collateral history should be taken only by a psychiatrist, but this is taught as an area of particular importance in psychiatric training. Psychiatrists are more likely to use the collateral history as a tool in the course of their everyday work, where patients are frequently unable to give an accurate account of their own history.

Vignette 4: A man behaving bizarrely in the street is brought into hospital by police under Section 136 of the Mental Health Act. He begins to experience central, crushing chest pain radiating down the left arm during the psychiatric assessment.

In reality, many patients are complex to manage and do not have problems which fit neatly under the category of either 'medical' or 'psychiatric'. In these cases, joint working is essential. The patient in vignette 4 needs urgent medical attention, and psychiatric assessment must be put on hold while cardiac investigation is prioritized. A psychiatric unit will not have the necessary equipment or expertise of nursing staff for this. In this situation, it is likely that psychiatric nursing staff will need to remain with the patient to ensure his safety and that of others. Psychiatric staff should not withdraw their support simply because a physical issue has become more pressing.

A combative, intoxicated overdose patient with a stated intent to die who is refusing medical intervention requires the combined expertise of the emergency department and the duty psychiatric team. Prompt attendance by a psychiatrist to assess the mental state, risk and capacity (*Table 3*), and to consider the necessity of restraint and coercion, will greatly help the emergency department team to carry out investigations and treatment that will potentially save the patient's life.

Conclusions

The idea of medical clearance is a source of misunderstanding between mental health professionals and emergency department clinicians, and this is largely down to there being no agreed definition. Sometimes 'medical clearance' is better determined by clinical presentation than by blood results, and it should not be assumed that 'psychiatric' symptoms are being caused by a 'functional' mental illness, regardless of the patient's psychiatric history.

There may be considered, broadly, two levels or subtypes of medical clearance. First, it may be defined as there being no evidence of a significant physical disorder that would prevent discharge from the general hospital, and therefore a complete handover of care to psychiatry, or alternatively, that there is no physical problem preventing psychiatric assessment. In short, the patient may be either medically cleared for discharge from the emergency department, or he/she may be medically cleared for psychiatric involvement.

For any patient who presents to the emergency department, a standard history should be taken as well as a relevant physical examination, and any investigations that are pertinent to the patient's presentation, also bearing in mind the past medical history. Obviously that is not always possible because of the patient's presentation; the patient might be incoherent or combative. A psychiatrist might be called upon to advise on management of such a presentation in order to facilitate any necessary investigations, rather than being automatically transferred to the sole care of psychiatry because of difficult-to-manage behaviour. When managing emergency department patients, psychiatrists can be particularly helpful in eliciting specialist aspects of the history including a mental state examination, taking a corroborative history (which is vital when there are prominent psychiatric symptoms), and accessing local specialty resources and information.

All clinicians should be prepared to work collaboratively and be aware of what resources are and are not available to each other. Psychiatrists should be clear about what they are requesting when asking for emergency department input, and think about what they can contribute to investigation and management rather than refusing to see patients who are not medically cleared. Emergency department clinicians need to understand the limitations of psychiatric wards and to be aware of situations that make it difficult or impossible to take a psychiatric history. There is often a difference between being medically fit for no further medical input and being medically fit for psychiatric assessment. Good communication between teams and a transparency about what has been done and the rationale for this should replace the need for a stock phrase used to rubber-stamp patients. **BJHM**

Table 3. Key points on capacity assessment

All doctors should be able to assess capacity, not just psychiatrists	
Capacity is decision-specific	
To have capacity, a person must be able to:	Understand information
	Retain information
	Weigh the decision in the balance
	Communicate their decision
Capacity may vary with time and must be reassessed as necessary	

Conflict of interest: none.

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KEY POINTS

- The action needed to 'medically clear' is different for every patient.
- Medical causes for psychiatric presentations should be considered and excluded.
- When psychiatric involvement is needed, this should begin as early as possible.
- Barriers to psychiatric involvement should be regularly reassessed.
- Patients with physical and psychiatric needs should be jointly managed wherever possible.
- There are two levels of medical clearance, and it should be clear which is being considered.