Behavioral Emergencies: Exams Bypassed in Aged

BY DIANA MAHONEY

NEW YORK — Geriatric patients presenting to the emergency department with behavioral emergencies are often referred to psychiatric services without having a basic medical work-up prior to transfer, according to the findings from a small retrospective.

"Despite the fact that it is well-known that many psychiatric emergencies in the geriatric population have an organic etiology, and the American College of Emergency Physicians [ACEP] policy recommends that these patients be evaluated for medical illness before being transferred for psychiatric care, the medical work-ups are frequently not happening," said Dr. Kathleen C. Diller, of Temple University Hospital in Philadelphia.

In a retrospective study conducted in an urban university-based psychiatric emergency setting, Dr. Diller and Dr. Ruth M. Lamdan of Temple University School of Medicine reviewed the charts of 105 patients aged 65 years and older who were seen in the university hospital's psychiatric emergency service between April 1, 2004, and March 31, 2007, and compared their clinical presentations, diagnoses, work-ups, and outcomes with those of 105 gender- and race-matched 18- to 64-year-old controls.

Compared with the controls, the geriatric patients were significantly more likely to present disoriented and on an involuntary commitment, to have significantly more medical diagnoses, to be on more nonpsychiatric medications, to present with psychosis or with cognitive impairments, and to be admitted to a psychiatric facility, Dr. Diller said in a poster presentation at the American Psychiatric Association's Institute on Psychiatric Services.

Despite these differences, "the elderly patients were not more likely to be seen in the medical emergency department prior to or after presenting to the psychiatric emergency service, nor were they more likely to receive a medical work-up in the emergency department."

Specifically, urinalysis was ordered for only 9.5% of the older group, and brain imaging was done in only 5.7% of them, Dr. Diller reported. "Documentation of complete cognitive evaluation was missing in 45.7% of the older adult examinations, and orientation evaluation was not done in 27.6% of them," she said.

The geriatric patients included in the sample were more likely to receive some element of a medical work-up in the psychiatric emergency services, "but these were not guided by chief complaint of physical examination finding," said Dr. Diller, who noted that ACEP recommends that medical evaluations be guided by patients' chief complaint.

Although limited by its retrospective design and by the possibility that older adults with significant medical comorbidities may have received a medical work-up in the emergency department and been admitted to medical facilities rather than referred to the psychiatric emergency service, the study findings suggest that many emergency clinicians were skipping even the most basic, inexpensive elements of the medical work-up, such as cognitive testing and urinalysis, Dr. Diller said.

Prospective comparisons are needed in order to make final recommendations for the emergency evaluation of the older adult who presents with psychiatric symptoms, but "specific protocols should be put in place to make sure all geriatric patients with psychiatric emergencies receive an adequate medical work-up," Dr. Diller stated.

Toward this end, she recommended that geriatric screening protocols should be incorporated into residency training programs and that residents be reminded to have a heightened index of suspicion for medical illness as the cause of psychiatric symptoms in elderly patients.

In addition, she noted, "residents must be able to screen for delirium in all clinical settings, and psychiatric residents must be able to perform a directed medical work-up based on patient history.

Both Dr. Diller and Dr. Lamdan reported having no financial conflicts of interest with respect to this research. ■

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Medical Professionalism Issues Linked to Axis I, II Disorders

BY JOYCE FRIEDEN

BALTIMORE — A significant number of medical residents who are referred for professionalism problems have Axis I or Axis II psychopathology.

Dr. Gabrielle S. Hobday, forensic psychiatry fellow at Emory University, Atlanta, and Dr. Glen O. Gabbard, professor of psychiatry at the Baylor College of Medicine, Houston, reviewed records of outpatient psychiatric evaluations of U.S. and Canadian physicians conducted by Dr. Gabbard from 1997 to 2009.

Extracting physicians who were in training at the time of referral, the researchers came up with 18 cases, which they presented in a poster at the annual meeting of the American Academy of Psychiatry and the Law.

Of the residents involved, 83% were male, and 72% were white. Their mean age was 34 years (range 26-47). Among the specialties involved, primary care—including family practice, internal medicine, and pediatrics—was the most common, at 55%.

The reasons residents were referred were grouped into four categories: sexual boundary violations (four residents), non–sexual boundary violations (three residents), disruptive/irresponsible behavior (nine residents), and clinical competence concerns (two residents). Eleven of the 18 subjects had had previous disciplinary measures, such as dismissal from a program or program probation; previous mental health treatment and/or evaluation; or medical board involvement.

Psychiatric diagnoses were common in this group, with 61% meeting criteria for personality disorders or significant personality traits, and 78% having been diagnosed with a non–substance abuse Axis I disorder. Another 16% were diagnosed with a substance abuse disorder, and 50% of the residents in the study had Axis I and II comorbidities.

Deciding whether to refer a physician-in-training for psychiatric help is not always easy, Dr. Hobday said in an interview. "Some people have been under the watchful eye of their program for a year, and things aren't getting any better. ... What do we do with this person who's been a resident for 4 years and only has 1 year left?"

Of the 18 trainees in the study, 12 were deemed fit for duty while undergoing concurrent treatment/rehabilitation. Psychiatric treatment, including psychotherapy and/or medication, was recommended in 15 cases.

"In this era of heightened concern about professionalism, great emphasis has been placed on education in medical school and . . . monitoring in residency," the authors noted. "However, we also have observed that education is not sufficient to address all of the underlying causes of misconduct."

The study did not involve outside funding. The authors said they had no conflicts of interest related to the study. ■

Some Speakers Continue to Ignore Disclosure of Conflicts of Interest

BY JOYCE FRIEDEN

Numerous speakers at medical meetings fail to disclose financial conflicts, despite explicit requirements for them to do so.

"Disclosures by physicians are largely self-reported, but there is reason to suspect that this may change in the near future," Dr. Kanu Okike of Brigham and Women's Hospital and Massachusetts General Hospital and colleagues wrote. "Legislation requiring all drug and device manufacturers to publicly disclose payments to physicians is currently pending in the U.S. Congress and has been met with widespread support."

They analyzed payments made to physicians in 2007 by five makers of total hip and knee prostheses that together account for nearly 95% of the market. Payment listings were found on each company's Web site and included a range of direct and indirect expenditures (N. Engl. J. Med. 2009;361:1466-74).

The authors compared the payments with conflict-of-interest disclosures made by physicians who either presented at or served as board or committee members at the 2008 annual meeting of the American Academy of Orthopaedic Surgeons (AAOS).

A total of 1,347 payments were made to 1,162 physicians during 2007. Overall, 166 physicians received payments from multiple companies, and 282 payments exceeded $100,000. About a quarter of the payments (344) were made to presenters or board or committee members at the AAOS meeting.

In 70% of the 299 cases that could be evaluated for topic relatedness, the payment was directly related to the topic of the meeting presentation. Overall disclosure rate for the payments was 71%, including 79% for directly related payments, 50% for indirectly related payments, and 49% for unrelated payments.

The researchers also surveyed 91 physicians who did not disclose payments; 36 physicians responded to the survey. Reasons for nondisclosure included the payment being unrelated to the presentation topic (39%) and misunderstanding the disclosure requirements (14%). In addition, 11% of respondents said the payment had been disclosed but was inaccurately printed in the program.

The authors noted that the 43 nondisclosed payments relating directly to the presentations totaled $4.3 million.

A limitation of the study included assessing payment relatedness by comparing the presentation topic with the specialty of the companies in question, which "could have underestimated the number of unrelated payments and, consequently, the overall rate of disclosure," they wrote.

As for their own disclosures, the authors noted that coauthors Dr. Mininder Kocher, Dr. Charles Mehlman, and Dr. Mohit Bhandari have received grants from or consulted for several medical device firms, including several of those mentioned in the study. No other conflicts of interest were reported. ■