



Psychiatric Patients in the Emergency Department: Rule Out Organic and Then What?

When confronted with a psychotic patient in your emergency department, where should you begin? Issues are complex and include the presence or absence of organic disease, suicide risk, substance abuse, and disposition. Using individual cases, the lecturer will review the features of functional diseases, including psychoses, depression, hostility, and anxiety. The lecturer will then use this information to recommend an efficient evaluation to exclude organic causes. Last, appropriate interventions will be presented, including the role of security, the use of pharmacologic agents, and referral options.

- Recognize the signs and symptoms of an acute behavioral emergency.
- Develop a systematic approach to the psychiatric patient that includes the exclusion of an organic etiology and the evaluation of suicidal potential.
- Discuss pharmacologic intervention and the use of physical restraints.
- Identify appropriate referral and treatment options for psychiatric patients.

WE-147

Wednesday, October 13, 1999

12:30 PM - 2:25 PM

Room # N223

Las Vegas Convention Center

FACULTY

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1999 SCIENTIFIC ASSEMBLY

Psychiatric Patients in the Emergency Department: Rule Out Organic and Then What?

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Acute Psychiatric Emergencies

Course objectives:

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- Identify appropriate referral and treatment options

Introduction

The challenge of psychiatric patients:

- considered difficult patients
- often elicit negative reactions from staff
- may display disruptive behavior
- disposition is difficult and time-consuming
- diseases are usually chronic

The general approach to the psychiatric patient:

- ***begin development of rapport;*** assess safety of self and patient, begin to establish a therapeutic alliance
- ***physiologic assessment;*** medical evaluation, diagnostic studies, possible restraint
- ***psychiatric assessment;*** mental status, risk to self or others, collateral information, diagnosis, formulation of treatment plan
- ***disposition;*** outpatient or inpatient, voluntary or involuntary, consultation, initiation of treatment

Other considerations:

- medicolegal issues
- psychiatric medications
- managed care

Case 1:

A 56 year old woman is brought to the emergency department by a friend after he received a call from her at 4:00 am complaining she "just couldn't sleep". The patient was apparently drinking today and told him she was tired and felt hopeless. Her friend mentions she has been drinking a lot more lately, has been increasingly withdrawn and tearful. He had not spoken to her in 3 weeks since she stopped coming to an evening class they both go to. He is concerned she may hurt herself if she's left alone. He knows she was "seeing a therapist" and takes "something for her nerves".

On examination she appears intoxicated. Her speech is slurred. Her pulse:134, BP:150/100, RR:20. Physical exam was otherwise unremarkable, neuro exam was non-focal but patient seemed unusually restless. Her affect was blunted, attention was poor, she was only oriented to person and was uncooperative to other testing or history taking.

Medical clearance

- what is a medical clearance?
- what is the utility of "screening labs"
- what if we don't identify the problem in the ED?

The psychiatric physical exam

- 0/98 performed physical exams on new outpatients
- 15% performed physical exams on new inpatients
- reasons were: to save time (58%); felt incompetent (53%) ; dislike of performing physical exams

Associated physical diseases in psychiatric patients:

- medical findings in 24% to 60%
- 7%-19% requiring acute treatment in ED
- 4% of "medically cleared" requiring acute medical treatment within 24 hours of admission
- 80% of missed acute medical problems could have been identified on H&P
- 4-fold increase in missed medical diagnosis in patients <55 yrs old
- most common exam neglected is the mental status exam, then neurologic

Associated substance abuse in psychiatric patients:

- substance abuse in up to 50%
- 25% with acute intoxication
- highest in personality disorders, schizophrenia

Laboratory screening:

- 352 acute psychiatric patients in ED
- 65 (19%) had acute medical problems for which:
 - history 94% sensitive
 - physical exam 51% sensitive
 - vital signs 17% sensitive
 - lab 20% sensitive
- the 3 not identified by H&P were asymptomatic anemia and mild hypokalemia
- self-reporting of illicit drug use and alcohol was 91% accurate
- 7% had an elevated WBC not attributable to any clinical significance

Summary:

- most acute medical illnesses can be identified on H&P
- this may be the last chance to identify these problems
- universal laboratory and toxicology screening is of low yield

Mental status exam

- multiple forms exist although very few are either practical or have been validated in the ED setting
 - helpful differentiating organic from functional disease
 - contributes to the assessment of competence
 - at a minimum it should assess;
 - orientation
 - memory (short and long)
 - attention (or calculation)
 - recall
 - language
 - thoughts
 - perception
 - mood/affect
 - judgement
-

Case 1 continued:

The patient becomes less responsive and hypotensive. Her temperature is 103.7F, she is hyperreflexic, has increased muscle

tone, and is having episodes of myoclonus.
Her friend returned to the home at your request and reports empty bottles of fluoxetine and a tricyclic. You decide not to medically clear her.

Medications: 2nd generation antidepressants

- numerous "2nd generation" antidepressants now on the market
- have rapidly replaced the traditional "1st generation" TCA's and MAOI's

Common features:

- act mainly by inhibiting presynaptic biogenic amine neuronal uptake, increasing available serotonin, norepinephrine, or dopamine
- no Na^+ , K^+ , or Ca^{++} channel blockade, therefore decreased cardiotoxicity
- dietary restrictions not needed (unlike MAOI's)
- no significant anticholinergic or alpha-blockade (except trazodone)
- generally safer, most fatalities in mixed drug overdoses
- missed on plasma and urine drug screens

SSRI's:

- Selective serotonin reuptake inhibitors: sertraline (zoloft), fluoxetine (prozac), paroxetine (paxil), fluvoxamine (luvox)

Pharmacology:

- structurally unrelated to TCA's
- increases cerebral serotonin levels by preventing reuptake
- large V_d and highly protein bound, not dialysable
- hepatic metabolism, active metabolites present up to 5 weeks

Indications:

- depression
- also: obesity, personality disorders, bulimia, obsessive-compulsive, panic attacks

Newer combination antidepressants:

- Non-selective serotonin reuptake inhibitors with other non-

serotonin psychotropic actions including dopaminergic and norepinephrine effects

- examples include: clomipramine (anafranil), venlafaxine (effexor), nefazodone (serazone), bupropion (wellbutrin)

Serotonin Syndrome:

Presentation:

- altered mental status, tremor, hyper-reflexia, myoclonus, diaphoresis
- hyperthermia, increased muscle tone, seizures, hypotension, death in severe cases

Etiology:

- increased activation of serotonin receptors in brainstem and spinal cord
- resembles neuroleptic malignant syndrome
- caused by drug-drug interaction, basically any drug that increases serotonin:
 - MAOI's, TCA's, amphetamines, cocaine, demerol, codeine derivatives, dextromethorphan, LSD, mescaline, buspirone, lithium

Treatment:

- principles of decontamination
- control hyperthermia
- watch for rhabdomyolysis
- consider cyproheptadine

Case 2:

22 year old angry, handcuffed male is brought to the emergency department by police for evaluation of a head laceration. He was

arrested for trespassing, became uncooperative in the police car and began to smash his forehead against the interior until it began to bleed. He is immediately locked in a psychiatric assessment room. He is screaming obscenities, threats and "I just want some _____ water" repeatedly. Police are asked to stay. He begins to pound his head on the glass until blood completely obscures the view. The patient agrees to sit and allows the emergency physician to speak with him after being told he would get some water soon. The physician remains at the open door with security standing by. The patient appears distracted, tangential and complains of voices instructing him to harm the police. He admits to drinking "two beers", and recently stopping his thorazine. He becomes suddenly more agitated stands up, and lunges for the physician. He is pushed into the room by security, the door is closed and locked.

Violent patients

Epidemiology

- survey of 127 teaching hospitals:
- 80% report at least one staff injury in the past 5 years
- 43% report physical attacks at least once a month
- 23% noted weapons displayed to staff at least once a month
- hospital assaults increased 46% between 1987-89
- 53% of all hospital assaults occur in the ED
- average cost of an assault in the emergency department was about \$5,000
- patients are perpetrators 77% of the time, visitors 23%

Predicting violence

- recognize the prodromes of violence; begins with anxiety, then defensiveness, then physical aggression
- in general clinicians' ability to predict violence is no greater than chance alone
- increased accuracy in study using features of past violence, thought disorder and drug use, but used to predict outpatient violence after discharge
- some conditions have a high association:
 - intoxication
 - withdrawal
 - organic mental disorders
 - head injury

seizures
functional; schizophrenia, affective, antisocial, borderline,
paranoia, adjustment

Protection from violence

- deterrence; signs stating weapons not permitted, visible security, metal detectors, secure single public entrance
- triage to an appropriate assessment room; sparse, solid walls, lockable, visible, exits clear of obstruction, equipment free, panic button
- never underestimate the potential for violence
- ACEP has summarized the hospital responsibilities to ensure the security of the ED environment in a policy statement:
 1. provide adequate security personnel, physical barriers, surveillance equipment, and other security systems
 2. coordinate these security systems with local law enforcement agencies
 3. develop written emergency department protocols for violent situations occurring in the ED
 4. educate staff on preventing, recognizing, and dealing with potentially violent situations

Approach to unrestrained patient:

- immediately assess safety, consider restraint early
- show of force
- maintain open exit for patient and physician
- distance of 6-8 feet
- allow patient to ventilate
- therapeutic alliance; non-judgmental, peace-offering
- submissive posture, avoid eye contact
- leave, consider restraint if any destabilization

Acute Psychosis

Identifying organic causes:

- history: sudden onset, >40 years old, fluctuating course, confusion, headaches, LOC, neuro symptoms, speech difficulties
- physical: abnormal vital signs, disorientation, neurological deficits

- mental status: visual hallucinations, global impairment of attention and cognitive function, delusions are disorganized, affect is labile, incoherent speech

Organic causes which may mimic behavioral disorders:

- CNS infection
- intoxication or withdrawal
- hypoglycemia
- encephalopathy
- hypoxia
- head injury, CNS bleed
- poisoning
- seizure

Medications: Antipsychotics

Atypical agents

Clozapine (clozaril)

- virtual absence of extra-pyramidal side effects, can cause NMS
- causes agranulocytosis in 1-2% of patients
- pharmacologically similar to benzodiazepines
- associated with a withdrawal state, respiratory depression

Olanzapine (zyprexa)

- similar to clozapine except no effect on white blood cells

Respirodone, Quetiapine (seroquel)

- much higher serotonin antagonism, lower dopamine antagonism
- relatively low incidence of EPS

Side effects

- dopamine receptor blockade leads to extrapyramidal symptoms, more common in high-potency neuroleptics
- EPS: acute dystonic reactions (severe muscle spasms, oculogyric crisis, rarely laryngospasm), akathisia, Parkinson's syndrome
- Treat with diphenhydramine 50 mg IV or benztropine 1 to 2 mg IV
- anticholinergic and alpha blockade can occur, more common in low-potency neuroleptics
- neuroleptic malignant syndrome rare, idiosyncratic, life-threatening reaction

Case 2 continued:

The patient is 4-point restrained by 5 security personnel, with one person controlling the head, all using face shields and gloves. The patient cooperates with the restraint, but once restrained continues to yell and thrash on the bed. Rapid tranquilization is performed using 5 mg of droperidol and 2 mg of ativan to ensure safety and allow

physical examination and studies.

Patient restraint

- includes chemical restraint, physical restraint, and seclusion
- considered when patient is a danger to self or others by virtue of a medical or psychiatric condition
- used to prevent harm, allow for examination of the violent patient
- when used appropriately restraints are more humane than allowing self-harm or harm others

Physical restraints

Principles of patient restraint:

1. should be individualized and afford as much dignity as possible
2. should be humanely and professionally administered
3. protocols to ensure patient safety should be developed
4. carefully document reasons for and means of restraint and periodic assessment
5. should be the least restrictive necessary
6. should conform to applicable laws, rules, regulations and accreditation standards

Adapted from ACEP Policy, Use of Patient Restraint, approved January, 1996.

Guidelines for the use of restraints:

- at least 4-5 people
- leather restraints are the safest and surest
- explain why to the patient, do not negotiate
- emphasize the therapeutic reasons, not punitively or as a threat
- allow the opportunity for cooperation
- start with 4-point restraint, one arm above and one below
- undress, remove all personal objects
- begin verbal intervention or rapid tranquilization
- never leave only one limb in restraint
- document indications, frequent patient rechecks
- reassess need at least every 2 hours

Chemical restraints

- preferred method of restraint by physicians since considered least restrictive and potentially therapeutic
- may be considered a greater infringement of rights than physical restraints because of alterations in a person's thoughts, expressions and motor activity, potential for long term effects

- dual purpose of control and therapeutic intervention

Medications: Rapid tranquilization

- neuroleptic agents or benzodiazepines or combination of both
- given every 30 minutes until desired effect is reached
- usually haldol or droperidol 5 mg IV or IM
- droperidol is more rapid in onset and has a shorter half-life
- must be aware of side-effects, particularly dystonic reactions, rarely neuroleptic malignant syndrome
- may consider addition of benadryl for sedation prevention of dystonia

Legal considerations: Involuntary commitment

Emergency psychiatric care and malpractice cases

- the number of malpractice cases involving psychiatric care in an emergency department is small
- in one review of 694 cases of emergency care, none involved psychiatric conditions
- in 262 closed claims against Massachusetts ED physicians, 4 involved psychiatric care (specifically, the release of suicidal or homicidal patients)
- these claims had the highest average indemnity

Involuntary commitment

- subject of continued legal and ethical debate
- deprives a patient of their constitutional right of liberty
- physical restraint under other conditions would constitute assault and battery, false imprisonment and an infringement of constitutional rights
- all 50 states have statutes requiring physicians to involuntarily detain a patient if the patient is judged to be dangerous to self or others

The legal conundrum:

- conflict between personal freedoms and societal need to protect from harm
- several malpractice cases where the patient left/escaped the ED and died by suicide or impaired judgment
- although the conflict was recognized, if there was evidence of possible incompetence and threat to self or others the cases often went against the physician

- there have also been cases brought against physicians for violation of personal freedoms, although less frequently
- in general, the cases were judged on the reasonableness of physician's actions and upheld the need for involuntary commitment

Physical restraints

- "restraints justified to protect others or self in the judgment of the health professional", Supreme Court decision, 1982, Youngberg v. Romero
- still must ensure restraint is not negligently performed, several inpatient cases of death/suicide while restrained and unsupervised (usually pose belt)

Chemical restraint

- need to distinguish between the dual purposes of the medication: control (involuntary commitment) versus treatment (substitute judgment in an incompetent patient)

Summary

- err on the side of safety, patient care and what is reasonable
- establish protocols and guidelines
- document well
- in general more cases are lodged against physicians for negligent disposition of a harmful patient than false imprisonment or assault and battery

Case 3:

A 78 year old male with mild dementia presents to the emergency department with acute delirium, agitation, visual hallucinations and fever. He has a low grade temp but no source of infection is found. You decide to admit him however, when you call his HMO, they suggest transfer to their psychiatric hospital.

Case 4:

A 35 year old, intoxicated male presents to the emergency department on a Saturday night requesting to see psychiatry. He has a long history of drug and alcohol abuse but wants help with what has become a hopeless situation. He explains to the triage nurse that he isn't sure he can go on living this way. When his managed care provider is called from registration, they deny approval for this visit suggesting he come to the crisis clinic next week.

Managed mental health care

Trends in emergency psychiatry:

- 1960's there was a push for deinstitutionalization
- facilitated by the advent of psychotropic medications
- 1980's "boom" in private psychiatric admissions, particularly in adolescents (4-fold increase between 1980-86)
- over the past 20 years the number of public psychiatric beds has dropped from 95% of the total (public plus private) to 50%
- 1990's fee for service replaced by managed care organizations
- length of stay decreased from 30-40 days to 10
- focus changed to crisis care and rapid discharge

Consequences of managed mental health care

- 80% of admissions to private facilities require preauthorization
- actively discourage enrollment of persons with serious and chronic mental health disturbances
- Medicaid populations with mental illness placed into MCOs
- little is known about effect on access, quality and outcomes

Impact on patients:

homeless

- approximately 40% of homeless people have a mental illness
- 100,000 low rent houses are lost year
- multiple agencies to assist; lack coordination, access difficult, repetitive
- few studies but appear to have decreased utilization of resources when in MCOs
- leads to increased demands on emergency services

dual diagnosis

- many psychiatric hospitals will not accept psychiatric patients active abusing substances
- many detoxification centers are reluctant to admit patients with psychiatric problems

Impact on Psychiatrists:

- limitations on outpatient visits, devaluation of psychotherapy
- replacement with allied health workers; social workers, psychologists
- therapies entering the realm of the primary care doctor - prozac nation

Impact on the emergency department:

- increased use of the ED by psychiatric patients for psychiatric and medical complaints: visits more than doubled between '71 to '84
- development of psychiatric emergency services programs, 10-fold increase in past 20 years
- less resources to access, increased ED stays, placement issues

Psychiatric patients and MCO's: Authorization and transfers

COBRA / EMTALA

- 1986 federal anti-dumping legislation to protect uninsured patients from being denied emergency care or being inappropriately transferred, mandated emergency care regardless of ability to pay
- mandated medical screening exam (MSE) for all patients who present to the ED
- 1994 "interim final regulations" for COBRA/EMTALA attempted to clarify some definitions
- psychiatric disturbances and substance abuse problems were included within the scope of an "emergency medical condition" as "...a behavioral condition placing the health of such person or others in serious jeopardy"
- managed care gate-keeping and liability was not addressed in this recent clarification

Potential responses to your authorization request:

- MCO approves further care at your facility
- arrange for an MCO physician to assume care on site
- request transfer to MCO facility
- further care denied

Refusal of care:

- you are required to perform a MSE
- denial of authorization only denies payment for ED services, not access to evaluation and stabilizing treatment
- if you feel the patient is unsafe for transport or discharge, request the MCO to take responsibility for the patient at the site (some states have legislation which requires this)
- in the end, do what is right for the patient
- if care unauthorized, explain to the patient that access to emergency services is not being refused, just not paid for by MCO

In the courtroom:

Wilson v. Blue Cross of Southern California

- patient was admitted for suicidal ideation
- request for longer stay denied
- patient committed suicide shortly after discharge
- *“not to approve further hospitalization was a substantial factor in bringing about the decedents demise”*
- case settled out of court
- made responsibility a shared duty

Safety of refusal:

- 1/3 of patients presenting with psychiatric emergencies have suicidal or homicidal ideation or both
- 33-40% never see a MCO physician in follow-up
- likely to be less compliance in psychiatric patients
- unclear what the MSE consists of, but needs to be more than “eyeballing”
- at minimum, MSE should assess competency, risk to self and risk to others
- difficult to address these issues without privacy and some time to develop a rapport

Transfers

The transferring physician must ensure:

- that the receiving hospital has adequate resources to care for the patient
- the medical benefits of transfer outweigh the risks

Transfer arrangements should include:

- written transfer protocols
- accepted guidelines
- interfacility agreements (transfer and return)

Medical v. functional: the financial debate

- many MCO's contract with a mental health “carve-out” programs
- “dumping” of medically unstable patients to a psychiatric facility by the MCO has been described
- disputes over payment between the MCO and the mental health “carve-out” program finds the patients caught in the middle of internal cost-shifting
- the EP must ensure admission to the appropriate service based on patient needs and safety

Ethical issues:

- compromising patient confidentiality and patient-physician relationship by involving third-party reviewers
 - enrollees may have to be labeled as mentally ill in order to qualify for mental health care
 - many programs are tied to work-site based programs increasing the risk that employees will learn of mental illness or substance abuse
-

Case 3:

A 41 year old woman presents to the emergency department complaining of chest pain. She describes the sudden onset of constant, diffuse chest tightness, exacerbated by deep inspiration. Although not short of breath she describes a choking sensation as though she can't get enough air. Associated symptoms include palpitations, lightheadedness, nausea, tingling and parasthesias of the hands. Her chest pain has resolved, however she states she feels as though she "is going to die".

Physical exam is completely normal. She is anxious, makes poor eye contact and appears frustrated. CXR, EKG are normal. Upon reviewing her medical record she has been to the ED 7 times in the past year. 8 months ago you referred her to a cardiologist for palpitations. Multiple visits and investigations, including a cardiac catheterization were all normal. In fact, this episode occurred while on her way to the GI clinic for her irritable bowel disease.

Panic Disorder

Epidemiology

- lifetime prevalence of 3.5%
- account for more ED visits than any other psychiatric illness, 60% will visit at least once a year
- symptoms are mainly physical; if undiagnosed can lead to years of unnecessary medical services
- twice as prevalent in females, peaks between 35 and 44 years

Definition:

Panic disorder is defined by four panic attacks in four weeks or one or more attacks followed by four weeks of continuous anticipatory anxiety.

Presentation of panic attacks:

- unexpected and rapid in onset
- peak within 10 minutes, lasts about 60 minutes
- no organic factor started or maintained the attack
- at least 4 of the following present in the first 10 minutes:

| | |
|-----------------------|---------------------------------|
| chest pain | lightheadedness |
| palpitations | derealization |
| sweating | fear of losing control or dying |
| trembling | tingling sensations |
| shortness of breath | chills or hot flushes |
| sensations of choking | parasthesias |
| nausea | |

Diagnosis:

- frequently made on the basis of exclusion of other causes
- in one large study 70% of patients diagnosed with panic disorders had been seen by 10 or more consultants prior to diagnosis
- most frequent consults were from cardiology, neurology and GI
- three categories have been described:
 1. symptoms consistent with panic disorder but new onset or not diagnosed; require some effort to exclude other causes depending on presentation
 2. known or, pattern consistent with, panic disorder and multiple prior negative investigations: avoid repeating the cycle of costly investigations, instead focus on the history and past pattern
 3. known panic disorder but symptoms different than usual; although patterns change, be vigilant for other disease process - use judgement
- differential diagnosis is broad:
 - drugs - sympathomimetics, caffeine, anticholinergics
 - drug withdrawal - alcohol, benzo's
 - endocrine - hyperthyroid, hypoglycemia, pheo
 - cardiac - ischemia, dysrhythmias, mitral valve prolapse
 - respiratory - PE, COPD, hypoxia
 - neurologic - vertigo
- although panic disorder is often delayed in diagnosis, it may also be overdiagnosed in some populations - in a study of 107 patients with proven PSVT 2/3's met the criteria for panic attacks and 50%

had symptoms attributed to anxiety/panic prior to diagnosis, especially if they were women

Etiology:

- appears to be a combination of behavioral and biological causes
- some genetic predisposition
- dysfunction or oversensitivity of some neurotransmitter systems (dopamine, serotonin, GABA), increased sensitivity to elevated CO2 levels

Case 3 continued:

The patient is told that all the studies are normal and is given an anxiolytic in the ED. She states that her symptoms have resolved but is concerned that this will happen again. After further reassurance she is discharged to the GI clinic and an appointment with her primary doctor is arranged for next week. 30 minutes later the nurse informs you that she refuses to leave. She wants to be admitted and have this sorted out before she goes.

Associated disorders:

- alcoholism and substance abuse (self-medication)
- sleep and eating disorders
- depression and generalized anxiety
- mitral valve prolapse and cardiac disease
- suicide in about 20%, higher than any other psychiatric disorder

Natural course; the 6 stages of panic disorder:

1. symptoms but do not meet criteria
2. meet the definition of panic disorder
3. hypochondriasis
4. agoraphobia
5. housebound, severe phobic avoidance
6. secondary depression and progressive disability

Treatment:

- address potential other causes if necessary (ex. event monitor for palpitations)
- look for associated disorders - alcoholism, depression etc.
- investigate the risk for suicidality
- one study showed only 14% were prescribed anxiolytics and 0% referred to a psychiatrist
- emergency physicians refer to psychiatry for this disorder less than other psychiatric illnesses, despite its higher prevalence
- tendency to focus on the somatic complaint, reluctant to suggest

- to patient that there may be a psychiatric component
- one ED study showed better outcome in patients instructed on the disorder and how to confront the precipitant versus reassurance alone
 - patients identified and treated early on (stage 1&2) are less likely to progress
 - it is important to contact the primary care doctor or psychiatrist to ensure follow up and discharge on a short course of benzodiazepines, even while other causes are being ruled out
 - antidepressants should be started by or in consultation with the patients psychiatrist or primary caregiver

Case 3 continued:

After further discussion, the patient describes a fear of going home. She lives alone and in fact rarely leaves the home except for medical appointments. Her partner left her 6 months ago because of her "medical problems" and has been unable to work for over a year. She admits to extreme frustration, hopelessness, insomnia and recently suicidal ideation. Although she has no plan she mentions she keeps a gun for safety.

Suicide

Epidemiology

- 8th leading cause of death in U.S., 2nd in persons under age 24
- 30,000/year, about 1.2/10,000 Americans
- ratio of attempted suicides to completed suicides is 40:1
- 2% have thought about it, 1% attempted

Risk factors and predictors

Factors suggestive of high risk:

| | |
|------------------|---|
| demographics: | male, >45 years old, unmarried, unemployed |
| medical: | chronic illness, alcoholism, drug abuse |
| psychiatric: | severe depression, panic disorder, psychosis, hopelessness, self-blame |
| suicide attempt: | frequent and prolonged ideation, multiple attempts, planned, lethality, rescue unlikely |
| resources: | isolated, poor rapport, poor insight, unconcerned family, uncooperative |

Modified SAD PERSONS Scale:

| | |
|------------------|--------------|
| <u>mneumonic</u> | <u>score</u> |
|------------------|--------------|

| | | |
|---|----------------------------------|---|
| S | Sex - male | 1 |
| A | Age- <19 or >45 | 1 |
| D | Depression or hopelessness | 2 |
| P | Past attempts or psych care | 1 |
| E | Excessive alcohol/drug use | 1 |
| R | Rational thinking loss/psychosis | 2 |
| S | Separated, widowed or divorced | 1 |
| O | Organized or serious attempt | 2 |
| N | No social supports | 1 |
| S | Stated future intent | 2 |

Suggested that a score of 6 or greater requires psychiatric evaluation, probable hospitalization

adapted from: Hockberger RS, Rothstein RJ. Assessment of suicidal intention by nonpsychiatrists using the SAD PERSONS score. J Emerg Med. 1988; 99:6.

Predictors:

- two large prospective studies followed 4,880 and 1,906 patients for several years
- both concluded that suicide is not currently predictable at the individual level
- the difference in male:female (3:1) may be mainly attributed to alcohol or drug abuse and gun ownership, not gender

Treatment

Stabilization

- all suicide behaviors should be taken seriously
- treat any medical emergency
- prevent further self-harm (weapon removal, isolation, restraint)
- sympathetic listening, manage one's own feelings and reactions
- be aware that emergency personnel are generally unsympathetic to suicide attempt patients and these feelings may affect care or patient compliance
- safest policy is to have a psychiatrist evaluate all potentially suicidal patients, however assessment can be made by an emergency physician

Medications

- serotonergic antidepressants do not appear to increase suicide, may in fact be protective, and are safer in overdose than TCA's or MAOI's
- antidepressants are usually not initiated by the emergency physician

Disposition

- high risk with strong, immediate intent requires psychiatric

hospitalization

- moderate risk patients with a positive response to initial intervention and with good social supports, may be discharged after psychiatric consultation; access to follow-up and an understanding and agreement with the plan is required
- psychiatric patients keep only 36% to 67% of scheduled appointments after an emergency visit
- "no harm contracts" are controversial

Legal considerations: The "No Harm Contract"

- verbal or written agreement in which the suicidal patient is asked to agree not to harm or kill himself or herself for a set period of time
- based on a survey of 31 therapists in 1973 where their experience with the technique was described (no statistics were done because of incomplete information)
- concept became established in literature with no empirical base
- may be beneficial in creating therapeutic alliance and outlining a treatment plan
- may falsely reassure the physician without lowering suicide risk
- no harm "contracts" **are not legally binding**
- may afford little protection in a suicide malpractice suit

Case 4a:

A 27 year old woman presents to the emergency department with the complaint of pelvic pain. Although clearly not an acute problem the pain is worse today than ever before. She expresses frustration at the inability of numerous previous investigators to solve this problem. Despite initial misgivings about any immediate solution to the illness, the physician is impressed by her remarkable cooperativeness and faith in his ability to solve her dilemma. Seduced by flattery, he begins to believe that perhaps he is the "only doctor that understands her".

He soon becomes the only doctor who can answer her multiple demands. With each normal investigation, the patient's need for reassurance and explanation multiplies. At the end of what has become an interminable shift, the exhausted physician arranges disposition for his reluctant, rejected patient. However, she instead returns on his next shift, too sick with her new, upper abdominal pain

to make her gynecology outpatient appointment.

The Difficult Patient

Defining the difficult patient

- indirect reference to the difficult patient found throughout the medical literature; the “problem patient”, the “disruptive medical patient”, the “unwanted patient”, and the “hateful patient”
- the difficult patient can be best described **as the patient that through their maladaptive behaviour and impaired patient-physician relationship causes negative reactions in the physician towards the patient**
- represents a very heterogenous group
- personality disorders, because of their rigid, maladaptive personality traits, commonly present as a difficult patient
- the substance abuser, the hostile patient, the malingerer and the emergency department repeater represent other common examples

The pathology of the impaired patient-physician relationship

- the failed patient-physician relationship is pathognomonic for the difficult patient
- several factors contribute to these failures:

Physician factors

- impaired communication
- insufficient patient education
- lack of specific training to develop the interpersonal skills required in the ED
- using preconceived stereotypes: the “truly sick” patient-type vs. the “difficult” patient
- personal biases and prejudices

Emergency department factors

- an environment plagued with distractions and frequent interruptions
- a pervasive sense of urgency and strict time constraints
- patients’ lack of choice regarding their physician or facility
- a single, brief opportunity to develop rapport

Complications of impaired patient-physician relationships

- risks to the patient; failure to identify and resolve the patients problem, missed medical diagnosis, premature discharge and inappropriate discharge
- negative impact on the staff; splitting, frustration, a sense of failure and defeat, burnout, litigation, the development of

nonconstructive stereotypes and unrecognized prejudices

Negative reactions: making them work for you

- by definition the physician's reactions and actions are influenced by the difficult or hateful patient
- identifying your negative reactions allows this otherwise unpleasant experience to serve a diagnostic and therapeutic role

Identification of negative reactions

- personalization
- arbitrary inferences
- the GOMER response
- rescue fantasies
- prejudice

Managing negative reactions

- recognition of negative reactions
- know your prejudices
- use your negative reactions as diagnostic data
- view the patients behavior as a symptom
- replace with a more rational response
- discuss the case with a coworker
- anticipate a realistic outcome

Diagnosis of the difficult patient

- labelling the difficult patient with terms such as "gomer" only contribute to the pathologic cycle of impaired patient-physician relationship
- alternate method for classification of the difficult patient has been proposed (Groves)
- based on the difficult patients' behavioral presentation and the negative reactions they precipitate:

1) Dependent clingers:

- the more care they receive, the more their needs multiply
- physician experiences frustration, exhaustion and failure
- a natural desire to discharge or refer the patient occurs
- patient feels rejected, returns on multiple visits to begin the same vicious cycle with the next victim
- dependent and histrionic personality disorders, malingerers and chronic psychiatric patients often present this way

Case 4b:

Groves' provides the example of the lawyer who in his refusal to

accept his illness, roamed from doctor to doctor demanding repeated tests and opinions, while threatening to sue the previous doctor who had tried to help him.

2) Entitled demanders

- employ intimidation, hostility and threats to attain their unreasonable excessive demands
- they are repulsive in their sense of superiority and deservedness
- the physician experiences the natural responses of disgust, anger and antagonism
- there is an urge to counterattack or to just accept the patients' terms, even if it means potentially compromising their care
- seen in paranoid, obsessive-compulsive and narcissistic personality disorders as well as in the substance abuser and the "VIP"

Case 4c:

A 58 year old, disheveled male, well known to the ED presents to the emergency department with an "unintentional" overdose and an unfilled script in his pocket. He is demanding a new prescription although he is certain won't work any ways.

3) Manipulative help-rejecters

- are the antithesis of entitlement; they believe nothing will help
- history of multiple emergency visits and frequent noncompliance
- verbal cooperation is contradicted by negative behavior that is self-defeating, covert and manipulative
- creates feelings of anger, self-doubt and frustration in the doctor
- borderline personality disorders, sociopaths and "crocks" frequently fall into this behavioral category

Case 4d:

An alcoholic with liver failure and esophageal varices presents hypotensive, encephalopathic with a GI bleed. He continues to drink despite multiple social interventions and frequent life-threatening upper gastrointestinal hemorrhages. During this resuscitation, his recovery is measured by his increasing hostility and verbal abuse.

4) Self-destructive deniers

- a particularly difficult patient to treat, they do not seek help
- repeatedly come to the emergency department in a moribund state as a result of their neglectful and self-abusive behavior
- are persistent in their self destruction and resist all attempts to help them

- staff respond with disgust, anger, frustration and helplessness
- substance abusers, chronically suicidal patients frequently fall into this difficult behavioral category

Treatment strategies

- several strategies can be used to “treat” the imperiled patient-physician relationship
- their purpose is not always to create a “good relationship” as this may be an unrealistic objective
- these strategies may simplify the care of the difficult patient and minimize potential patient and physician “complications”
 - 1) teamwork
 - 2) structure
 - 3) point out impasses, share your reaction
 - 4) setting limits
 - 5) improved communication
 - 6) time out
 - 7) support
 - 8) physical and chemical restraint

Case 4a continued:

She returns for a third visit after a brief hiatus. The limitations and difficulty with addressing her obviously complex, yet chronic concerns on a Saturday morning are pointed out in a supportive manner. After evaluation, much reassurance and some limit setting a plan for outpatient evaluation is arranged with her primary doctor. Just prior to discharge she states that she would prefer not to see her doctor. She is upset with her doctor for discussing her recent diagnosis PID with her partner. In fact, she states she is so angry she has thought about going to her office and killing her for what she said.

Legal considerations: Duty to warn

- physicians are bound to medical confidentiality, ethically and legally
- the conflict arises when we are priviledge to information that may represent a threat to an identified third party
- in the case *Tarasoff v. The Regents of the University of California* it was upheld that a doctor can owe a duty to warn a third party when that third party is in danger due to the medical or

psychological condition of the patient

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