What Does “Medical Clearance” for Psychiatry Really Mean?

Medical clearance refers to the medical evaluation of patients in the emergency department (ED) (or similar setting) whose symptoms appear to be psychiatric in origin. The objective is to determine whether serious underlying medical illness exists, which would render admission to a psychiatric facility unsafe or inappropriate (Zun, 2005). Patients are said to be medically clear in at least three situations (Weissberg, 1979):

- The patient has no medical illness.
- A medical illness is known to be present but is not thought to be the primary cause of the patient’s symptoms.
- It is thought that a medical illness caused the patient’s symptoms but medical treatment is no longer necessary.

DEFINITION—OR LACK THEREOF

Although the term sounds official and definite, controversy has surrounded medical clearance for more than 3 decades. A thorough search of the literature failed to reveal any information on the origins of the term (Weissberg, 1979). No criteria exist for what medical clearance truly consists of, what evaluation is required, or what the status of the medically cleared patient actually is. The process has been described as “imprecise, unstandardized, and commonly fraught with problems” (Zun, 2005, p. 37).

There may be considerable differences in perceptions of medical clearance between the medical referring source and the receiving psychiatric service. Many psychiatric units would like to require a standard approach with a history, examination, and a set of laboratory tests be completed before a patient is declared medically clear. Medical personnel, on the other hand, may feel that such an approach is unnecessary and wasteful of resources, arguing that only medically indicated procedures be performed.

OVERLOOKED PROBLEMS AND MISDIAGNOSIS

Medical problems may include a variety of psychiatric symptoms such as confusion, depression, anxiety, apathy, personality changes, delusions, hallucinations, psychosis, and mania. Patients with psychiatric symptoms do sometimes have problems that may be missed by inadequate medical evaluation, and this has been documented in a number of studies from the 1970s to the present. For example, in a study of 658 consecutive psychiatric outpatients receiving careful medical evaluations, researchers...
found an incidence of medical disorders productive of psychiatric symptoms in 9.1% of cases. Forty-six percent of these patients had medical illnesses previously unknown to either them or their physicians (Hall, Popkin, Devaul, Faillace, & Stickney, 1981). An investigation of 100 state hospital psychiatric patients admitted consecutively to a research ward and screened for physical illnesses revealed that 46% had an unrecognized medical illness that either caused or exacerbated their psychiatric symptoms (Hall, Gardner, Popkin, Lecann, & Stickney, 1981). Henneman, Mendoza, and Lewis (1994) found that 63% of 100 consecutive patients ages 16 to 65 with new psychiatric symptoms had an organic etiology for their symptoms, including 3 who had abnormal cerebrospinal fluid findings. In their study of 298 ED patients admitted to a psychiatric unit, Tintinalli, Peacock, and Wright (1994) found that 4% required acute medical intervention within 24 hours of admission.

The issue of misdiagnosis has continued to persist with time. Recent studies of patients both older and younger than 65 have shown that more than 2% of psychiatric admissions were due to an unrecognized medical problem (Hall, Popkin, Devaul, Burke, & Hart, 2010, in press). Common causes of misdiagnosis include lack of an appropriate mental status examination, inadequate physical examination, failure to obtain available medical history, not addressing abnormal vital signs, and failure to obtain indicated laboratory studies (Reeves, Pendarvis, & Kimble, 2000). The need for appropriate medical evaluation of patients with psychiatric symptoms would seem to be evident.

SCREENING PROCEDURES

On the other hand, evidence suggests that universal screening procedures are not necessarily warranted and may not be cost effective. An analysis of 12 studies that reported specific yields of various screening procedures found that medical history, physical examination, review of systems, and tests for orientation have relatively high yields—but routine laboratory investigations have low yields—for detecting active medical problems in patients with psychiatric symptoms (Gregory, Nihalani, & Rodriguez, 2004). Thus, medical evaluation of psychiatric patients could be argued to consist of obtaining a history, performing an appropriate physical and mental status examination, and completing appropriate testing when indicated (Zun, 2005). From this point of view, patients with a primary psychiatric complaint coupled with a documented past psychiatric history, negative physical findings, and stable vital signs who show no signs of current medical problems could be referred to psychiatric services without the use of ancillary testing in the ED (Korn, Currier, & Henderson, 2000). More extensive studies should be carried out in patients for whom risk factors are identified. Factors suggesting the presence of a medical, rather than a psychiatric, problem include no previous psychiatric history, extremely sudden onset, onset before age 12 or after age 40, disorientation, depressed level of consciousness, abnormal vital signs, focal neurological deficits, specific physical abnormalities, and visual or tactile hallucinations (Reeves et al., 2000).

MORE DESCRIPTION NEEDED

Thus, potential conflict and disagreement may exist between medical and psychiatric services regarding “medical clearance.” Regarding medical evaluations in emergency settings, the American Psychiatric Association’s (2006) Practice Guideline for the Psychiatric Evaluation of Adults, second edition, states:

such examinations usually are limited in scope and rarely are definitive.... On the basis of clinical judgment and the specific circumstances the psychiatrist may need to request or initiate further general medical evaluation to address diagnostic concerns that emerge from the psychiatric evaluation. (p. 11)

From the emergency medicine side it has been said that some may consider the issue of medical clearance “the bane of existence for emergency physicians everywhere who must transfer patients to a psychiatric facility” (Zun, 2005, p. 35). So what does it mean when we see the term “medical clearance”? Actually, very little. The meaning may vary widely among clinicians and is often somewhat subjective. There are no absolute definitions, and the term has a greater capacity to mislead than to inform (Weissberg, 1979); subsequent caregivers may erroneously believe a patient is indeed clear of all medical conditions (Korn et al., 2000). We agree with previous suggestions that the phrase medically clear is inaccurate and should be replaced by a thorough descriptive note documenting the history, physical examination, mental status, laboratory results, medical diagnoses, and recommendations for follow-up medical evaluation while on the psychiatry unit (Tintinalli et al., 1994). In that way, patients will be viewed in terms of their actual status rather than relying on an assumption based on an ambiguous designation. Unfortunately, medical clearance may be too deeply embedded
in the ED or psychiatry inpatient unit culture to be changed (Slade et al., 2007).

REFERENCES

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