

# HOSPITAL PHYSICIAN®

## PSYCHIATRY BOARD REVIEW MANUAL

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The *Hospital Physician Psychiatry Board Review Manual* is a study guide for residents and practicing physicians preparing for board examinations in psychiatry. Each quarterly manual reviews a topic essential to the current practice of psychiatry.

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## The Art of Consultation

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## The Art of Consultation

Jerome J. Schulte Jr, MD

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### INTRODUCTION

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Consultation psychiatry began in the 1930s when the need for assessment and treatment of medically ill general hospital patients with psychiatric symptoms was recognized. Prior to this time, inpatient psychiatric care was delivered in stand-alone state or private psychiatric hospitals. With the creation of general hospital inpatient psychiatric units, psychiatrists and other medical specialists began working together under one roof and consulting on each other's patients. Since that time, there has developed an extensive literature on psychosomatic medicine, which studies the role of emotions and psychology in the creation and perpetuation of medical illness.<sup>1</sup> Consultation psychiatrists use the biopsychosocial model as the basis of assessing and treating medically ill patients with psychiatric symptoms. This manual will review important information derived from the psychosomatic medicine literature and the field consultation psychiatry.

It is estimated that nearly one third of medical patients in general hospitals have psychiatric disorders.<sup>2-4</sup> That rate increases to two thirds among those patients who are high utilizers of health care services,<sup>5,6</sup> and the same statistics are seen in the outpatient primary care setting. Treating psychiatric disorders in these patient populations has the benefit of not only decreasing psychiatric morbidity but also decreasing length of hospital stay,<sup>7-11</sup> making utilization of outpatient services more efficient, and improving compliance with medical treatment. The opposite also seems to be true: untreated psychiatric syndromes in medically ill patients increase health care costs.<sup>12-14</sup> In light of these statistics, it should be noted that less than 10% of those in need of psychiatric consultation are identified.<sup>15,16</sup> The major diagnostic categories are delirium, dementia, and depression.<sup>5,6,17</sup>

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### GENERAL APPROACH TO THE CONSULTATION

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Consultations differ from inpatient and outpatient psychiatric assessment in that the main goal in consultation work is to answer the question posed by the physi-

cian requesting the consult, with secondary goals of providing a psychiatric diagnosis and treatment of the psychiatric condition. Often the question may be nebulous. The first rule of consultation psychiatry is to contact the physician requesting the consult to understand the reason for the consult and the expectations of the consultee. Expectations of the consultant by the consultee are listed in **Table 1**.<sup>18,19</sup>

In the process of speaking to the physician who requested the consult, valuable collateral history is often obtained. During this conversation, the consulting psychiatrist starts to formulate a biopsychosocial assessment of the patient and should listen not only to the facts of the case but also for the affect displayed by the physician requesting the consult. Listening to the physician's affect (which often mirrors the affect of the patient) helps to initiate the process of identifying patient defense mechanisms, such as regression, and helps to identify personality characteristics the patient may have, which contributes to assessment of Axis II disorders. Further collateral history is obtained by the consultant by speaking with nursing and other staff and by chart review. Then, with the background of collateral history, the patient should be interviewed.

### CONSULTATION STYLE AND PATIENT CONFIDENTIALITY

On meeting the patient, the consultant should introduce him/herself and inform the patient that the consultee has requested a psychiatric consultation. Inform the patient of the reason for the consultation. Often, and unfortunately, the consultee has not informed the patient of the consultation request. Whether or not the patient was informed of the consultation should be asked in the preconsultation conversation with the consultee. Most patients will accept psychiatric consultation, even if not forewarned, but some may become angry. It often helps to use a gentle approach toward the patient. Start by stating that the attending physician requested the consultation in an attempt to try to provide the best medical care possible to the patient, and that the patient's physician felt the patient's diagnostic concern was beyond his or her level of expertise and so requested that a specialist see the patient. It is important for the consulting psychiatrist to listen intently to the patient during the first few minutes of