



Improving the diagnosis of physical illness in patients with mental illness who present in Emergency Departments: Consensus study



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ABSTRACT

Objective: The aim of this study was to establish consensus among clinicians in order to produce recommendations to optimise the diagnosis of physical illness in patients with mental illness who present in Emergency Departments (EDs).

Method: A list of recommendations was derived from qualitative interviews conducted with 39 doctors and nurses working in EDs in four general hospitals in England. Using a modified nominal group technique, we then asked a selected group of 15 doctors and nurses to take part in a group discussion with two voting rounds in order to decide which recommendations are most beneficial and feasible.

Results: Five recommendations met the a priori criteria to be considered 'strongly supported'. These included: having a psychiatric liaison team staff available 24 hours a day in the vicinity of the ED; developing detailed guidelines regarding intoxicated patients and regarding parallel assessment of patients by both ED and psychiatric staff; and having regular meetings between representatives of both departments.

Conclusion: In addition to suggesting specific recommendations, the study stresses the advantages in increasing the accessibility of psychiatric staff in the ED but also identifies challenges regarding joint work and division of responsibilities between them and the ED acute team.

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Introduction

A growing number of studies in recent years have reported disparities in diagnosis and treatment of physical illness when comparing people with mental illness to the general population [1]. Inadequate or less thorough procedures when the patients had mental illness were reported in hospitalisation and pathology tests for diabetes [2,3], in coronary re-vascularisation procedures and in basic health assessments such as blood pressure monitoring [4–6] as well as in screening for cancer [7]. It has been suggested [8,9] that such disparities and their resulting delayed or wrong diagnosis might have contributed to the considerable shorter life expectancy and quicker deterioration of physical illnesses among people with mental illness compared to the general population [10–13].

One form of disparity in diagnosis towards people with mental illness is “diagnostic overshadowing” or the mis-attribution of physical symptoms to mental illness. There is evidence of a similar phenomenon suffered by people with learning disabilities [14–16], or by old people

[17,18]. There is also evidence of an opposite phenomenon whereby non-recognition of some types of mental illnesses is higher for people with physical complaints or pain [19] or for old people with medically unexplained physical symptoms [20]. There is some evidence of diagnostic overshadowing provided by users of mental health services [21–23]. However, until recently little research was conducted in order to investigate the context in which diagnostic overshadowing of people with mental illness occurs and the mechanisms leading to it. In addition, while various studies evaluated the effectiveness of psychiatric liaison services [24], very few investigated their role in reducing diagnostic overshadowing.

One of the first such studies [25] analysed interviews with clinicians in one London general hospital, and found that diagnostic overshadowing was commonly acknowledged as a significant phenomenon and identified eight barriers to diagnosis for people with mental illness presenting with a physical health problem in their setting. These belonged to three broad categories: problems in eliciting a history, problems in the ED setting, and problems related to labelling and stigma [25].

In order to gain a wider perspective and more generalisable data regarding diagnostic overshadowing, we conducted a larger scale study using qualitative interviews with doctors and nurses in the EDs, and also with psychiatric liaison teams, in four general hospitals in London

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[26]. The study had two stages. First we conducted the qualitative interviews, which we refer to as study-1.

Study-1 found that more than three quarters of the interviewees reported one or more incidents in which psychiatric disorder led to misdiagnosis, or delayed examination or treatment with a varied degree of seriousness and with a range of consequences. The two most severe cases reported in this context involved the death of patients who refused to be examined and staff failed to conduct any assessment of their mental capacity to refuse treatment. There were also five cases in which delayed diagnosis led to irreversible, long-term damage to the patients' health. There were reports of more frequent 'near misses', a total of eleven specific cases. A typical 'near miss' happened when the ED staff 'medically cleared' a patient and referred him to the psychiatric liaison staff for mental health assessment, whereupon the latter group insisted upon further physical examinations during which an organic problem was diagnosed. In other eight cases reported by interviewees no lasting damage was caused by the delayed diagnosis but the patient suffered considerable discomfort, such as having to go back and forth between the psychiatric ward and ED, sometimes more than once [26]. The study also found that the direct or immediate challenges for correct diagnosis are complex presentations, for example presentations that may look like episodes of mental illness because the patient is confused, disorientated or depressed, whereas in fact they are a result of organic cause; medically unexplained symptoms (MUS); and non-cooperation or challenging behaviour by patients. The main indirect or contextual factors were time pressures – in particular the four-hour discharge (from ED) targets, and stigmatising views held by some staff members [26].

Based on the analysis of the data collected in study-1, we derived a list of recommendations aimed at reducing diagnostic overshadowing and addressing other challenges involved in the diagnostic process of people with mental illness presenting in EDs. We then used a modified nominal group technique in order to maximise consensus among clinicians regarding the most feasible and beneficial recommendations from this list. The aim of this paper is to report and discuss the results of these two voting rounds of the modified nominal group technique. We explain the potential of each recommendation to optimise the diagnostic process, and analyse the reasons for variation in the level of support for each recommendation among the clinicians.

Materials and methods

The modified nominal group technique

We have used the modified nominal group technique, also known as the RAND Appropriateness Method (RAM). The RAM is one of several group consensus methods developed in recent decades to reach an agreement among experts on guidelines in clinical practice [27–29]. RAM integrates elements from the Delphi method and the Nominal Group Technique and consists of two stages. First, a panel of experts are asked to vote on a list of suggestions via mailed questionnaires. They are then invited to a meeting in which the results of the questionnaire are fed back to them and, after discussing their views, each expert is again asked to vote on the same list [27]. We asked our panel to vote on recommendations derived from an analysis of the qualitative interviews conducted as part of study-1.

Qualitative interviews (study 1)

The original group of interviewees was composed of doctors and nurses working in EDs and psychiatric liaison teams in four general hospitals in South London [26]. In order to collect data from a diverse group of staff that will enable us to depict a rich picture of views about diagnostic overshadowing in all the hospitals, we sought a purposive sample of participants from each ED and ten from each of the psychiatric liaison teams. We aimed to include all levels of experience and seniority and

both nurses and doctors in each team at each site and also diversity in terms of age, gender and ethnicity. In all, we have reached data saturation after interviewing 21 nurses and 18 doctors at various levels of experience and seniority. Interviews took place between October 2012 to October 2013, and each lasted about an hour. In addition to being asked about the scope and nature of diagnostic overshadowing [26], all participants were invited to suggest recommendations to optimise the diagnosis of people with mental illness who present with physical problems.

Deriving the recommendations

The interviews were fully transcribed verbatim. Thematic analysis was used to analyse the data. The transcriptions were coded by one researcher using NVivo software. The analysis was thematic and the following sub stages: (1) familiarization with the data and immersing in the data, including reading transcripts and notes and listening to the audio dialogue in order to extract main themes and ideas; (2) thematic framework development, identifying the key issues and concepts present in the data and creating a coding tree which is the organisation of set of headings in which people's views, experiences and behaviours can be organised in [26,30]. The coding tree was conducted both inductively, based on the data and deductively based on the research questions (3) indexing the data – sorting all the parts of the data that are about the same thing and belong together. The analysis identified 13 recommendations.

The voting panel

We approached 20 out of the 39 clinicians who were interviewed and invited them to take part in the consensus group consultation. The criteria for selecting this subsample were based on our intention to create a purposive sample of 15 participants, which is the recommended maximum number of RAM participants [28,29]. We aimed to recruit a group of clinicians from all the hospitals, whereby all professional groups are represented as well as a range of seniority. We also included in this sample all staff who, according to the interviews, had some impact on policy decision-making or implementation in their department.

Scoring

We asked the participants to give each recommendation a score with regard to two categories: how beneficial it would be in optimising the diagnostic process, and how feasible it would be to implement. Both categories had a Likert scoring scale of 1–9, and in each case 1 represented 'not at all' (i.e. not at all beneficial or not at all feasible) and 9 'highly' (i.e. highly beneficial or highly feasible). One recommendation, to allow ED staff access to computerised records of patients' mental health history, had a different scoring. For this recommendation, 6 different and specific categories of access were defined, whereby 6 was 'full access' and 0 'no access' (see Table 2 below). Regarding another question, about a one-hour training session, we did not ask about feasibility. Instead, the aim of this question was to rank the priorities of one-hour training sessions to be taught as part of the routine one-hour doctors' training sessions taking place several times a week in most EDs.

Criteria for recommendation

Following our criteria for the level of support, recommendations were set a priori at four levels, turning into three levels after the second round of voting (when levels 3 and 4 were merged into one category of 'Rejected'):

- A. 'Strongly supported recommendation' – In order to gain 'strongly supported' status, a recommendation had to gain at least a median

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