On-Call Geriatric Psychiatry

Handbook of Principles and Practice

Ana Hategan
James A. Bourgeois
Calvin H. Hirsch
Editors

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We dedicate this book to the aging adults around the world who grow old along with us.

Foreword

An older man sits in the waiting room of a busy emergency department. He has refused to eat for 3 days, hardly speaks to family, and fainted at his home, prompting his family to bring him in for an evaluation. He saw his primary care physician 1 month prior who diagnosed "depression." She prescribed sertraline for him and scheduled an appointment to see him at 6 weeks for follow-up. "It will take that long to determine if the medication is working." The man took the medicine for a week then stopped because he did not think it was working. Therefore, in the ED sits this older man with his daughter for 3 h waiting to be seen. The daughter had no idea of where else she can turn.

When the on-call psychiatrist arrives, what does she do? Does the patient need hospitalization? Is another prescription in order? Are beds available if admission is required? Will the patient and family agree for him to be admitted? If not, is commitment appropriate? If outpatient treatment is the best next step, to whom does the on-call psychiatrist refer the patient? Where does the responsibility of the on-call psychiatrist end and another provider's begin, that is, how does the provider assure a safe clinical handover? If, as is often the case, a geriatric psychiatrist or even a psychiatrist is not available, who will make the diagnosis and provide the care needed? What must these providers know in order to provide adequate care? These questions must be answered and care provided within the context of the busy, fast-paced environment of an emergency department. The same issues arise for on-call psychiatry in a general hospital, on an inpatient psychiatric unit, not to mention in the outpatient setting.

The historical practice of psychiatry, at its best, was slow medicine, practiced by a physician who works in a setting that encourages time to listen and follow a patient closely.[1] On-call psychiatry is embedded in fast medicine, and our practice must be embedded within this context. Practitioners therefore can be thankful for this excellent book edited by Ana Hategan, James Bourgeois, and Calvin Hirsch which calls out this unique yet critical slice of psychiatric practice so often neglected. I am not aware of a book which addresses the specific needs of on-call psychiatry (though there are a number of books on emergency psychiatry – not quite the same). The

[1] Victoria Sweet. God's Hotel: A Doctor, a Hospital, and a Pilgrimage To the Heart of Medicine. New York, Riverhead Books, 2012

book is a hefty one, yet the authors and editors have provided many aids to permit the practitioner to find essential information quickly.

The first such aid is a series of clinical pearls. These highlighted paragraphs provide the reader the type of insights that a seasoned practitioner conveys to a student on rounds, historically one of the foundations for the training of physicians. At the end of each chapter, a list of key points can be found which provide a quick summary of the main points of the chapter. Clinical vignettes are sprinkled throughout the book, and these bring the real world of on-call psychiatry continually to the attention of the reader. We have neglected the value of the "case report" in our journals and textbooks in recent years in favor of empirical data. These case reports bring to life the world of the psychiatrist and other practitioners who finds themselves on call at night or over a weekend or during the midst of a busy clinical day.

Among the aids available, however, I would especially call to the reader's attention the tables and figures. For example, the tables in Chap. 12 provide a primer for much of what is needed when evaluating the side effects of psychotropic drugs and the ever central issue of drug-drug interactions that are so critical given the polypharmacy experienced by older adults. The reader could gain much by simply looking through these tables periodically as a method of keeping critical information necessary for competent practice ever before him.

No foreword can do justice to the wealth of useful and practical guidance in this book. Yet I want to focus on a few critical issues which I believe to be especially relevant yet undervalued by those who provide mental health care in on-call situations. The first, which is sprinkled throughout the book, is the importance of teamwork. Those who write texts can easily emphasize teamwork in theory, yet these writers provide numerous examples of how teamwork can be practiced in the service of patients during emergent situations.

In Chap. 2, the authors emphasize the importance of the physical exam. No on-call psychiatrist can assume that a thorough physical exam has been performed, especially in an emergency department or in an outpatient clinic. If the patient is agitated, unruly, or abusive, the physical is easily neglected. Not only must the on-call practitioner have the skills to perform the physical (and obtain necessary lab work), that practitioner must also have the skill to calm the patient so that a physical exam can be performed with consent. The need to approach the patient with dignity and a plea for cooperation is emphasized in Chap. 5. The authors call practitioners to an anti-oppressive approach (respect of the patient). In a fast-moving on-call situation where time is of the essence, it is so easy to be authoritative (and some emphatic decision-making is necessary). Yet an autocratic approach may not only undermine the immediate attempts to intervene, it may also reduce the chances that a patient and family will seek emergency help in the future, perhaps leading to tragic consequences because of delay in obtaining adequate care. First impressions are critical impressions, and the on-call psychiatrist is an exemplar of first impressions. In addition, such an approach is just the right thing to do.

Emergency departments are locations of risk for older adults. In Chap. 16, the major issue of boarding in the ED (keeping patients on hold for days and perhaps even weeks) is highlighted, and the risk for adverse consequences is clearly noted.

To the medical community at large, not to mention the public, this inhumane and ineffective way to manage psychiatric patients is a major public health challenge. Emergency departments are dangerous places for older adults with psychiatric disorders when patients are boarded, even though they may be lifesaving in an acute situation.

In Chap. 25, the authors focus upon suicide and violence. Though any practitioner working with older adults should be acutely aware of the high rates of suicides among white males, we tend to forget the possibility of violence in elders. Just recently I read of a person murdered in a long-term care facility by a roommate, probably due to agitation resulting from cognitive impairment. The authors are to be commended in recognizing this potential critical problem and providing guidance, a public health approach to guidance, that can be implemented. Though we cannot predict accurately when a violent act will occur any more than we can predict a heart attack, we can take steps to reduce the risk.

The psychiatric community should be thankful that this resource is now available and thankful that these thoughtful clinicians have devoted their time to providing guidance for practitioners who are "on call."

Durham, NC, USA Dan Blazer, MD, MPH, PhD

Preface

With the worldwide graying of the population, owing to lower birth rates (in many countries) combined with longer lifespan due to management of infectious diseases, diabetes mellitus, stroke, and heart and renal diseases, clinicians urgently need to enhance their skills in managing older, sicker patients, in whom complex age-related physiology and psychosocial needs interact with multiple comorbidities and their treatment. Added to this is the longer life expectancy of patients diagnosed with schizophrenia and bipolar disorder with modern psychiatric treatment, plus greater surveillance and interventions for neurocognitive disorders. Despite these trends, access to inpatient geriatric psychiatric beds remains tragically limited. All of this conspires to increase the likelihood that clinicians will encounter (while on call to cover various healthcare institutions) geriatric psychiatric urgencies and emergencies. Drawing on the current clinical literature in geriatric psychiatry and psychosomatic medicine, the chapter authors have endeavored to provide a current, pragmatic, and concise guide to the expedient clinical assessment and management of the various clinical problems encountered in on-call geriatric psychiatry.

The after-hours setting offers specific challenges, as consultants are expected to exhibit a high degree of competence and confidence in approaching complex clinical situations. In particular, medical trainees (resident physicians and medical students alike) and other mental health professionals may have limited experience in geriatric psychiatry. Due to the shortage of psychiatrists available to provide on-call consultation in many care delivery systems, on-call clinical urgencies in the management of psychiatric illness in geriatric patients are the province of many medical specialists, nurse practitioners, physician assistants, and other health professionals. As such, the editors hope that many clinicians will (we hope) find this volume useful. Similarly, we hope that this volume serves as a concise refresher for other psychiatrists (e.g., general adult psychiatrists, child and adolescent psychiatrists), who may primarily be office- or clinic-based, but may occasionally see geriatric patients in an on-call circumstance. All this is to make the geriatric psychiatry subspecialty more accessible and less daunting to clinicians who do not see geriatric and/or consultation-liaison cases that often but need to be able to function capably "when the time comes."

This handbook refers to the care provided to an older adult, or geriatric patient, and to evidence-based contemporary care strategies. It covers basic principles and practice tips for on-call psychiatric and general medical care of the geriatric

psychiatric patient in various institutional settings, where an on-call clinician may be required to provide care for conditions and in circumstances that differ from accustomed daily practice, approach the boundaries of clinical expertise, or invade the clinician's comfort zone. In particular, crisis and on-call interventions in care settings may require the psychiatry resident physician or the psychiatric consultant:

(i) To evaluate the psychiatric patients in the emergency department and if needed admit them to the inpatient psychiatric units
(ii) To respond to any urgent psychiatric consults called in by another inpatient medical service
(iii) To respond to any medical or psychiatric urgencies on the inpatient psychiatric units
(iv) To manage on-call psychiatric consultation requests at other care institutions, e.g., nursing facilities, rehabilitation units

An older adult is not just a person who is age 65 years or older. Socioeconomically challenged adults (including homeless and incarcerated persons), as well as those with chronic substance abuse, may physiologically age more rapidly than their age-matched, less disadvantaged counterparts in the community. An adult who is younger than age 65 can be a victim of elder mistreatment if the circumstances of abuse relate to dependence on others due to developmental or acquired physical or mental disability. This book also covers the utility of contemporary technology, such as telepsychiatry/telemedicine, which can overcome geographic and transportation barriers by making state-of-the-art geriatric psychiatric consultation available to clinicians and their patients at clinics remote from consulting psychiatrist. The medicolegal context for the practice of medicine is also ever changing. Decisions such as to allow natural death and advance directives, the use of restraint, and seclusion, among others, are complex and strictly regulated.

The editors were motivated to mobilize our many chapter authors to compose this concise on-call geriatric psychiatry handbook based on years of experience in geriatric psychiatry (AH), medical center-based psychosomatic medicine and emergency psychiatry (JAB), and geriatric internal medicine (CHH). *On-Call Geriatric Psychiatry*: *Handbook of Principles and Practice* compiles resources to help clinicians respond effectively to the types of calls they are likely to encounter regarding geriatric patients, details a pragmatic approach to diagnosing and managing psychiatric illness in these often patients, facilitates communicating with colleagues and patients' families, and helps clinicians avoid common pitfalls that arise from these calls. Finally, we are deeply grateful to our many chapter authors from various professional disciplines, who care for geriatric patients in a variety of institutional settings, and to our patients, who are our ultimate teachers and without whom this volume would not be possible.

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