

320 seconds) compared with the control group (median 55 seconds; range 30 to 201 seconds) ($P < .001$). The absolute and relative effects were -95 seconds (95% CI -110 to 15 seconds) and 4.82 (95% CI 3.58 to 6.48). No difference was observed in number of attempts to successful arterial puncture for blood gas analysis, patient cooperation, or patient pain. We did not observe any immediate adverse events in either of the groups.

In accordance with our study findings, the routine use of ultrasonographically guided puncture of the radial artery for blood gas analysis does not seem to have a higher success rate compared with the conventional technique.

Christian B. Laursen, MD, PhD
Department of Respiratory Medicine
Odense University Hospital
Odense, Denmark

Rasmus Lydum Pedersen, MD
Annmarie Touborg Lassen, MD, PhD
Department of Emergency Medicine
Odense University Hospital
Odense, Denmark

<http://dx.doi.org/10.1016/j.annemergmed.2015.01.016>

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist and provided the following details: The study was performed without any specific funding. Dr. Laursen was funded by research grants from Odense University Hospital, Odense, Denmark, given to the Department of Respiratory Medicine at the same institution. Dr. Lassen was funded by an unrestricted grant from the philanthropically private fund the Tryk Foundation, given to the University of Southern Denmark.

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One More Reason to Ban “Medical Clearance” for Psychiatric Evaluation?

To the Editor:

The study by Pelaccia et al,¹ “How and When Do Expert Emergency Physicians Generate and Evaluate Diagnostic Hypotheses? A Qualitative Study Using Head-Mounted Video Cued-Recall Interviews,” identified that 25% of diagnostic hypotheses were generated before the physician saw the patient. With the exception of anxiety attack and alcohol poisoning, the remaining scenarios in this study were medical in nature, and the relatively straightforward psychiatric examples presented in this study’s scenarios had the highest self-reported degree of certainty.

What if they explored scenarios of patients presenting with psychiatric chief complaints that were referred for, or in systems that required a form of, “medical clearance”? As a psychiatrist working to improve behavioral health integration in a large, urban, academically affiliated emergency department (ED), I have spent many hours working with emergency physicians and listening to how they think about patients with psychiatric chief complaints. The cognitive decisionmaking process of intuitive reasoning described in this study may be altered by the evaluation context. There is evidence that unrecognized physical illness as a reason for psychiatric hospitalization is a problem.² My belief is that a cognitive shift occurs among experienced emergency physicians in the pre-examination phase while they are in a “medical clearance posture.” This shift can sometimes lead an otherwise highly skilled emergency physician to categorize a patient with a psychiatric complaint or disturbance by default as “low medical risk,” leading to a novice decision process characterized by the confirmation bias.³

Identifying a causal medical diagnosis in a patient with psychiatric symptoms and recognizing acute medical conditions that require urgent care should be the primary focus of ED evaluations, ideally with access to behavioral health expertise to facilitate clinical decisionmaking and to mitigate medicolegal risk.⁴ This study provides useful insights into how emergency physicians make decisions, and the method has the potential to identify strategies that enhance decisionmaking processes when physicians evaluate psychiatric chief complaints. The psychiatric cases in this study may not have been constructed to identify the effect of varied evaluation contexts, but a future study could help inform policy and practice.

Glenda Wrenn, MD, MSHP
 Satcher Health Leadership Institute
 Department of Psychiatry and Behavioral Sciences
 Morehouse School of Medicine
 Atlanta, GA

<http://dx.doi.org/10.1016/j.annemergmed.2015.01.022>

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The author has stated that no such relationships exist.

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In reply:

We thank Dr. Wrenn for her thoughtful comments on our findings and on the methods we used to explore clinical reasoning. The objective of our study was to identify the general process of reasoning involved in emergency medicine regardless of the nature of the cases. The only inclusion criterion in regard to the cases was the presence of a potential or actual vital emergency. Hence, the anxiety case was included in our study because the patient was primarily admitted to the emergency department (ED) with a complaint of chest pain.¹

The presence of a considerable number of patients tagged as “psychiatric” and who also experience somatic problems legitimizes the question raised by Dr. Wrenn.² The issue is to determine, from the clinical reasoning point of view, whether the initial identification of a patient as psychiatric can influence the decisionmaking process involved in admitting the patient or “medically clearing” him or her.

Our study was not designed to explore this question. However, several studies provide indications that this could very well be the case. Our findings point to the influence of information received before the encounter.¹ Other studies have similarly shown that the context in which the initial management of patients occurs considerably influences the decisionmaking process.³

Context should not be restricted to the setting of the encounter: specific patient characteristics should also be considered as elements of context.⁴ It appears that the intuitive component of decisionmaking is most prone to the influence of context.⁵ Factors such as the patient’s age, sex, body weight, and psychological status could therefore represent “distracting cues” that could lead to inappropriate decisions.⁵

The effect of these contextual factors on the decisionmaking process is directly related to the physician’s goals.³ This raises the question of the potential dangers of pursuing a single goal; for instance, medical clearance. Although it seems difficult if not futile to expect physicians to control the influence of the context on their reasoning process, especially when it is intuitive and hence occurs largely at a subconscious level, changing their goals could provide a more fruitful way to reduce the risk of inappropriate decisions for patients whose main complaint is psychiatric. We suggest that managing patients with psychiatric complaints at the ED should not rely solely on a highly restrictive diagnostic method (aiming at medically clearing them) but rather be based on a global diagnostic approach to avoid confirmation bias. This shift in reasoning may require better training of emergency physicians in the proper management of psychiatric patients.

Thierry Pelaccia, MD, PhD
 Centre for Training and Research in Health Sciences
 Education (CFR-PS)
 Faculty of Medicine
 University of Strasbourg
 Prehospital Emergency Care Service (SAMU 67)–Centre for
 Emergency Care Teaching (CESU 67)
 Strasbourg University Hospital
 Strasbourg, France

Jacques Tardif, PhD
 Department of Pedagogy
 Faculty of Education
 University of Sherbrooke
 Sherbrooke, Quebec, Canada

Emmanuel Tribby, PhD
 Faculty of Educational Sciences
 University of Strasbourg
 Strasbourg, France

Christine Ammirati, MD, PhD
 Department of Emergency Medicine
 Amiens University Hospital
 Amiens, France