Unspoken ethical challenges of many psychiatric consultation services

Andrés Jovel, MD

A psychiatric consultation service in an academic medical center usually is a robust and busy setting. In addition to expert faculty, the service is staffed by trainees (psychosomatic medicine fellows and psychiatry residents), nurse practitioners, and medical students. I have been drawn to this growing field, which is evolving hand in hand with advances in medical therapy (eg, new antineoplastic, antiretroviral, and anticonvulsant regimens) and surgical intervention (eg, heart, lung, and gut transplantation).

As a consultant, I have learned that we have an obligation to a dual clientele:

- **the patient**, through an established doctor–patient relationship
- **the primary team**, which requires our assistance or raises questions about management.

While working as a trainee in providing psychiatric consultative services, I have noted a number of ethical challenges that consultants face. Below are noteworthy examples.

Justice: Is less, more?

We live in an era of growing advocacy of the recognition, acceptance, and treatment of mental illness.[1] However, there does not appear to be enough psychiatric providers for the American population.[2] Regrettably, a timely psychiatric assessment is, for many, a unaffordable luxury; in some regions of the United States, the wait for an outpatient psychiatric appointment is longer than 6 months.[3]

When a patient is admitted to the hospital, admitting physicians often consider ordering a psychiatric consult if they suspect an underlying psychiatric disorder or if they would like an expert's opinion on some matter—such as (1) medications already prescribed for the patient as an outpatient and (2) a patient's decision-making capacity in complex situations—without reflecting on how much of a commodity this expert opinion is. (After all, in an ideal world, concerns about cost shouldn't factor in to what we offer our patients.)

Different practitioners have different thresholds for requesting a psychiatric consultation; no clear guidelines or recommendations exist as to how to "calibrate" one's self to be a good consultee. As psychiatrists, we rarely call for a cardiology consult just because a patient is hypertensive and takes a diuretic at home, or call in an orthopedic surgeon because a patient with a history of arthroplasty has knee pain today. Sometimes, however, it seems to me that our non-psychiatry colleagues don't think twice to ask for our services if their patients have a history of mental illness, even if it's well controlled.

There is no winning formula for calculating how many psychiatric providers and resources (represented by the clinical currencies of, respectively, full-time equivalents and relative value units) a consultation service

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Dr. Jovel is a Public Psychiatry Fellow, Columbia University Medical Center/New York State Psychiatric Institute, New York, New York. He was a Psychosomatic Medicine Fellow, Jackson Health System/University of Miami, Miami, Florida, when he wrote this article.

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should have, but efforts have been made to solve this mystery.[4] Some institutions track, with different methods and variable accuracy, the number of consults they provide annually; others wing it. Lack of accuracy and standardization means that the system is prone to sacrificing quality for quantity in the provision of services, and to provide services in an inconsistent manner (think: better quality on slower days).

Nonmaleficence: Good intentions…

Within the U.S. health care system, a consulting psychiatrist must diagnose a billable condition to be reimbursed for a consult. But what if a so-called soft consult is requested and, after the evaluation, a major mental disorder that warranted our time and expertise can't be identified?

That situation places the provider in an awkward position. Up-diagnosing might seem like a necessity to ensure reimbursement but, in a society that still stigmatizes mental illness, the health risks of charting a major mental disorder (and prescribing a vaguely warranted psychotropic) might outweigh the benefits for some patients, in the long run.

Coding systems can impact and complicate this scenario even more. We are required to comply with coding systems by providing as many predetermined historical and clinical details of any specific major mental disorder as we can document. As we become more detail-oriented, I wonder if we are losing touch with the reality of our patients' suffering and deviating from the human emotional experience, as we focus on complying with the health care system and maximizing hospital reimbursement.

Beneficence: The care you would want for your loved ones

For me, an attractive aspect of becoming a psychiatric consultant in the medical setting was to function as a mental health ambassador, so to speak. We often evaluate patients who have never seen a psychiatrist before (eg, when there are symptoms of acute stress disorder in a trauma patient or postoperative delirium in a patient who does not have a psychiatric history). On those occasions, we have the opportunity to make an effective, long-lasting intervention with our clinical encounter, accurate diagnosis, medication recommendations, and outpatient referrals.

Sometimes, the best follow-up plans and intentions are undone by uneven discharge coordination efforts and limited community resources. Some medical institutions have become better at tracking reasons for re-hospitalization and at making post-discharge telephone calls to support good transition to outpatient services. Often, it is necessary to call on nonprofit organizations and public institutions to provide referral and crisis services, but we can always do a better job at offering our patients a comprehensive mental health treatment plan, even from the consultation arena.

Clinical Point

Follow-up plans and best intentions are sometimes undone by uneven discharge coordination efforts and limited community resources

Autonomy: Who is in control?

Psychiatry provides varying levels of intervention for acutely mentally ill patients. Laws and criteria for involuntary commitment and the use of psychotropic medication under such circumstances vary from state to state.[5]

In the consultation-liaison setting, we often co-manage patients with a neuropsychiatric disorder that precludes them from participating fully in medical decisions. Other times, patients come to our attention involuntarily (eg, by way of medical admission) having a high level of premorbid autonomy: They make their own life decisions, choose not to engage in psychiatric treatment, administer their funds (when they have them), and so on.

Complex ethical situations can arise when (1) there is disagreement between physician and patient and (2) payment for care or insurance coverage plays a role in disposition plans or long-term placement. Public

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institutions might have a *modus operandi* that allows for extra room to deliberate and keep the treatment conversation going—more so than for-profit health centers, where financial forces can sway providers' judgment toward autonomy, regardless of what is best for the patient.

Summing up: Let's be Hippocratic psychiatrists

As many forces continue to influence the way we practice the art and science of medicine and psychiatry, it's important to pay close attention to ongoing challenges and utilize organized medicine to advocate for better ways of running an effective consultation service in an ethical manner. As a trainee and future psychosomatic medicine psychiatrist, I am committed to starting these conversations wherever I go.

We need novel ways to look at, question, understand, study, and review our clinical practice to effectively tackle these challenges as we continue advancing as a field.

Clinical Point

A complex ethical situation can arise when payment for care or insurance coverage plays a role in disposition plans

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